MAPOC Meeting

May 2024

CT Department of Social Services

Agenda

- Value-based contracting: Home and Community-Based Services (HCBS)
- Managed care

Value-Based Payment (VBP): Home and Community-Based Services (HCBS)

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 to return home at transitions of care.
Context / Rationale	Members report that healthcare 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. ↓ avoidable hospitalization 2. ↓ rate of discharge to nursing home 3. ↓ health inequities 4. ↑ number of members meeting their personal goals

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 (LTSS)
- 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
  - Health Information Exchange
  - Learning collaboratives
    - Racial equity
    - Person-centered care
    - Meaningful use of data

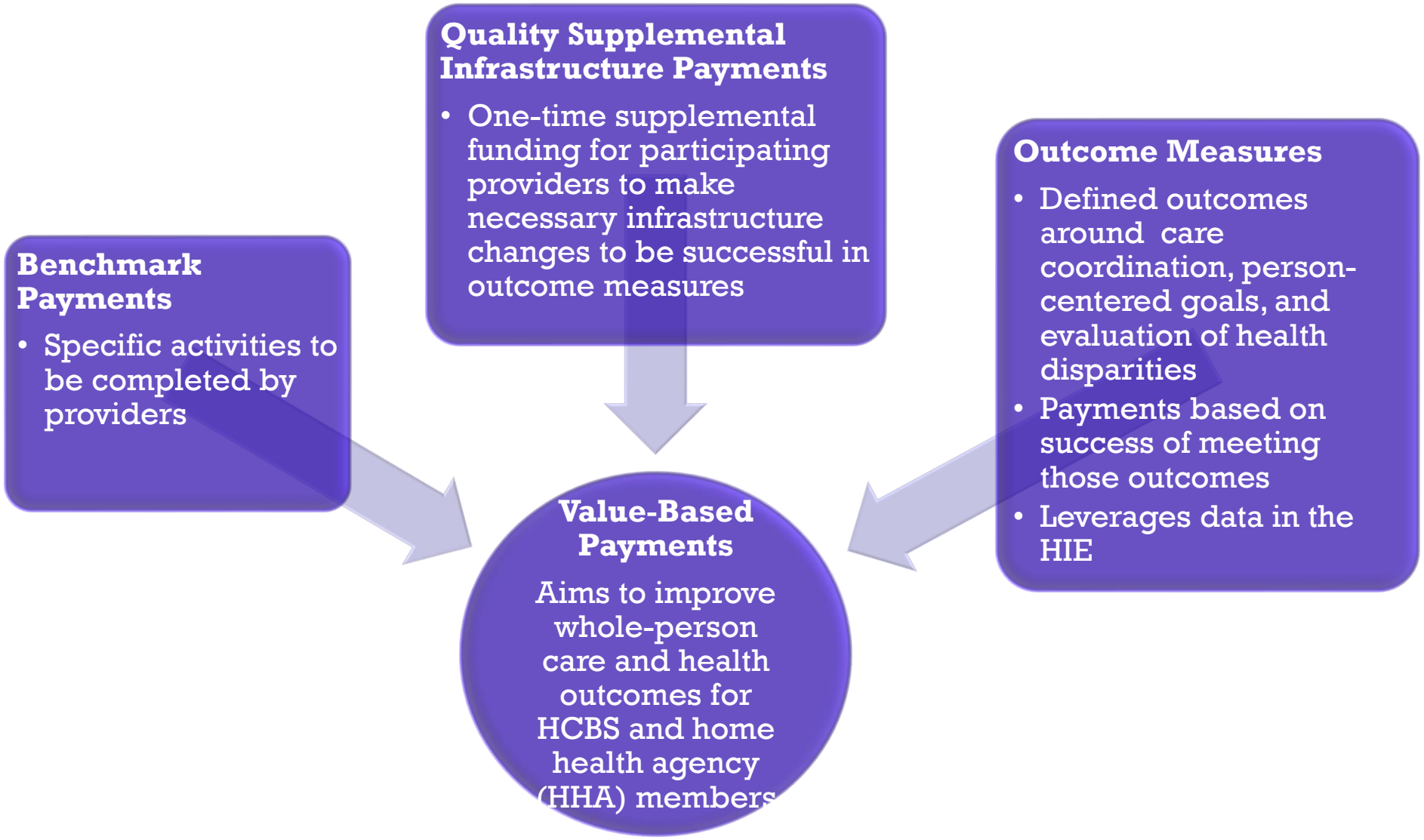
Community Options Partners for Design, Development and Implementation of Innovations

