

Cover Sheet

National Governors Association Request for Applications: Developing State-Level Capacity to Improve Health and Reduce Cost of Populations with Complex Care Needs

Connecticut

Track 2.0

Team leader:

Kate McEvoy, Esq.
Director of Division of Health Services
State of Connecticut Department of Social Services
55 Farmington Avenue
Hartford, CT 06106
860-424-5383
Kate.mcevoy@ct.gov

Administrative Coordinator:

Elizabeth Brinley
860-424-5683
Elizabeth.brinley@ct.gov

Letter of support from Governor (2 pages)

Awareness of complex care needs models if they exist in the state:

In context of having implemented an Intensive Care Management (ICM) program on behalf of all Medicaid beneficiaries, the Connecticut Medicaid program performed an environmental scan of existing state models designed to support the needs of individuals with complex health profiles. The model that appears to be the best complement to Medicaid ICM is a patient navigation approach launched by Project Access – New Haven (PA-NH). PA-NH was founded in 2009 by a group of dedicated physicians who were concerned about health inequities in the Greater New Haven community. They partnered with local hospitals, health centers, and community organizations to explore and address the problem of inadequate access to medical care. PA-NH’s research objective around Medicaid beneficiaries is as follows: “Medicaid-insured patients often experience barriers to timely primary care and frequent the emergency department (ED) for conditions that could be treated in a primary care setting. Increasing access to primary care may reduce ED overutilization, but more information is needed to inform development of interventions that reduce access barriers and improve primary care engagement. PA-NH and the Yale-New Haven Hospital (YNHH) ED have partnered to improve primary care utilization and reduce ED visits for Medicaid beneficiaries through intensive patient navigation (PN). PN services include: connection with a primary care provider (PCP) if needed, appointment scheduling/reminders, accompaniment to a PCP visit, development of a care plan with the PCP, and assistance overcoming access barriers (e.g., transportation coordination).”

Brief Narrative:

Connecticut Medicaid proposes to focus its participation in Track 2.0 of the National Governors Association “Developing State-Level Capacity to Improve Health and Reduce Cost of Populations with Complex Care Needs” opportunity on examining whether and how a local high utilizer intervention - Project Access New Haven’s model of patient navigation - could be paired with Connecticut Medicaid’s existing claims-based risk stratification and Administrative Services Organization-based Intensive Care Management (ICM) interventions to further improve outcomes, including, but not limited to, 1) rates at which Medicaid beneficiaries fail to fulfill primary care and specialty visits (no-show rates); 2) inappropriate use of the hospital emergency department; and 3) readmissions to the hospital. The PA-NH model represents great potential to augment the Connecticut Medicaid’s ICM model in targeted areas of the state.

Connecticut Medicaid’s ICM currently focuses around the following:

Interventions through our medical ASO, CHN: CHN utilizes a stratification methodology to identify members who presently frequent the emergency department (ED) for primary care and non-urgent conditions as well as those at risk of future use of acute care services. High risk members are defined as those who have claims data of

seven (7) or more ED visits in a rolling year; members with twenty (20) or more ED visits in a rolling year are defined as ED Super Users and are considered highest risk. ICM focuses on high risk members with multiple co-morbid, advanced, interrelated, chronic and/or behavioral (psychiatric and/or substance abuse) conditions. These members frequently exhibit instability in health status due to fragmented care among multiple providers, episodes or exacerbations and/or complications and impaired social, economic and material resources and tend to have higher ED utilization. Many of these members are homeless and are in need of coordinated housing and access to health homes. Individuals with multiple chronic conditions benefit from an integrated plan of care that incorporates behavioral and non-medical supportive services.

Interventions through our behavioral health ASO, Value Options: Under the direction of the three state agencies that manage the Connecticut Behavioral Health Partnership (the Departments of Social Services, Mental Health and Addiction Services, and Children and Families), Value Options used claims and other data to identify the five Connecticut hospitals that were associated with the greatest number of Medicaid high utilizers. ValueOptions then designed and implemented a multi-pronged approach to reduce the inappropriate use of the emergency department for individuals with behavioral health conditions. This approach includes 1) assigning ICM care managers to individuals who have visited the ED, with a primary or secondary behavioral health diagnosis, seven or more times in the six months prior to participation in ICM; 2) assigning peer specialists to members who could benefit from that support; and 3) dedicating a Regional Network Manager to help facilitate all-provider meetings to address the clinical and social support needs of the involved individuals. These provider meetings are multi-disciplinary and include, but are not limited to representatives from housing organizations, substance abuse and mental health providers, shelters, Federally Qualified Health Centers, and staff from the respective EDs.

ICM interventions have: 1) **reduced** emergency department (ED) usage for members engaged in the CHN ICM program by 15.1% and **inpatient admissions by 50.7%**; 2) **reduced** overall readmission rate within 30 days by 2.9%; 3) **reduced** readmission rate by 44.4% for those members receiving CHN's intensive discharge planning; 4) **improved** outcomes for individuals served by the ValueOptions ICM program, including a **72.7% reduction** in total days in a confined setting; a **73.5% reduction** in psych days; a **69.2% reduction** in inpatient detoxification days; and a **10.5% increase in total days in the community**; and 5) **improved** outcomes for individuals served by the BeneCare ICM program, including: a **reduction in use of the ED for dental care to less than 5%**; and an **increase in utilization of preventative dental services by children** served by HUSKY A and B **from 36% in 2008 to 58% in 2013**.

