

# Centers for Medicare and Medicaid Services (CMS) Demonstration to Integrate Care for Medicare-Medicare Enrollees (MMEs) Overview of the Department of Social Services (DSS) Draft Application

## What are the key features of the Demonstration?

In partnership with the Departments of Mental Health and Addiction Services (DMHAS) and Developmental Services (DDS), the Department of Social Services (DSS) intends to implement the Demonstration to Integrate Care for Medicare-Medicare Enrollees for MMEs age 18-64, and age 65 and older. The Demonstration will integrate Medicare and Medicaid long-term care, medical and behavioral services and supports, promote provider practice transformation, and create pathways for information sharing through key strategies including:

- data integration and state of the art information technology and analytics;
- Intensive Care Management (ICM) and care coordination in support of effective management of co-morbid chronic disease;
- expanding access for MMEs to Person Centered Medical Home (PCMH) primary care;
- electronic care plans and integration with Connecticut's Health Information Exchange to facilitate person-centered team based care;
- use of performance measures concerning quality of care and care experience to assess impact and to determine eligibility for performance payments; and
- a payment structure that will align financial incentives
  - advance payments for care coordination and supplemental services
  - performance payments to promote value

## How will these strategies be implemented?

- **Model 1 (ASO)** will primarily address the need for more coordination in providing services and supports, through such means as data integration, predictive modeling, Intensive Care Management (ICM) and electronic tools to enable communication and use of data. MMEs will be aligned with the ASO model if they are not enrolled in a Medicare Advantage (MA) Plan, or aligned with an Accountable Care Organization (ACO) as of December 1, 2012.
- **Model 2 ("Health Neighborhood")** will incorporate all of the building blocks of Model 1 and enhance them by creating dynamic, innovative, person-centered local systems of care and support that are rewarded for providing better value over time. Model 2 will provide more personalized ICM and care coordination under the auspices of a Lead Care Manager who is chosen by the MME. Further, Model 2 will feature provider networks that are connected through tools including care coordination agreements, electronic care planning and communication tools and a team-based care coordination approach. Finally, Model 2 will offer supplemental benefits including chronic illness self-management education, falls prevention, nutrition counseling, case management and medication therapy management. A subset of the

MMEs who participate in the Demonstration will be passively enrolled in Health Neighborhoods (HN) based on receiving primary care from a participating HN provider. These MMEs will be notified that they have been assigned to an HN and will have the option to decline to participate.

Further, the Department will work with CMS to identify and overcome identified barriers to achieving the goals of the Demonstration that relate to coverage rules. An example of this is that to qualify for Medicare coverage in a skilled nursing facility (SNF), an individual must have been hospitalized for at least three consecutive days and be admitted to the SNF for the condition for which he or she was hospitalized. This in some cases represents a perverse incentive to hospitalize an individual who could otherwise be directly and effectively served by a SNF. DSS will through the application seek authorization from CMS to waive this "three-day" rule.

### Why is the Demonstration necessary?

- Connecticut MMEs have complex, co-occurring health conditions
  - roughly 88% of individuals age 65 and older has at least one chronic disease, and 42% has three or more chronic diseases
  - 58% of younger individuals with disabilities has at least one chronic disease
  - 38% has a serious mental illness (SMI)
- MMEs use a disproportionate amount of Medicaid resources and Connecticut is spending much more than the national average on MMEs
  - the 57,568 Connecticut MMEs represent less than one-tenth (10%) of Medicaid beneficiaries in Connecticut yet they account for thirty-eight percent (38%) of all Medicaid expenditures
  - per capita Connecticut Medicaid spending for the 32,583 MMEs age 65 and over and the 24,986 MMEs with disabilities under age 65 is fifty-five percent (55%) higher than the national average
- comparatively high spending alone on MMEs has not resulted in better health outcomes, better access or improved care experience
  - illustratively, in SFY'10 almost 29% of MMEs were re-hospitalized within 30 days following a discharge, and almost 10% were re-hospitalized within 7 days following a discharge
  - MMEs have reported in Demonstration-related focus groups that they have trouble finding doctors and specialists that will accept Medicare and Medicaid, and often do not feel that the doctor takes a holistic approach to their needs

- in the current Fee-for-Service (FFS) system, providers have little incentive to provide person-centered care that is mindful of duplicative and avoidable costs

*Today, no system of providers in any part of the state can measure the value they provide to MMEs. And no system of providers can tell whether they are providing better overall value over time. Providers have a direct influence on how MMEs use the health care system, and can help them avoid costly, preventable hospitalization and re-hospitalization, as well as placements in nursing homes.*

### **Who will benefit? How?**

An older adult with COPD who lives alone and who has experienced multiple unexplained falls and associated hospitalizations within the past six months will be able to work with her Access Agency care manager and a team of providers (e.g. primary care physician, cardiologist, pharmacist, home health nurse and OT) to examine the reasons for the falls and implement interventions that will reduce or eliminate her need to go to the hospital.

