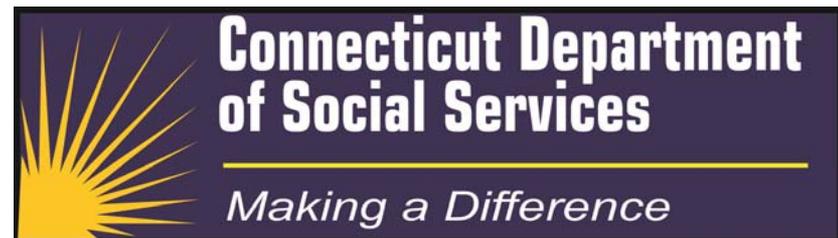
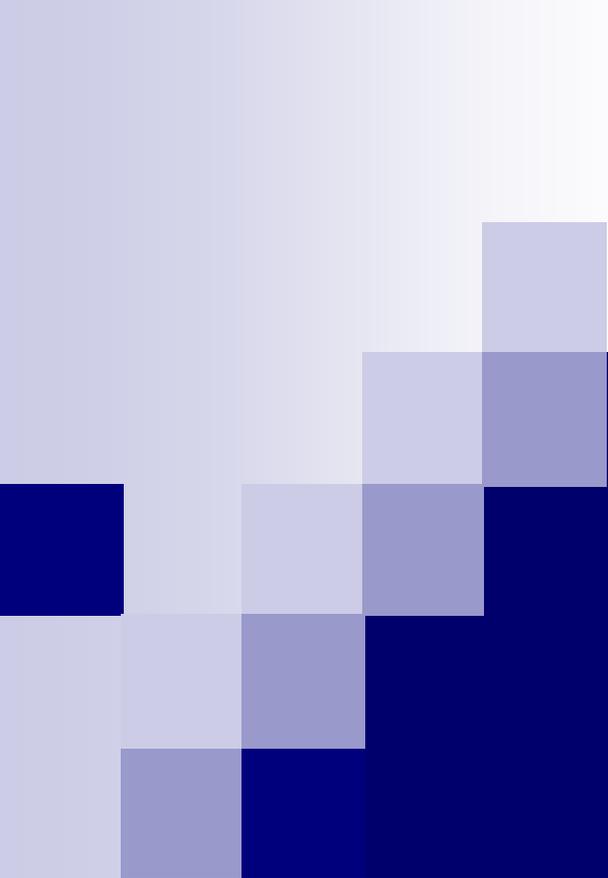
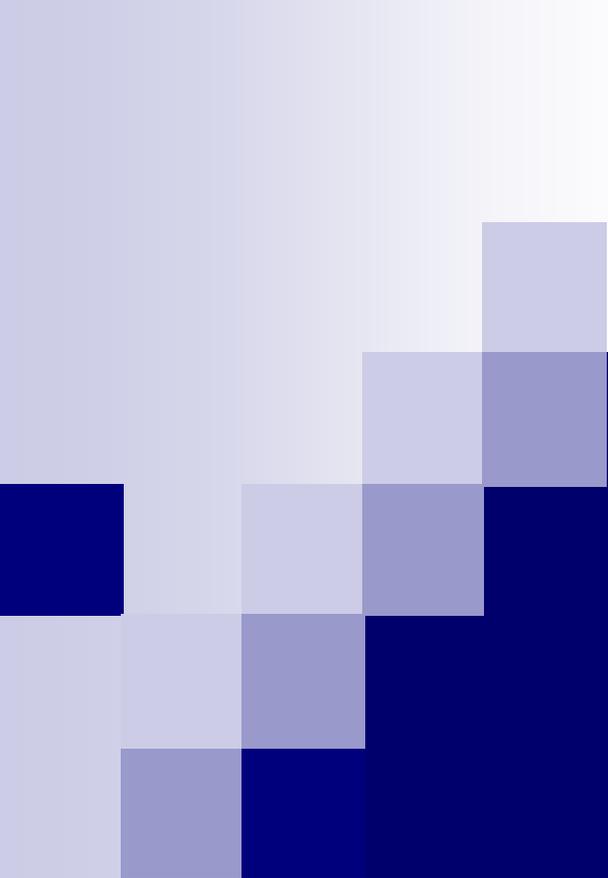