- 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 (HIE) – Connie
- National Committee for Quality Assurance (NCQA)
- Yale-New Haven Hospital Center for Outcomes Research and Evaluation (Yale CORE)

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 members' 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

Value-Based Payments – HCBS Providers – Overview



Value-Based Payment – HCBS Providers and Existing Research

CMS implemented the Home Health Value-Based Purchasing (HHVBP) Model under Medicare - January 2016 through December 2021

9 geographically diverse states randomly selected with mandatory participation by all home health agencies with the remaining 41 states used as comparison states

The HHVBP model provided financial incentives to home health agencies for improvements in quality of care and looked at **utilization**, **quality measures**, and **patient experience**

CMS wanted to "…*test the impact of providing financial incentives to home health agencies for improvements in quality of care….and how the financial incentives under the model influenced agency behavior, and, in turn, impacted health outcomes and Medicare spending*…" HHVBP Evaluation Final Report (cms.gov)

Value-Based Payment – HCBS Providers and Existing Research

1 The Research Shows HCBS Resulted in…

- Reductions in unplanned hospitalizations, nursing home use, and emergency department use (followed by inpatient admission)
- Modest Improvements in functional status
- Evidence of modest growth in health disparities

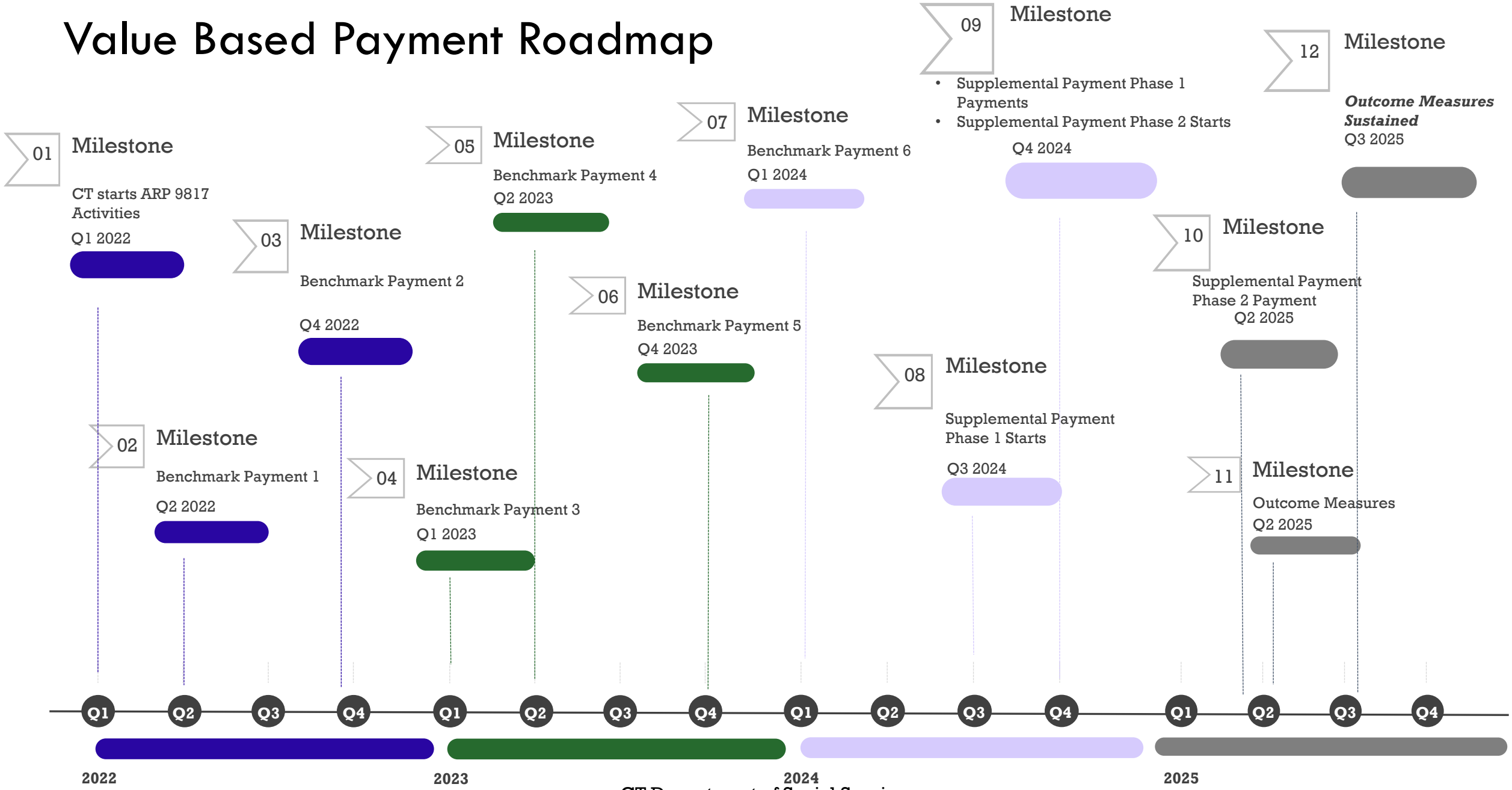
2 CMS Learned the Importance of…

1. Data analytics and monitoring: to support improvement and benchmarking activities, including adoption of electronic health records (EHRs) and use of predictive software
2. Staffing and Training
3. Clinical strategies, including timing of care, increasing communication with patients, and working with post-acute care providers

3 DSS Applying Lessons Learned by…

1. Incorporating Trainings and Learning Collaboratives in Benchmark Periods:
    1. Trauma Informed Care Racial Equity Training
    2. Person-Centered Planning
    3. Navigating and using data in the HIE Connie
2. Creating HCBS Portal and Program Tools in Connie
3. Establishing Person-Centered Goals with NCQA
4. Working with Yale CORE to establish measures to address health disparities

Value Based Payment Roadmap



Managed Care

"Ask" from OTG + process

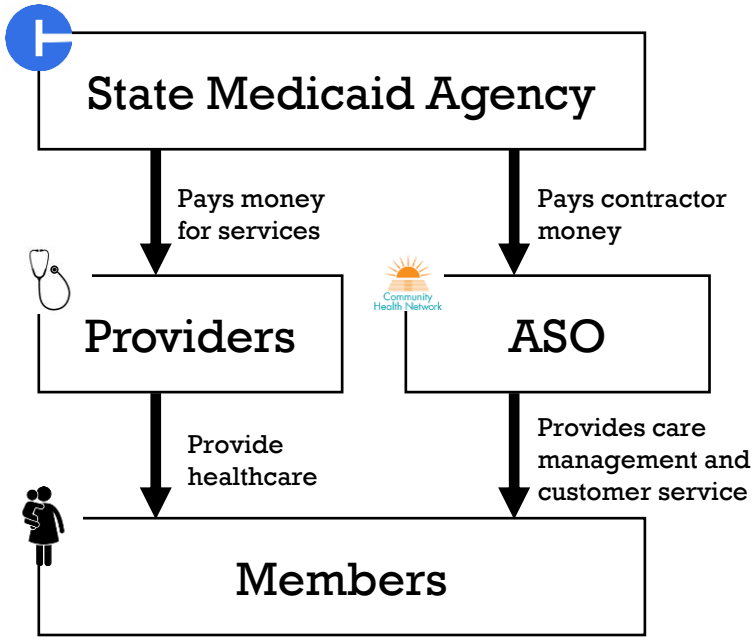
The "ask" from OTG	"*Explore* managed care, inclusive of the LTSS population. Gather enough information to make a data-driven recommendation"
Context	Connecticut is one of a small number of states with no managed care We are currently experiencing a Medicaid deficiency (but spending lower than peer states)
Our proposed process	1. Align on the criteria (*see later in this presentations*) 2. Think carefully about what populations and services to investigate further 3. Gather information needed to fill out criteria for each option, including getting quotes from managed care organizations 4. Make a data-driven recommendation

