

## Proposed Elimination in Budget of Funding Health Neighborhoods for Dually Eligible Pilot Program

DATE: April 16, 2015

MAPOC is concerned about the proposed elimination of funding in the Governor's budget for the federally funded pilot initiative. Creating Health Neighborhoods will improve health outcomes and control costs of people in Connecticut who are dually eligible for Medicare and Medicaid.

We believe this funding should be restored to the budget and have suggested some possible ways to reduce the funding in our recommendation. There is an interrelationship between the state's rebalancing initiative and retaining a stable network of community and institutional providers. If that network is undermined by reducing already insufficient Medicaid rates to providers, the state will undercut progress that has been made in controlling costs. The Health Neighborhood initiative is an outgrowth of this progress, targeting a population that is underserved due to the state's inability to manage both Medicare and Medicaid costs. This initiative gives the state access to Medicare data that allows the total care of the most expensive population on Medicaid to be managed by targeting their needs before they are at risk of institutionalization.

- ✓ The dually eligible population represents less than 10% of CT's Medicaid beneficiaries, but accounts for 38% of Medicaid expenditures.
- ✓ Per capita CT Medicaid spending on this population (57% are over age 65 and 43% are under age 65; 38% of all dually eligible are people with serious mental illnesses) is **55% higher than the national average with no better health outcomes, access to care, or improved health care experience.**

The Health Neighborhood initiative allows the state to:

1. Coordinate care for BOTH Medicare and Medicaid funded services, which does not currently happen. If we implement the project, the federal government will provide the state with \$13 million in funding to manage the pilot. The amount in the state budget, which the Governor proposes to cut, is the state's match for the Medicaid covered care coordination services. Currently they are not covered services but are fundamental to the health neighborhood model of health maintenance and care delivery.
2. There is significant physician and health care professional buy-in for this initiative with the Connecticut State Medical Society, hospitals and other providers developing plans to potentially be leaders in their respective areas for this pilot. (There will be 3 to 5 pilots covering approximately 3,000-5,000 people out of 57,000 who are dually eligible).
3. This initiative would be a shared savings pilot that would allow the state to focus resources and cost savings on the highest cost Medicaid population, fostering better health outcomes and controlling state spending. The state would receive savings achieved in both Medicare and Medicaid above a minimum floor of savings required by CMS. The state would then give providers some of those savings, to which DSS is creating a formula. There is opportunity for the state to realize significant savings associated with improved care delivery and outcomes for this population.
4. This approach could bring hospitals and community providers together, and align their interests in client care and funding, produce better outcomes for clients, and reduce the trend of state spending over time because of the focus on care coordination and improved outcomes.

Planning for the Health Neighborhood pilot has been uniquely collaborative, bringing together disparate interests in a transparent, thoughtful, data-driven process. Over the last three years, planning for the pilot has created and strengthened constructive relationships across diverse groups in our state, building a framework and model for effective future reforms. It would be unfortunate to waste this achievement that could be expanded to more populations across our state. The collaboration and cooperation to date has demonstrated that, when the focus is on quality improvement and the efficiencies this generates, savings may be possible.

**If necessary, the state can mitigate the impact on the budget by the following:**

- ✓ **Reduce the first year funding because there is still not a signed agreement with CMS and implementation could not realistically begin until sometime in 2016. (See attached suggested timetable for implementation of Health Neighborhoods)**
- ✓ **DSS is asking Mercer to estimate potential savings from this initiative, to inform the Legislature's decision. It is possible that savings the state realizes can offset more of the state's matching funds, with less "shared savings" going to providers. In an effort of collaboration and shared interest in proving the model, it was the providers who proposed a shifting of the shared savings to make sure that the state had an increased opportunity to cover its portion of initial spending.**
- ✓ **Reevaluate the viability of the initiative in early 2016. The Health Neighborhood pilot should only go forward if provider participation is sufficient for the project to be effective.**

To cut this modest amount from the budget not only throws three solid years of work away, but, more importantly, it also throws away an opportunity to demonstrate an approach that can improve health care outcomes, control costs for the most vulnerable and most costly group on Medicaid, provide the state with a federal/state shared savings model, and give the state access to Medicare data that allows full coordination of care for those dually eligible before they are at risk of institutionalization. This innovative and revolutionary model of care coordination and delivery is based on shared decision making, shared responsibility and the collective interest of all involved to improve care and health outcomes for Connecticut's citizens. The Complex Care Committee believes this model is worthy of a pilot and believes that there is real potential for improved outcomes and cost savings.

WORKING DRAFT TIMETABLE FOR THE IMPLEMENTATION OF HEALTH NEIGHBORHOODS AND THE  
STATE'S SHARE OF COSTS

1. DSS and Federal Center for Medicare and Medicaid Services (CMS) sign a Memorandum of Agreement—8/1/2015
2. DSS develops shared savings model with input from MAPOC—10/1/2015
3. DSS issues RFP for Health Neighborhood Coordinators—12/1/2015
4. DSS issues contracts for Health Neighborhood Coordinators—03/15/2016
5. DSS certifies Care Management entities who will coordinate direct health care for dually eligible recipients. 4/15/2016
6. Enrollment begins and continues in Health Neighborhoods for Dually eligible recipients.— 5/15/2016 and on
7. Care Management entities begin evaluation of newly enrolled dually eligible recipients **(THIS WILL BE A MEDICAID BILLABLE SERVICE AND THE STATE'S SHARE IS 50% OF THE COST. GIVEN THAT ENROLLMENT MAY JUST BEGIN AT THE END OF THE FISCAL YEAR, THE COST TO THE STATE MAY BE ABOUT \$1.3 MILLION.)**
8. Dually eligible recipients will continue to be enrolled into FY 2017. The projected full cost of \$13 million would likely not be realized until FY 2018. **It is estimated that in the 2<sup>nd</sup> year of the biennium—FY 2017, the potential cost to the state would be about \$6.5 million.**
9. **The state will begin to see savings in Medicaid costs towards the second half of FY 2017.**

**PLEASE NOTE: DSS IS CURRENTLY WORKING WITH MERCER TO ESTIMATE POTENTIAL SAVINGS FROM THIS INITIATIVE. THE STATE WILL ALSO RECEIVE A SHARE OF ANY SAVINGS IN MEDICARE, NOT JUST MEDICAID, ABOVE A CERTAIN THRESHHOLD.**