Presentation to the Medicaid
Care Management
Oversight Council
January 25, 2011





State Demonstrations to Integrate Care for Dual Eligible Individuals



The Opportunity



Dual Eligible Demonstration

Source

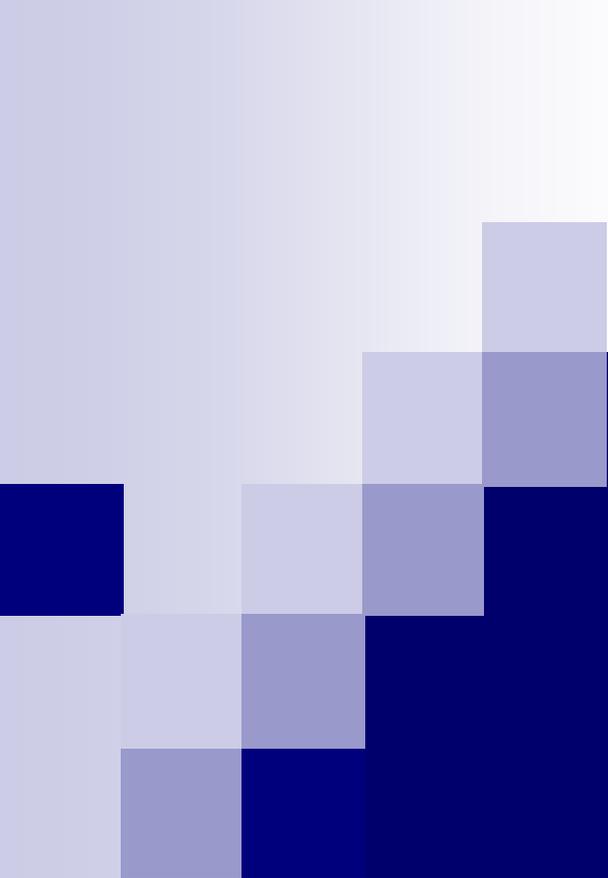
- Center for Medicare and Medicaid Innovation Center (CMMI)
- Federal Coordinated Health Care Office



Dual Eligible Demonstration

Purpose

- Provide funding to support design of innovative service delivery and payment models for dual eligible individuals
- Build on new approaches (e.g., health homes, accountable care organizations) to create new person-centered models that align the full range of acute, behavioral health, and long term supports and services and improve the actual care experience and lives of dual eligible beneficiaries



Connecticut Landscape

Dual Eligible Demonstration

Core Challenges

- Services are highly fragmented, duplicative or unnecessary, and often delivered in inappropriate settings
- Coordination of medical care, behavioral health care, long-term care and social supports is critical and lacking
- Providers do not have complete information on an individual, leading to service gaps and duplication in treatments

Dual Eligible Demonstration

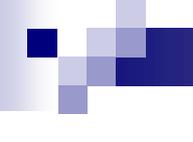
Core Challenges

- Lack of access to physician specialists
- Financial and performance incentives are not aligned among providers and with the best interests of the beneficiary in mind
- Results in unnecessary and avoidable...
 - emergency department visits
 - hospital admissions
 - diagnostic and treatment services
 - nursing home placements
- Results in poor quality of life

Dual Eligible Demonstration

Current Initiatives

- State unit on aging initiatives for chronic care
 - Eric Coleman model of transitional coordination
 - Stamford Chronic Disease Self-Management Program
- Behavioral Health Partnership (CT BHP) expansion to include dual eligibles
- UCONN medication management and dementia care initiatives
- Centers of care focused on geriatrics



Dual Eligible Demonstration

Current Initiatives

- BH/primary care integration with several Local Mental Health Authority led initiatives
- Primary Care Case Management program (PCCM)
- Primary Care Medical Home accreditation
- Multi-payer Advanced Primary Care Demonstration (MAPCP)

