

Setting underservice measure priorities for CT Medicaid health neighborhood pilots
 MAPOC Complex Care Committee -- Underservice workgroup
 Committee poll results – 11 underservice committee members of 20 voted, plus 2
 member of the Complex Care Committee
 October 8, 2014

Reminder: Some measures are missing (possibly your favorites). Some of the missing metrics can be measured from the health neighborhood application/geo mapping, and one measure (percentage of individuals without a care plan in 30,60, 90 days) is the only metric that comes from the portal – so it is our top priority in that category by default. Only four of our metrics cannot be measured at this time (not bad).

1. Please indicate your priorities for measurements using claims data below starting with 1 = highest priority, etc.

	Score	Rank
Percentage of individuals who fail to have an initial person-centered plan in writing developed within one month following a significant change in health status or transition between care settings	5	1
Monitor denied care or claims, or denied care requests/ prior authorization denials	5.5	2
People with high health costs	6.8	3
High utilizers of urgent care	7.2	4
Readmissions	7.5	5
Monitor for increasing or decreasing risk scores by provider/neighborhood -- cherry picking, underservice and/or overbilling	7.5	6
People with multiple disorders	8.2	7
People with behavioral health diagnoses	8.5	8
People transitioning between levels of care	8.5	8
Monitor for the lack of professionals caring for someone with a complex condition, i.e. brain injury	10.3	10
People with missed prescription refills	10.8	11
Ambulatory care-sensitive condition admissions	11.5	12
Repeated use of providers outside the neighborhood	11.9	13
People with brain injury	12.8	14
Adolescents, especially with mental health issues	13.2	15
People with a specific disability	13.7	16
Substance use treatment	14.4	17
Transportation	15.2	18
Pain management services	15.5	19
Oral health	16	20

2. Please indicate your priorities for measurements using randomly sampled chart reviews below starting with 1 = highest priority, etc.

	Score	Rank
Determine if people are getting the services – type, scope, and duration – that is included in their care plan or individual service plan -- If they aren't getting services identified in the plan, why not?	1.6	1
Evaluate outcomes – are people achieving their goals, as spelled out in the care plan?	2.6	2
Interruptions or discontinuing usual treatment, prescriptions, labs, or transportation patterns for people with chronic illness	3	3
Monitor for the lack of professionals caring for someone with a complex condition, i.e. brain injury	3.8	4
Monitor people without close family or caregiver involvement	4	5

3. Please indicate your priorities for measurements using additional software on claims with 1 = highest priority, etc.

	Score	Rank
Reduction in prescriptions/requests for home care services relative to previously or a parallel population- hours/week, duration after traumatic incident, surgery, etc.	3.7	1
Reductions in referrals to specialists relative to previously or a parallel population, controlling for health status	3.8	2
Reductions in duration or intensity of the "therapies"- PT, OT, ST- relative to previously or a parallel population	4	3
People with multiple disorders	4.2	4
Reductions in prescriptions/requests for imaging services relative to previously or a parallel population (including CAT-scans, PET scans v. MRIs)	4.9	5
People with behavioral health diagnoses	5.3	6
People with a specific disability	6.1	7
Pain management services	6.4	8
People with brain injury	6.6	9

4. Please indicate your priorities for measurements using patient experience of care surveys below starting with 1 = highest priority, etc.

	Score	Rank
Percentage of appointments where individuals had to wait more than a day to see a primary care provider for urgent	1.5	1

issues or more than a week, to see a specialist or to receive a recommended procedure for urgent issues.		
Percentage of individuals reporting a communication issue with their provider of medical or LTSS services and supports	1.6	2
Percentage of appointments missed due to lack of transportation	2.9	3



Nancy Wyman

LIEUTENANT GOVERNOR
STATE OF CONNECTICUT

September 30, 2014

Re: Independent Consumer Advocates' Concerns about and Request for Revisions to Medicaid-Related Provisions in Connecticut's State Innovation Model Grant Proposal, dated July 19, 2014

Dear Independent Consumer Advocates:

We appreciate the concerns raised in your letter of September 12, 2014 to the Center for Medicare and Medicaid Innovation, and your longstanding commitment to our Medicaid program and its clients. We acknowledge that we have accelerated our commitment to the use of a shared savings program as one means to achieve our shared vision for better healthcare for Medicaid beneficiaries.

While developing Connecticut's SIM grant application and in the application itself, we provided assurances that the Department of Social Services ("Department") will engage the care management committee of the Medical Assistance Program Oversight Council to review and comment on all aspects of the shared savings program design and the selection of provider participants. This process will enable advocates to further articulate issues of interest and concern, and work with the Department to refine the program's design to ensure protection of beneficiary interests.

The Department previously released information about Medicaid participation in SIM in a report entitled "[DSS Response to SIM Questions](#)," which responds to some of the questions raised in your September 12th letter. Your letter also discusses the importance of assessing the effects of shared savings on other populations. There are a number of Accountable Care Organizations (ACOs) in Connecticut and still more, longer standing ACO-type arrangements in other states, involving Medicare but also commercial payers. We will ask the Equity Access Council to review whether the experience with these other populations can inform our efforts here in Connecticut.