Agenda

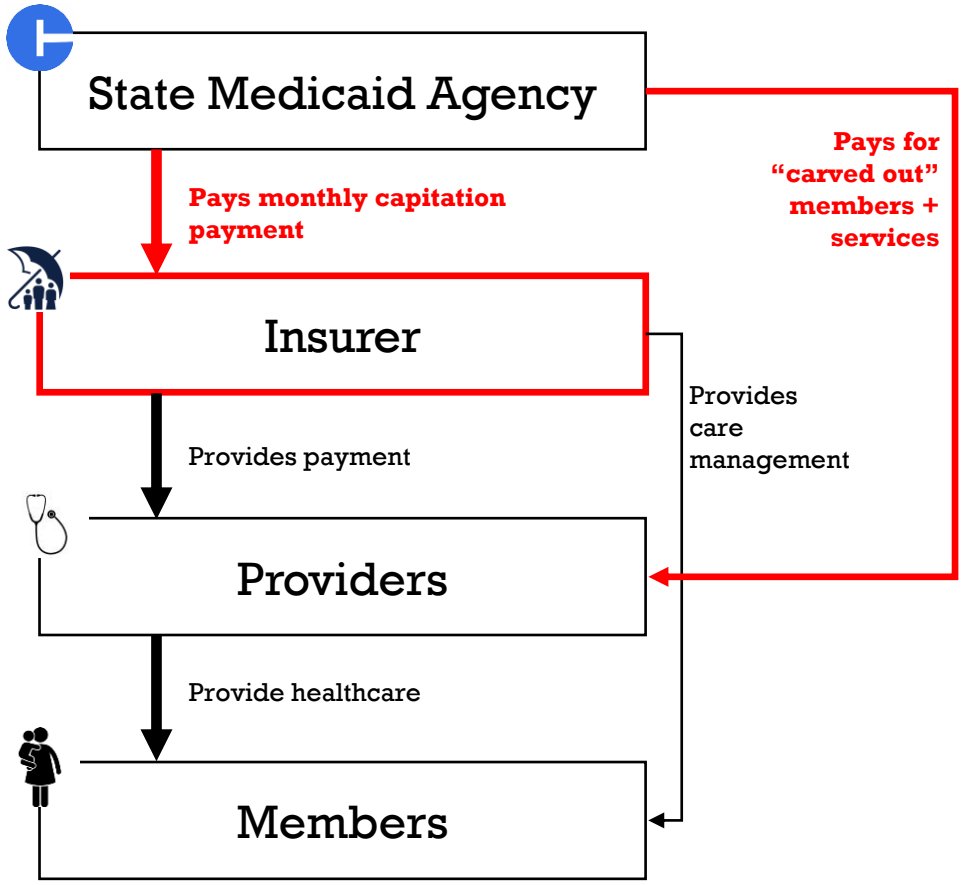
1. **What is managed care?**
2. What are national trends?
3. Draft criteria for making a decision

Comparing "Fee for Service" and "Managed Care" models

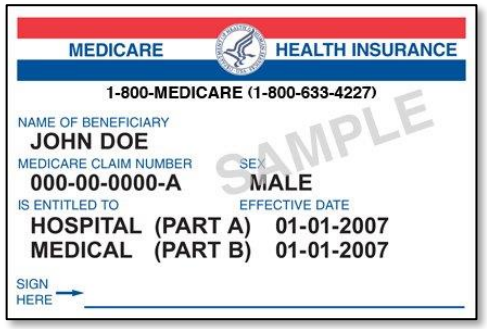
Fee-For-Service (Traditional & Managed)



Managed Care



Today, CT Medicaid uses a "managed" fee-for-service model

	(A). Traditional Fee For Service	(B). Managed Fee For Service *(CT Medicaid Model)*	(C). Capitated Managed Care
Example	Traditional Medicare 	Most large employers ("self-insured") + HUSKY 	Managed Care Organizations (MCOs) 
Overview	Payer sets rates and determines benefits Generally little care management (CM) or utilization management (UM)	Payer sets rates and determines benefits Payer hires Administrative Services Organization (ASO), who conducts CM, UM, etc.	Payer sets broad regulatory framework and pays capitation payment to managed care organizations Managed care organizations set rates, develop network, UM, CM and other policies