Dual Eligible Demonstration

Core Problem

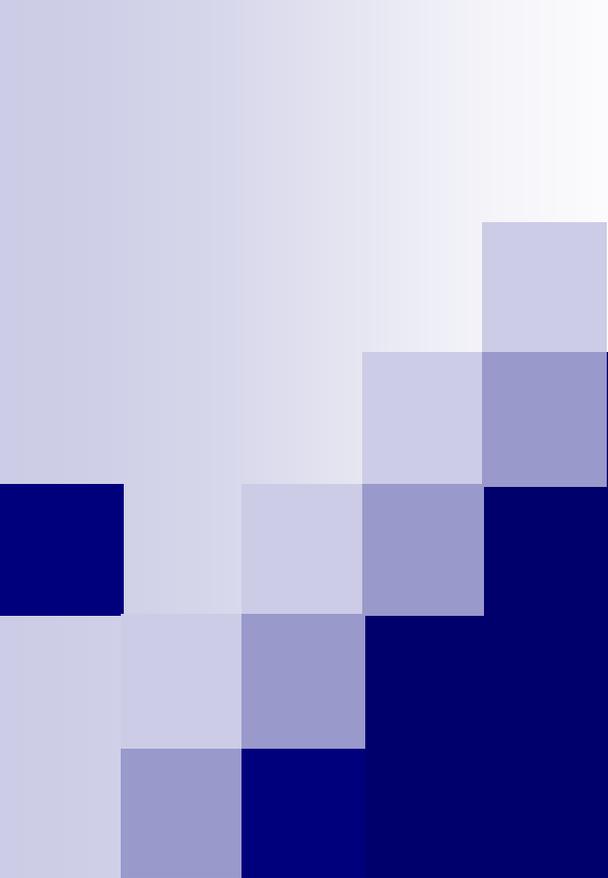
- Isolated initiatives cannot overcome the fragmentation inherent in the way that services are organized and delivered
- No system of providers in any part of the state can measure the value they provide to dual eligible beneficiaries
- No system of providers can tell you whether they are providing better overall value over time



Dual Eligible Demonstration

Overarching Goal

Create dynamic, innovative local systems of care and support that are rewarded for providing better value over time.



The Integrated Care Organization Model



Integrated Care Organization

Program Model

- Establish local Integrated Care Organizations
- Lead agency contracted with a consortium of provider partners and DSS
- Broadly accountable for:
 - Primary, specialty and hospital care and other healthcare services
 - Long term care services and supports
- Includes person centered health home(s) with broad array of services and supports

Person Centered Health Home

Core Team

- Primary Care Providers (PCPs)
- APRNs for ongoing support during and between regular visits, as well as in hospital or rehab facilities to facilitate communication and discharge planning
- Care coordinators (w/ appropriate specialization)
- Access Agency Case Managers (or other waiver case manager in out years)
- Pharmacist to provide consultation for persons with multiple chronic medications, and
- Behavioral health practitioners

Patient Centered Health Home

Enhanced Services and Supports

- Comprehensive initial and annual assessments of medical, behavioral, social, transportation, medical equipment, and support needs
- Home visit upon enrollment and at subsequent annual comprehensive assessments
- Specialty care clinics including at least two specialties that meet the needs of the elderly population

Patient Centered Health Home

Enhanced Services and Supports (cont)

- Assistance with linking to services such as transportation, specialty medical services, and needed social services and supports,
- Person-centered care plans developed with and by dual eligibles and family caregivers that provide for the maximum amount of self-direction desired,
- Medication management services through an on-site consultation with the PCP and pharmacist,
- Hospital, rehab and nursing home transition coordination including medication reconciliation by the pharmacist