A younger individual with diabetes and bipolar disorder will be able to enlist his behavioral health entity care manager and a multi-disciplinary team to work on strategies for understanding his conditions and effectively managing them.

Providers that have historically had few opportunities and tools to do so will have means and opportunity to be in direct contact and to collaborate. Examples of this could include:

- connections between home care staff and pharmacist to address medication adherence on behalf of an MME who lives at home alone;
- connections between primary care physician offices, hospital discharge planners, Access Agency staff and providers of home and community-based long-term services and supports (LTSS) (home health, adult day care) in support of an MME who has been repeatedly hospitalized for breathing difficulties and is about to be discharged to her home; and
- connections between behavioral health providers and social services staff to help gain access to a rental subsidy that stabilizes an MME's housing and prevents the transiency that inhibits effective management of a chronic condition.

### **How will MMEs' rights be protected?**

The Demonstration will retain and expand upon the existing array of Medicare and Medicaid beneficiary protections. Further, the Initiative will establish customer service standards for the Medical and BH ASOs, HNs and clinicians/providers that will be providing education to and supporting the needs of participants. A non-exclusive list of these protections will include:

- strict adherence to existing statutory and State Plan requirements concerning beneficiaries' right of choice of provider
- right to participate in and to identify "next friend(s)" to join in participating in care planning;

- right to receive care that is consistent with values and preferences;
- statutory protections concerning rights of grievance, appeal and (Medicaid) fair hearing;
- Health Insurance Portability Act of 1996 (HIPAA) rights concerning “protected health information” (PHI);
- right to opt-out of information sharing;
- right of access to health records;
- informed consent regarding participation in Intensive Care Management (ICM);
- with respect to participation in an HN, right to disclosure of additional benefits of participation, financial incentives related to quality and cost, and right to opt-out; and
- rights of accommodation, including, but not limited to, rights afforded by the Americans with Disabilities Act of 1990.

Further, the Department will work with CMS to assess the feasibility of a unified grievance and appeals system to streamline and universalize the process through which MMEs address such issues as eligibility determinations and re-determinations, limitations on or denials of approval for services and supports, and termination of eligibility. This is anticipated to include identifying a statewide Ombudsman entity through which grievances could be submitted.

Finally, the Department will implement safeguards to ensure that MMEs receive necessary care in support of good health outcomes and a high quality of care experience. These safeguards will include 1) provider standards; 2) provider education through learning collaboratives; 3) population-specific studies of outcomes; and 4) audits.

### How will the financing work?

#### Payment Streams: Source and Description

Payment Stream and Source of Funding	Description
1. Start-Up Payment Funding – State/Federal Administrative Matching Funds	The Demonstration will make available Start-up Supplemental Payments as a prospective payment to approved Health Neighborhoods only. The Demonstration intends the start-up supplemental payment to offset a portion of the costs associated with developing and implementing a Health Neighborhood.
2a. APM I Funding – State/Federal	Connecticut is currently administering a PCMH program. PCMH qualified practices receive a combination of enhanced FFS and PMPM performance incentives. Connecticut anticipates converting this program from enhanced FFS to advanced bundled payments (APM1). This is expected to

Payment Stream and Source of Funding	Description
<p>Projected Savings</p> <p><b>2b. Risk Adjusted APM II</b></p> <p>Funding – State/Federal Projected Savings</p>	<p>be launched concurrent with the Integrated Care Demonstration. The Department will introduce APM I and will extend the PCMH program to the MMEs that participate in the Demonstration. This will be done for all qualified PCMH practices and all members aligned with these practices, whether or not they are participating with a HN.</p> <p>Connecticut will introduce risk-adjusted APM II under the Demonstration. This payment will bundle reimbursement for intensive care management, nutritionist consultation, pharmacist consultation, case management and chronic disease self-management education. APM II will be paid to HNs for MMEs aligned with the HNs. Extension to all MEs is under consideration.</p>
<p><b>3. FFS Payments</b></p>	<p>The Demonstration will utilize the existing Medicare and Medicaid payment methods</p>
<p><b>4a. PCMH Performance Payment Program</b></p> <p>Funding – State/Federal Projected Savings</p> <p><b>4b. HN Performance Payment Program</b></p> <p>Funding – State/Federal Actual Savings</p>	<p>The Demonstration will extend the state’s PCMH Performance Program to Demonstration participants. The program will reward providers for providing the highest quality care in the most efficient and effective settings. The payments will be based on PCMH-specific performance against benchmarks (performance incentive payment) and improvement (performance improvement payment) over time.</p> <p>The State will establish a Performance Payment Pool for each HN that will be jointly funded by a withhold from the targeted per member per quarter APM II and from savings determined based on the HN’s actuarially determined savings target. Distributions from the Performance Payment Pool will be made based on HN-specific performance against benchmarks (performance incentive payment) and improvement (performance improvement payment) over time.</p> <p>Shared savings will be calculated by comparing risk adjusted PMPM amounts to actuarially sound PMPM benchmark targets for a comparable population. Included in the calculation of the actuarially sound PMPM targets will be Medical Cost Trend, Program Changes, Administration Expenses, as well as any offsets as a result of advanced payment.</p>