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1. What is managed care?
2. **What are national trends?**
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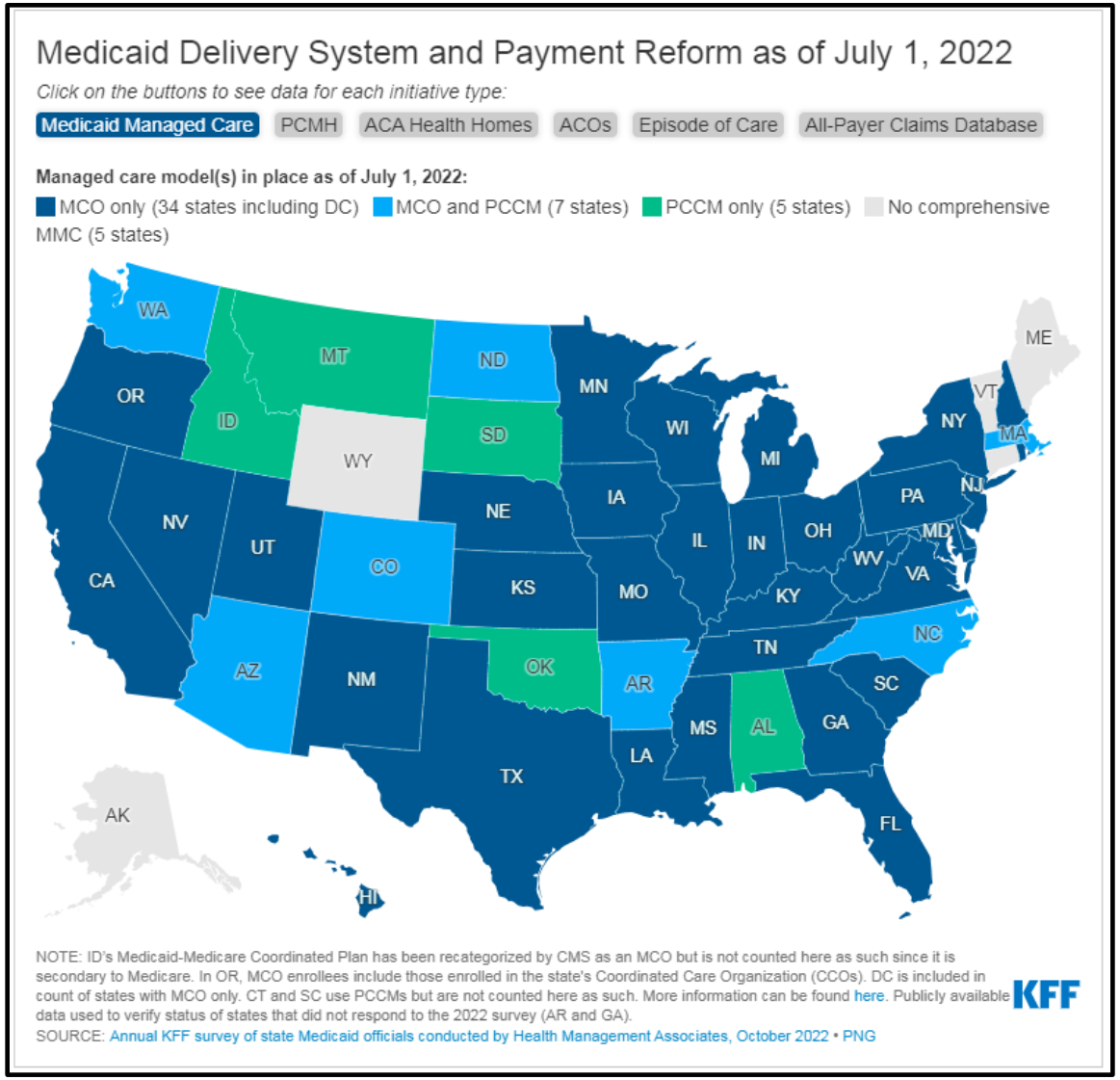
As of July 2022, 45 states have some form of managed care for at least some of their population