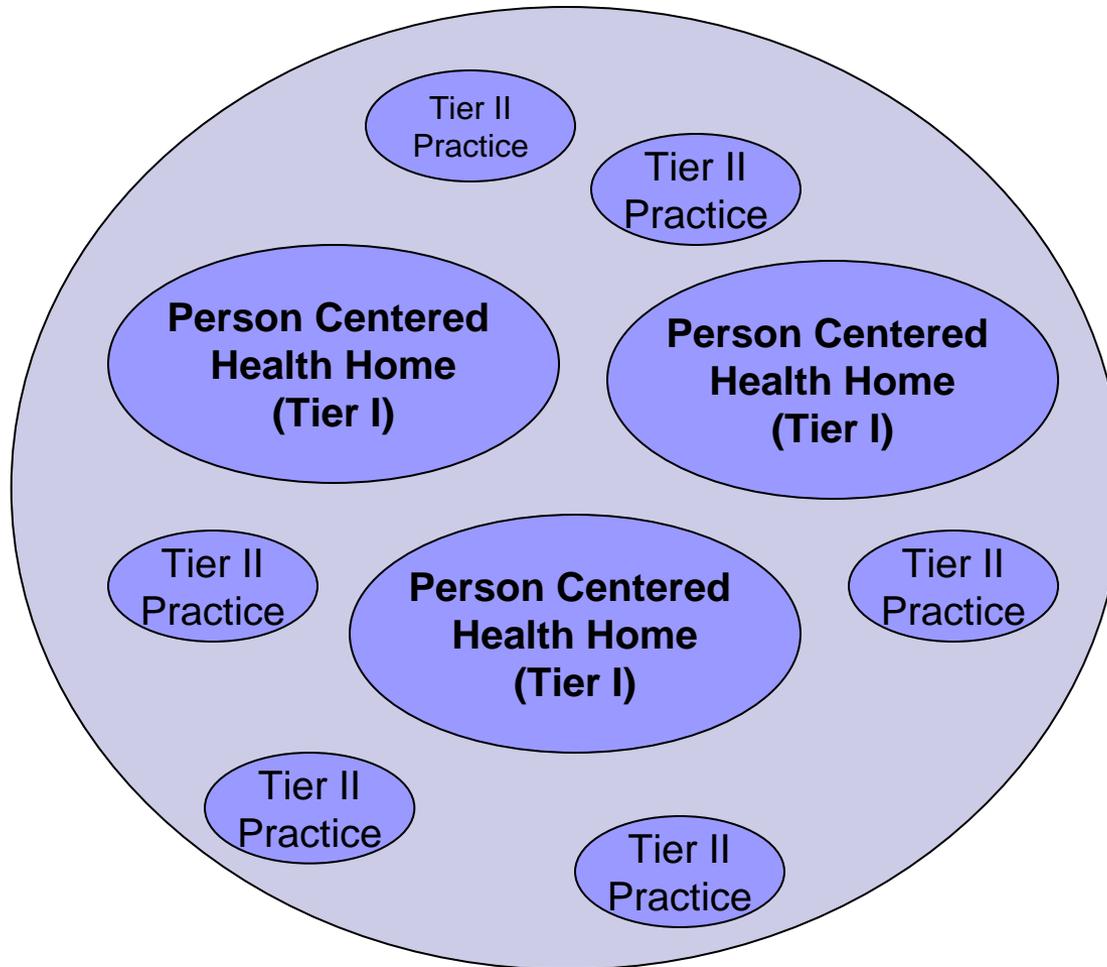
Patient Centered Health Home

Enhanced Services and Supports (cont)

- Dementia assessment with family education and support curriculum,
- On-site assessments of activities of daily living and level of care,
- Enhanced communication through use of electronic health records and an electronic person-centered care plan,
- Warm line access to a nurse practitioner, care coordinator, case manager, or other team member as a way to ask questions about health, treatment, housing, family, transportation, safety, or other issues

