

State of Connecticut
GENERAL ASSEMBLY



Council on Medical Assistance Program Oversight
Complex Care Committee

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www.cga.ct.gov/med/

March 20, 2015 at 9:30 AM in LOB Room 2A

Notes

Attending: Rep. Susan Johnson, Sheila Amdur, Matthew Katz, Siobhan Morgan, Nancy Navarretta, Kate McEvoy, Bill Halsey, Karyl Lee Hall, Molly Gavin, Ellen Andrews, Marie Smith, Jill Benson, Tracy Wodatch, Maureen McCarthy, Cynthia Del Favero, Deb Migneault, with staff support from David Kaplan.

Karyl Lee Hall was on the conference call "focus group" and should be added to those notes.

Update on Status of CMS Discussions – Matt Katz said state may be concerned that we are not saving enough, and feds concerned saving too much which they would have to give back to state! Matt proposed that state keep more savings, with focus on those who are most complex, taking out the "low end" of risk. Physicians would be willing to take more risk to assure this project goes forward.

a. Bill clarified that everyone would still get the care so lower risk would be in Model 1. Still would have to be up front funding.

b. Also need PMPM that covers cost of care coordination.

c. Jill Benson said that as a provider would also agree that they would be willing to forgo savings to make this possible. Jill said CHR also ran numbers in Hartford and Windham. First year would be loss regardless of model. Windham barely broke even, Hartford viable. If only highest risk served, only Hartford viable. Windham area not viable because of fixed costs that must be spent regardless on numbers served. If HN could be expanded, might make it more viable.

d. Bill Halsey said that for CHN to run new Medicare data to get risk stratification, their vendor had to be on federal use agreement. This just occurred, so integrated file will be sent and risk stratification will be redone. DSS will take out risk levels 1 & 2, and then see what rate is, and whether it is within the CMS financial model.

e. In response to Rep. Johnson question about other states, Kate McEvoy said that about the only state that is a non-managed care state is Washington, which is using Health Homes for the Duals initiative, not our model, so it is comparable to what CT is proposing.

3. Risk Adjusted Care Coordination Rate:

CMS has indemnified their risk. Kate said the terms of this initiative are weighted towards CMS—50% of Medicare savings net of any increase in Medicaid savings but: there is a minimum savings threshold the state must achieve which is non-negotiable, and there is a constraint on any growth in Medicaid expenditures. Several states have dropped out of this initiative because of this.

- a. Mercer did develop savings projections at the beginning of this that were “enormous” but did not take into account rebalancing initiative. Kate did not think that Mercer’s analysis took that into account so this information was not released. Kate has asked Mercer to relook at the of the savings information. Kate distributed information from the two applications submitted to CMS, from rebalancing and from other sources. State’s application has been pending with CMS for two years for grants for data and system modifications, for educational materials, for formation of HNs, administrative grants to lead agencies. Grant funds can’t be used for supplemental or care coordination or any direct services. State’s share of these direct services are what was cut from the budget--\$10 million in 2016, and \$15 million in 2017.
- b. Ellen asked if Mercer could give us a range of savings taking into consideration rebalancing and Health Homes. Rep. Johnson asked when data would be available—Bill said risk stratification has to be done first then Mercer analyzes. DSS will try to expedite process, based on Rep. Johnson’s request.
- c. Jill asked if Jen Associates data would be available regardless of what happens to this initiative. Kate said this was the first time they have had this integrated data set so can look at impact of Medicare “three day” stay on cost for nursing homes, which is arbitrary and not medically based. DSS is tracking this. DSS would need funding for Jen contract and refreshing data and they want to go forward with this. Deb Polun said if we don’t move forward with this, will we have access to Medicare data. Bill said they do not know if they will, or what Jen contact would cost going forward.
- d. Initial PMPM of \$116 and then reduced to \$111. Marie Smith said her work at CMMI re higher risk comprehensive primary care was \$60-\$85, and she did not find it remarkable to have this rate for a much more complex population being \$30 more. Bill said that CMS seems to have a range they expect which they haven’t really shared with state. CMS has broken population into segments—those in community, in institutions, in waivers—and also have stratified the savings related to these segments. CMS has asked that Mental Health waiver population be removed from Model II and also lower risk populations. Karyl Lee Hall said we should ask CMS to disclose their actuarial assumptions.
- e. Molly Gavin said that CCCI has the most experience with this population, and is paid \$120/month/client, with high staff turnovers to private sector because their rates are so slow. CCCI is struggling to manage financially with mostly social service care managers

and some nurses, and she does not see how anyone can accomplish this with the rates being discussed. Average caseload is 85 individuals and is very challenging to manage. Bill said that they don't want to propose anything that is not viable.

- f. Projected "Savings" from Duals Initiative –Kate said that we could look at this in terms of later year implementation, given pace of discussions with CMS. (Therefore, would allow adjustments in 2nd year of budget if this is not viable.)

5. Impact of Governor's Budget Recommendation on Initiative –Tracy Wodatch said that state should preserve what they have already and not allow cuts that have been made to mental health, home health and other areas. Ellen noted that we have to improve what we have to increase viability in the future of financing health care services.

All state agency reps left at this point at 10:30 a.m.

Is the \$15 million in 2nd year also encompassing of state's 25% share in administrative costs? Sheila suggested framing a position to MAPOC leadership that the CMS Duals application allows us to access federal admin \$; that CT has higher costs of care overall for those who are dually eligible; that the first year funding in the budget could be reduced due to time it has taken to negotiate with CMS—perhaps to 3rd quarter of 2016; that the legislature evaluate what the savings may be accrued and how this offsets state expenditures. It was stressed that the state should only go ahead with the initiative if the PMPM is viable for care coordination is viable.

- By first year would know if it's viable with CMS
- By 2nd year would know if it's going to achieve savings
- Also that we now can't manage dually eligible without access to Medicare data
- Meg asked if number of Neighborhoods could be scaled back to make this less expensive—should be discussed with DSS.
- Karyl Lee Hall said there are two issues: should funds be restored to budget and then if project is viable re CMS.
- Deb Polun/Molly Gavin/Tracy Wodatch and Meg Morelli said that there must be a stable network of community and institutional providers so we cannot undercut progress that has been made in controlling costs. The duals initiative is an outgrowth of this, targeting a population that is underserved due to inability to manage Medicare and Medicaid costs.

Sheila will develop a draft position statement for comment to be sent to MAPOC leadership.

Sheila Amdur thanked Quincy Abbot for his service on the Complex Care Committee. Quincy has given his resignation from the Committee.

6. Next meeting—April 24, 2015