We look forward to working with you during the implementation of our multiple efforts in SIM to improve the health of our state's population.

Sincerely,

Nancy Wyman
Lt. Governor

Roderick Bremby
Commissioner, Department of Social Services



Dannel P. Malloy
GOVERNOR
STATE OF CONNECTICUT

October 30, 2014

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
United States Senate
104 Hart Office Building
Washington, DC 20510

The Honorable Fred Upton
Chairman
Energy and Commerce Committee
United States House of Representatives
2183 Rayburn House Office Building
Washington, DC 20515

The Honorable Henry Waxman
Ranking Member
Energy and Commerce Committee
United States House of Representatives
2204 Rayburn House Office Building
Washington, DC 20515

Dear Chairmen Wyden and Upton, and Ranking Members Hatch and Waxman:

Thank you for your letter of July 29, 2014, concerning the Children's Health Insurance Program (CHIP). I appreciate the opportunity to address the merits of and continued need for federal funding for this vital program.

Connecticut has made it a priority to ensure that all of its citizens have access to high quality and affordable health insurance. Connecticut's state-based health insurance exchange, Access Health CT, enrolled over 200,000 people during the first open enrollment period. This reduced Connecticut's rate of uninsured from 7.9 % in 2012 to 4% – one of the ten largest reductions in the country. Over 80% of these new enrollees qualified for Medicaid. Connecticut Medicaid is now serving almost 770,000 individuals, over 21% of the state population.

Connecticut's CHIP, which is known as HUSKY B, is an essential source of coverage for 14,119 children under age 19. Additionally, the program provides federal match for additional income-eligible children in Connecticut's coverage group for children and relative caregivers, which is known as HUSKY A. CHIP provides a broad range of preventative care, behavioral health, and dental services that support Connecticut children in early childhood development, school readiness and performance, and overall well-being.

- increased access to primary care practitioners for children age 12-24 months by 4% to 99.5%;
- increased access to primary care practitioners for children age 25 months to 6 years by 3% to 97%;
- increased immunization rate for adolescents (Tdap/Td Total) by 7%;
- increased lead screening in children by 21.5%; and
- increased number and percentage of children age 3 to 19 who received preventive dental care to 69% (HUSKY A) and 73% (HUSKY B).

The demographics of children served by CHIP/HUSKY B are as follows:

- 48.2% are female and 51.8% are male;
- 10.1% identify as African-American;
- 22.5% identify as Hispanic; and
- 70.6% identify as Non-Hispanic White.

2. What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?

The PPACA Modified Adjusted Gross Income (MAGI) conversion increased the maximum income eligibility limit for HUSKY B from 300 to 323% of the Federal Poverty Level (FPL). Additionally, Connecticut availed itself of the option to eliminate the crowd-out for coverage.

3. To the extent the following information is readily available and you believe that it is relevant, please describe the services and or benefit and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

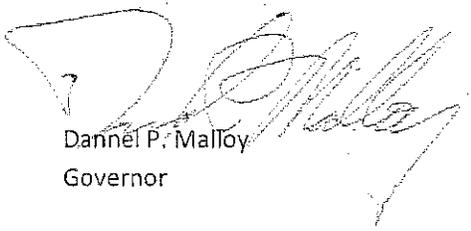
CHIP/HUSKY B provides a much broader range of behavioral health benefits than do exchange and employer-sponsored health plans. Additionally, CHIP/HUSKY B covers dental services with among the best geo-access of Medicaid programs in the country. Dental services are only covered through the exchange through purchase of stand-alone plans, and are typically covered by employer-sponsored health plans on a much more limited basis. There are no monthly premiums and a limitation on annual out-of-pocket costs of 5% of gross income in Connecticut's Band 1 for CHIP coverage; and a modest monthly premium of \$30 for one child and \$50 for two or more children, and a limitation on annual out-of-pocket costs of 5% of gross income in Connecticut's Band 2. These modest cost-sharing obligations (low if any premium, no deductible, limitations on out-of-pocket costs) are substantially less than would be paid for a Connecticut Qualified Health Plan (QHP).

across Medicaid and CHIP; administrative or *ex parte* renewals; presumptive eligibility; express lane eligibility; and premium assistance option). Connecticut has qualified in Federal Fiscal Years 2011 (\$5.2 million), 2012 (\$3.0 million) and 2013 (\$1.6 million) for CHIPRA performance bonuses. Over and above activities related to Medicaid, Congress could support access to and adequacy of coverage under QHPs by:

- examining the incidence of families affected by the "family glitch" and considering appropriate remedies;
- reviewing the cost effectiveness, network adequacy and scope of coverage of QHPs with respect to supporting the needs of children and families; and
- providing ongoing support for the in-person assister functions that have been funded under PPACA.

Thank you for the opportunity to share our perspective. Continued funding for CHIP is essential. Failure to preserve CHIP funding will jeopardize continued coverage for children in demonstrated need for these supports and necessarily expose states to significant budget constraints. I respectfully request that you make resolution of this pending issue a high priority.

Sincerely,



Daniel P. Malloy
Governor