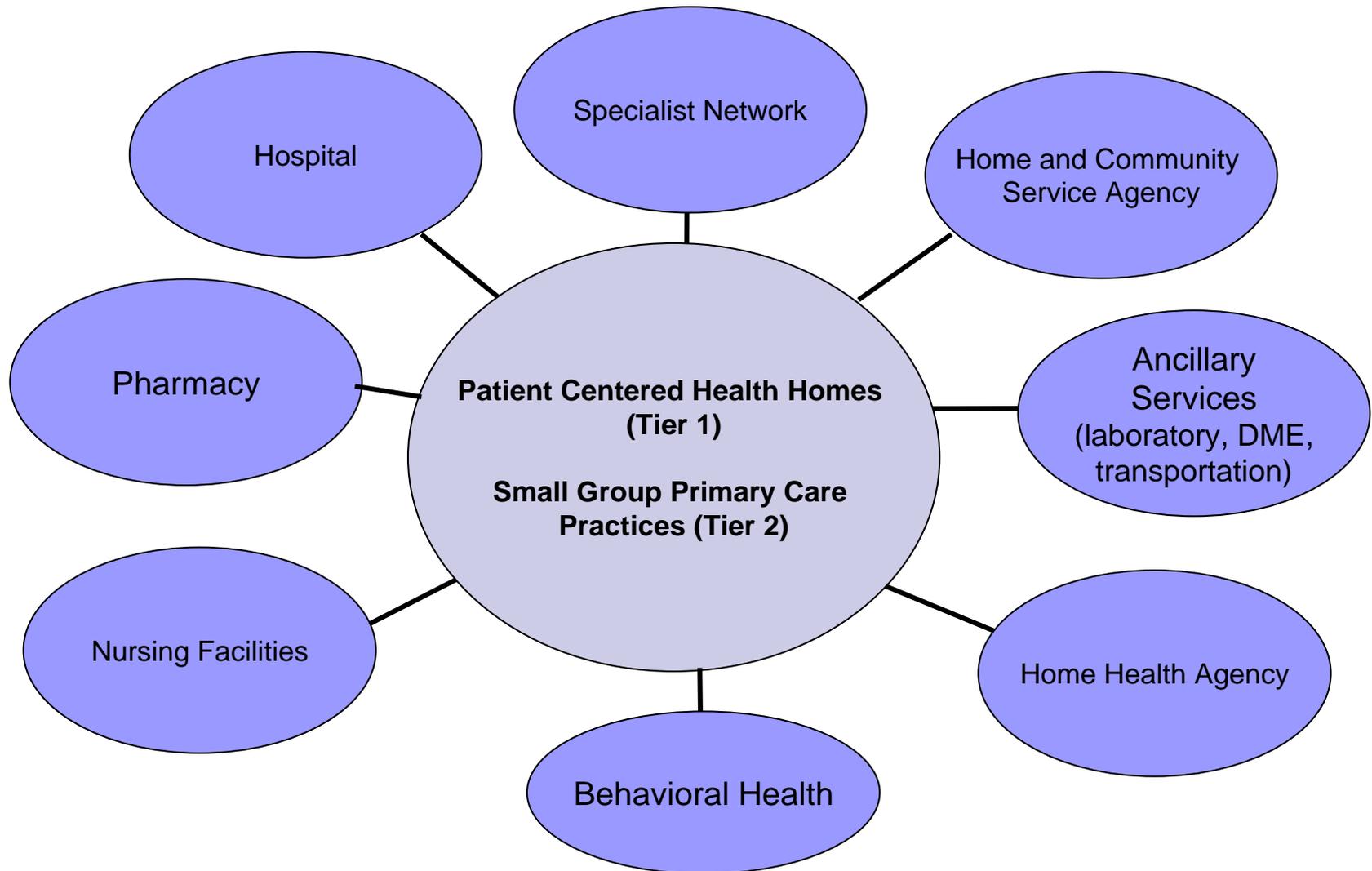
Integrated Care Organization

Small Group Primary Care Practices



Integrated Care Organization

Hub and Spoke



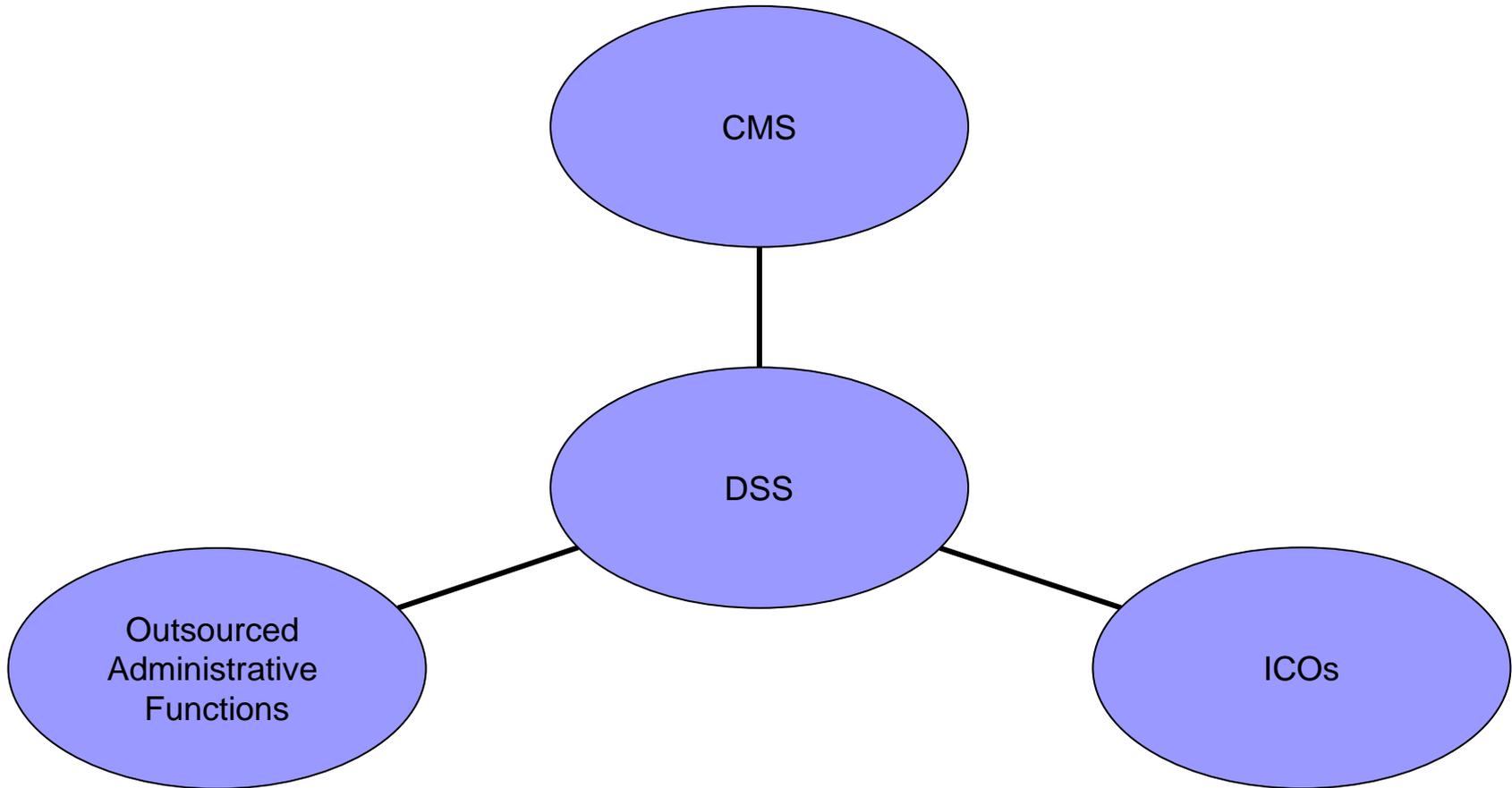
Integrated Care Organization

Hub and Spoke

- Partnership “spokes” will extend from the health home and small practice “hub”
- Extended service team partners comprised of hospitals, nursing homes, and extended primary, acute, specialty, rehabilitation, behavioral health, HCBS services, and pharmacy providers connected as a virtual team through electronic communications or in-person as needed