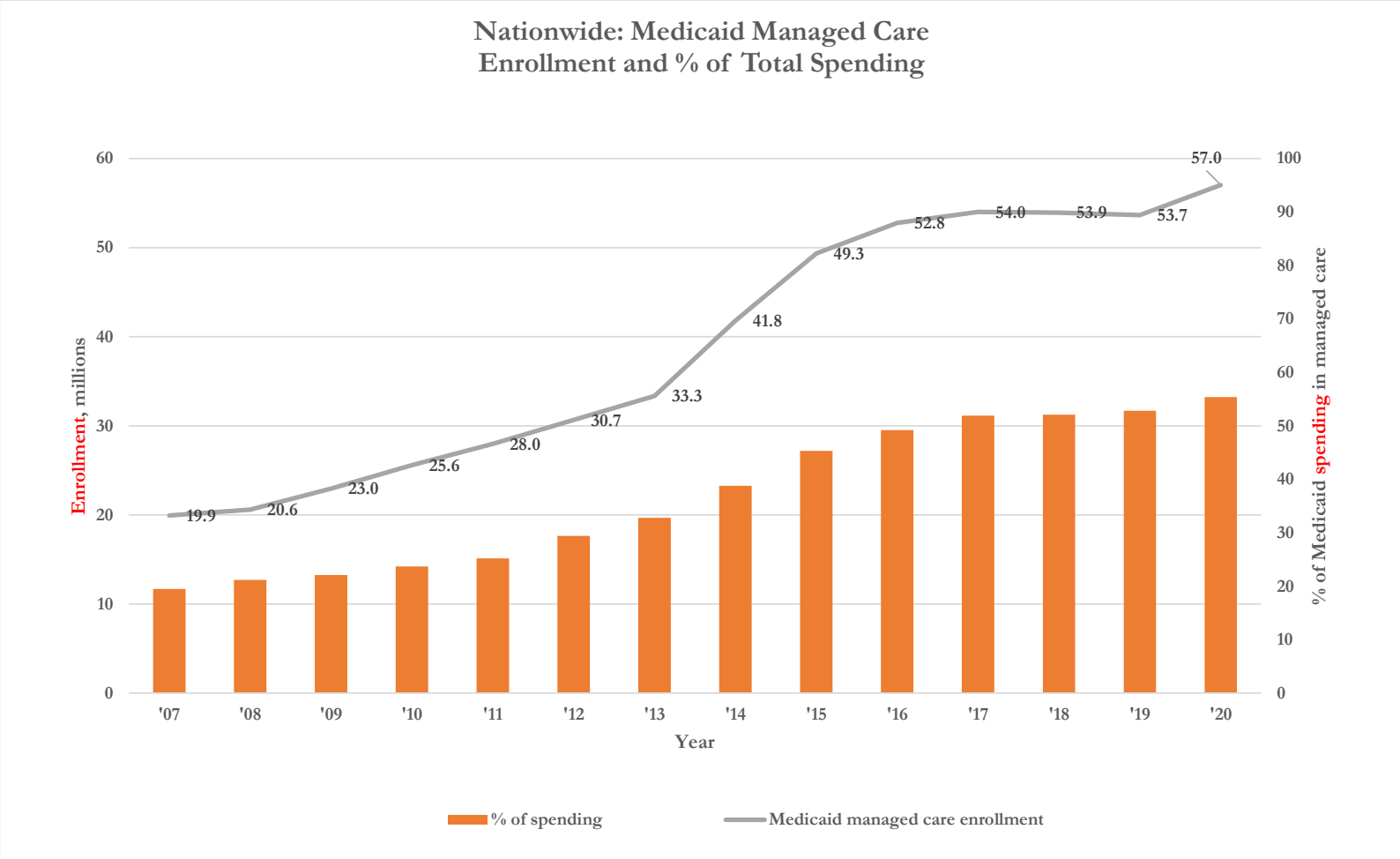


Medicaid Managed Care Organizations (**MCOs**) cover a comprehensive set of benefits (acute care services and sometimes long-term services and supports). MCOs are at financial risk for the services covered under their contracts and receive a per member per month "capitation" payment for these services.

Primary Care Case Management (**PCCM**) programs retain fee-for-service (FFS) reimbursements to providers but enroll beneficiaries with a primary care provider who is paid a small monthly fee to provide case management services in addition to primary care.

Source: KFF (link)

Nationwide, managed care enrollment has grown rapidly, accounting for 57m people (72% of Medicaid enrollment)



Sources: KFF (link) and Healthmanagement.com (link)

Agenda

1. What is managed care?
2. What are national trends?
3. **Draft criteria for making a decision**

Draft criteria to evaluate our options

Input from MAPOC welcome!

Criteria	Details
(1). Safeguards	How do we ensure that our members are protected?
(2). Member voice + input from other stakeholders	Do our members want this? Do other key stakeholders (e.g. providers) want this? If we move forward, does member satisfaction improve?
(3). Cost	Compare projected costs under the status quo (and reforms) to the bids that we receive, including admin costs
(4). Quality, including equity	Healthcare quality measures, such as CMS LTSS measure set. Think carefully about equity: stratify measures by RELD (race, ethnicity, language, disability).
(5). Feasibility	Is there a viable path forward? Capacity: is the state ready?
(6). Alignment with state priorities	How does each model support other priorities in Medicaid, LTSS, and healthcare more generally?

Proposed next steps to evaluate our options

Input from MAPOC welcome!

Engage with key stakeholders	Design and implement RFI	Evaluate proposals against criteria *(next slide)*	Make initial recommendation
Example stakeholders: • Members • Legislators • Providers • Advocates • Community-based organizations • Tribal nations • Academics • Sister state agencies • Other state Medicaid programs • CMS • Etc.	Request for Information (RFI) to help the state gather information to make decision	Tee up options For each option, populate the updated criteria described in the next slide	Make initial recommendation based on criteria Next steps could include pursuing one or more of the following options: • Maintain status quo • Maintain overall structure but propose reforms • Adopt PACE • Adopt managed care • Others TBD