## What are the key budget implications?

It is estimated that Connecticut will receive \$2 to \$4 m from CMMI in support of the Demonstration. These funds will underwrite costs of implementation, including:

- adjustments to the Department's MMIS system
- integration of Medicare and Medicaid data
- electronic infrastructure costs of connecting ASO systems with the Connecticut Health Information Exchange (HIE)
- initial actuarial analysis in support of the proposed payment model
- enrollment counseling
- consumer materials
- program evaluation

Additionally, Connecticut will be eligible for Federal Medical Assistance Payments (FMAP) as follows:

- Ongoing staff and administrative expenses in the Department, ASOs, MMIS, Mercer and ACS
- PCMH payments (APM I) for participating MMEs
- Advanced payments (APM II) for Health Neighborhoods

## What is the expected impact on Medicare/Medicaid costs?

Mercer has provided preliminary overall savings estimate for this population in excess of \$300 million over the course of this demonstration. DSS is reviewing the assumptions underlying this projection. Adjustments to these assumptions may reduce the overall projected savings. Also, note that these savings estimate includes other initiatives that impact this population including the rightsizing initiative, which is already factored into the state's budget projections.

## How does this relate to other reform initiatives?

1. The Demonstration will align with and expand the scope of Connecticut's practice reform structures.
  - Effective January 1, 2012, Medicaid medical services were transitioned from a managed care infrastructure to a medical ASO, CHN-CT. Connecticut's medical and behavioral health (BH) ASOs now provide a broad range of services, including: member services, Intensive Care Management (ICM), predictive modeling based on Medicaid data, statewide and provider specific performance measurement and profiling, utilization management, and member grievances and appeals. Under the Demonstration, the ASO will comprise Model 1, and will use integrated Medicaid and Medicare data to perform predictive modeling of those MMEs most in need of ICM, offer enhanced ICM, and provide data analytic support to the HNs. The ASOs are provided with annual performance payments contingent on meeting access and quality standards. Historically, the Department has achieved its best results when ASO and provider performance goals are in alignment. For this reason, performance targets and payments for

both ASOs will be aligned with the overall performance goals of the Demonstration and with the performance goals of the HNs.

- The Department implemented also implemented its Person-Centered Medical Home (PCMH) initiative on January 1, 2012. Key features of PCMH practice transformation that support the goals of the Demonstration include embedding limited care coordination functions within primary care practices, capacity for non face-to-face and after hours support for patients, and use of interoperable electronic health records. All PCMH practices will receive performance payments in return for meeting care experience and quality targets. The Demonstration will extend the PCMH program and associated participation and performance payments to MMEs. The enhanced capabilities afforded by PCMH recognition will support the work of the ASOs, as direct service providers, and the HNs, as members of their networks.
2. The Demonstration will be a key element of a laboratory environment in which a co-occurring shared savings initiative will be implemented. Although Connecticut was not selected as a market for purposes of the Comprehensive Primary Care Initiative (CPCI), Accountable Care Organizations (ACO) are anticipated to be part of the landscape.

CMS will contract under its Shared Savings Program to enter into Medicare gainsharing agreements with new legal entities that will be known as Accountable Care Organizations (ACOs). ACOs will include groups of providers and suppliers of services (e.g., hospitals, physicians, others involved in patient care) that will work together to coordinate care for a minimum of 5,000 Medicare fee-for service patients. While several groups are in process of ACO formation in Connecticut, this option has not yet been implemented. Medicare savings that yield will be shared between CMS and the ACOs, with ACOs that participate under the one-sided model eligible to receive up to a cap of 50% of savings and ACOs that participate under the two-sided model eligible to receive up to a cap of 60% of savings. Eligibility for shared savings will be based on whether quality performance standards established for four domains (patient/caregiver experience, care coordination/patient safety, preventative health and at-risk population) have been met, based on national benchmarks. Initially, all measures will be compensated on a pay-for-reporting basis. CMS will transition a portion of the measures from a pay-for-reporting to pay-for-performance in the second performance year, and all but one of the remaining measures in the third performance year.