- Agreements with existing Area Agencies on Aging, Aging and Disability Resource Centers and Independent Living Centers

Integrated Care Organization

Role of DSS



Integrated Care Organization

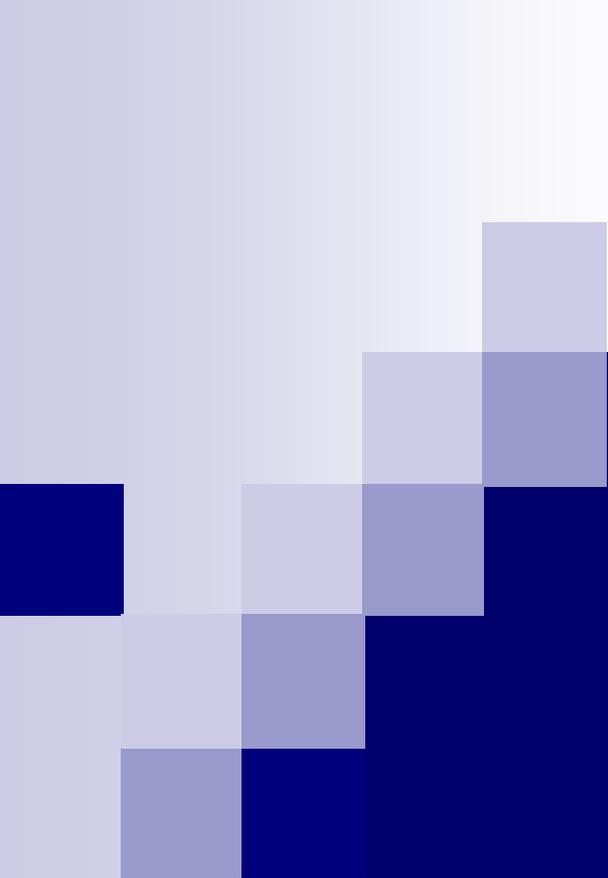
Role of DSS

- Set overall program objectives in consultation with Care Management Oversight Council
- Contract with CMMI to administer demonstration
- Receive Medicare gain share distributions and distribute to ICOs
- Establish ICO qualifications
- Administer ICO contracts
- Existing Medicaid administrative activities including state plan, policy, contracting, credentialing, claims, administrative hearings, HIT incentive payments, federal claiming, etc.

Integrated Care Organization

Role of DSS

- May provide or contract for:
 - Call center services
 - ICO enrollment
 - Measurement of ICO quality and outcomes
 - Cost aggregation by ICO
 - Actuarial services
 - Provider profiling
 - Health informatics including predictive modeling, population health management, health risk stratification, health risk assessment as needed to support ICO performance



Other Program Features

Program Features

Administration

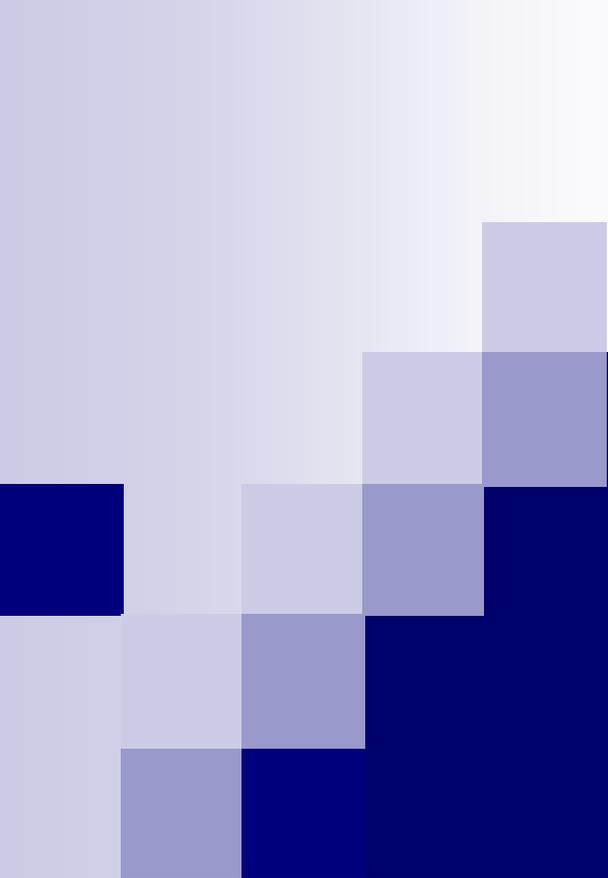
- RFA to select 3 to 6 ICOs to begin operation in fourth quarter CY2012
- Administrative PMPM to ICOs to support service enhancements
- Medicare pays all claims for Medicare funded services
 - Current rates and methods
 - Existing due process rights
- Medicaid pays all claims for Medicaid funded services
 - Current rates and methods
 - Existing due process rights



Program Features

Population, Freedom of Choice

- Stage 1 focus on dual eligibles over 65, in communities and institutions
- Stage 2 focus on expansion to under 65 with disabilities
- Automatic attribution to ICO
- Freedom to change PCPs and/or ICOs
- Freedom to go to any other Medicare or Medicaid provider
- Freedom to opt out



Measuring Value

The Value Equation

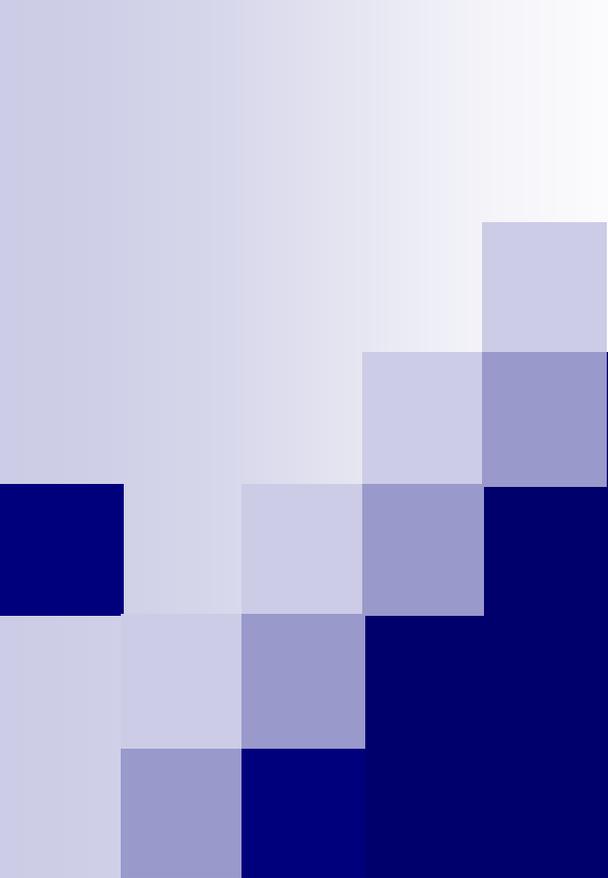
- Value = **Quality & outcomes** / **cost**
- **Quality and outcomes** measurement domains will focus on perception of care and satisfaction with the care process, clinical efficiency, access to care, quality of care and outcomes of care across the continuum of health services and all enrolled individuals

The Value Equation

- Value = Quality & outcomes / cost
- Cost will include all Medicaid and Medicare funded service costs associated with the care and support of enrolled individuals across the continuum of health services

Quality and Outcomes

- Develop new measures consistent with program goals
- Compile measurement set from existing tools:
 - Member Satisfaction: CAHPS
 - Effectiveness of Care Measures: HEDIS
 - Outcomes Measures: AHRQ Prevention Quality Indicator Measures and HEDIS Use of Services
 - Gaps in care: Rand's Assessing Care of Vulnerable Elders (ACOVE-3)
 - MDS for Nursing Facility
 - QBAI/OASIS data for home health



Financing and Reimbursement



State and CMS Medicare Program

- Medicare currently pays and would continue to pay for physician, hospital, lab, home health, medial equipment and supplies and other services
- Under demonstration, state would measure Medicare savings (if any) for the demonstration population
- Medicare and state would share Medicare savings net of administrative costs
- Sharing of savings may be contingent on achieving statewide quality and outcome targets



State and ICO

Medicaid & Medicare Programs

- Medicaid currently pays and would continue to pay cost-share for Medicare covered services (cross-over), and the full range of home health, behavioral health, dental, medical equipment and supplies, home and community based services, skilled nursing facility services and other Medicaid state plan services
- Under demonstration, state would measure Medicaid and Medicare savings (if any) for each ICO's enrolled demonstration population
- State would share Medicaid and Medicare savings net of administrative costs
- Sharing of savings would be contingent on achieving statewide quality and outcome targets



ICO and Provider Partners

Medicaid & Medicare Programs

- ICO would reinvest a portion of savings to support continued innovation and improvement in value
- ICO would also distribute a share of the savings to its provider partners, or
- Alternatively, a direct distribution of share of savings by state to providers

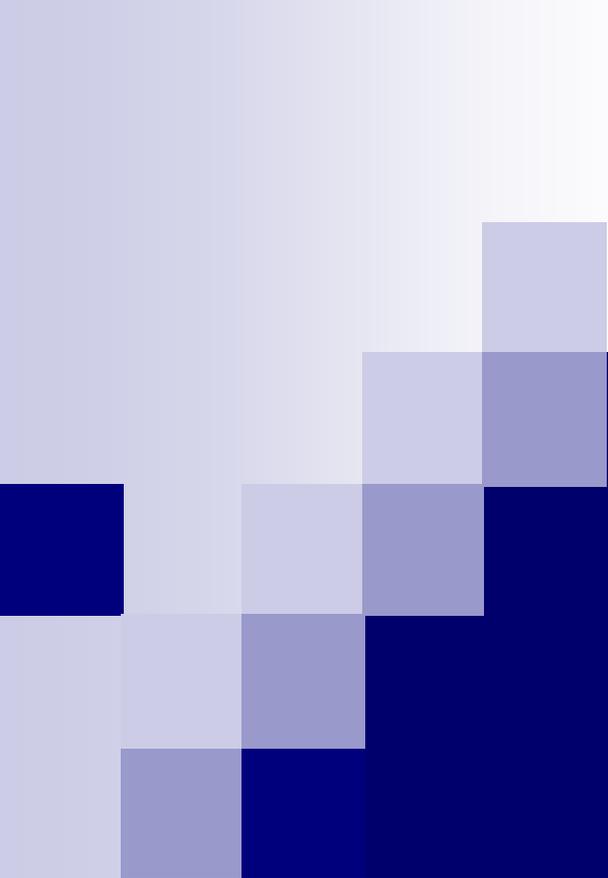
Method for Determining Savings Medicare

- Savings measured against a projected per member per month (PMPM) budget target
- PMPM budget target calculated based on approach used by the CMS Medicare Advantage program for the dual eligible special needs plans
- Includes risk adjusted payments and adjustments for Medicare program changes and fee schedule changes that are outside of the control of the state
- Additional adjustments may be needed to reflect any risk characteristics not currently reflected in the CMS Medicare Advantage program methodology such as differentiation by nursing home versus community

Method for Determining Savings

Example

	PMPM	Enrollment	Budget
Risk Cell 1	\$ 700	45	\$ 31,500
Risk Cell 2	\$ 800	60	\$ 48,000
Risk Cell 3	\$ 900	56	\$ 50,400
Risk Cell 4	\$ 1,000	35	\$ 35,000
Risk Cell 5	\$ 1,100	45	\$ 49,500
Risk Cell 6	\$ 1,200	25	\$ 30,000
Risk Cell 7	\$ 1,300	98	\$ 127,400
		364	\$ 371,800
Monthly PMPM	\$ 1,021		



Questions?