Although the above interventions have demonstrated considerable success, Connecticut wishes to evolve its current federated ICM approach to one that includes local strategies, such as the successful patient navigation model launched by PA-NH.

State Policy Academy Team - Connecticut proposes to include the following team: Kate McEvoy, Director of the Division of Health Services (Medicaid Director), Department of Social Services (DSS) – will act as team leader; Dr. Robert Zavoiski, Medical Director, DSS – will provide clinical oversight and act as lead liaison with Medicaid Administrative Services Organizations (ASOs) (medical, behavioral health, dental and non-emergency medical transportation); Karen Andersson, Director of the Behavioral Health Partnership, Department of Children and Families (DCF) – will represent DCF in its role as partner agency in the Connecticut Behavioral Health Partnership; Colleen Harrington, Director of Managed Services Division, Department of Mental Health and Addiction Services (DMHAS) – will represent DMHAS in its role as partner agency in the Connecticut Behavioral Health Partnership; Dr. Kathy Maurer, Medical Director, Department of Correction (DOC) – will represent DOC and Medicaid beneficiaries with corrections involvement; and Anne Foley, Undersecretary, Office of Policy & Management (OPM) – will represent Connecticut’s budget and planning agency.

Demonstrated commitment from relevant leaders across state government - All Connecticut human services departments, as well as the Department of Correction, and the medical ASO, which performs data analytic functions for Medicaid, will be represented. The above individuals already regularly collaborate on a range of integration projects in support of Connecticut Medicaid beneficiaries. Connecticut’s team leader, Kate McEvoy will convene the above group and will facilitate decisions of the team around strategic direction, engagement with proposed partner Project Access New Haven, engagement with stakeholders, participation in obligations of the NGA Policy Academy, and development of an implementation pathway for the proposed patient navigation strategy.

Health information technology and data analytics capability - Connecticut Medicaid is uniquely situated in its data analytic strength. Since 2012, Connecticut Medicaid has had the benefit of a fully integrated set of claims data across all categories of Medicaid services. The Department’s medical ASO, CHN, maintains this data within the Utilization & Cost Analyzer (UCA) system, an analytical and data discovery tool that includes Medicaid claims, member eligibility, and provider data. UCA utilizes QlikView software and is uploaded monthly with claims, member eligibility, and provider data directly from CHN’s data warehouse specific to the Connecticut Medicaid program. UCA provides a simple, rapid, and comprehensive means of assessing medical cost and utilization trends in various cuts of the claims, member eligibility and provider data with multiple layers of drillable investigative analysis, down to the claim, member and provider level.

CHN has extensive predictive modeling and data analytic capabilities through use of DSTHS CareAnalyzer®, a web-based tool that combines elements of patient risk, care opportunities and provider performance. The tool is updated on a monthly basis with Medicaid claims, member

eligibility, provider data and lab results. CareAnalyzer® includes two main components: quality measures including NCQA HEDIS® certified measures and the Johns Hopkins ACG® (Adjusted Clinical Group) system. In addition, CareAnalyzer® contains a series of reports designed to provide information on provider effectiveness (quality of care) and provider efficiency (cost of care). CHN uses the HEDIS® measures within CareAnalyzer® to monitor performance throughout the year on key measures. Performance is monitored at the population level, by setting (e.g., PCMH, hospital clinic, and non-PCMH community practice) and at the individual practice level. Data is also pushed out to PCMH practices.

Further, the Department of Social Services is charged with: 1) convening a cross-agency Health Information Technology (HIT) Council that is developing strategic direction around electronic exchange of information; 2) developing a Medicaid provider directory; 3) promoting the use of DIRECT messaging; and 4) through federal TEFT grant funds, incorporating within replacement of the Department's Eligibility Management System a Personal Health Record (PHR) for recipients of long-term services and supports. These tools will support provider communication and coordination around the needs of individuals with complex care profiles.

Comprehensive stakeholder engagement plan - The Connecticut team will engage with a range of stakeholders including, but not limited to, the four Medicaid Administrative Services Organizations (CHN – medical ASO; Value Options – behavioral health ASO; BeneCare – dental care ASO; Logisticare – non-emergency medical transportation ASO), Project Access New Haven, the Connecticut Hospital Association, and the Connecticut Association of Health Care at Home. Connecticut Medicaid has been in communication with PA-NH over the last several years and will build on that existing relationship.

Connecticut's stakeholder engagement will focus upon 1) creation of an advisory group composed of members of existing, statutory, Medicaid oversight bodies; and 2) engagement with a range of grass roots, consumer-based groups that are focused on beneficiary experience and engagement with Medicaid. Connecticut has the benefit of two existing, longstanding stakeholder groups that will be tapped to create an advisory group in support of this initiative. The Medical Assistance Program Oversight Council (MAPOC) is charged under statute with a broad range of oversight functions relating to all aspects of operation of Connecticut Medicaid. The Behavioral Health Partnership Oversight Council is similarly charged under statute, with a focus upon behavioral health. Both councils meet monthly, and are affiliated with a range of committees that also typically meet monthly. Further, the project work group will reach out to a number of standing, consumer-based groups including, but not limited to, the Kitchen Cabinet of the Christian Community Action Agency of New Haven, and the Caring Families Coalition of the United Connecticut Action for Neighborhoods, to solicit their views on barriers to effective access to care as well as proposed enabling tools and solutions for individuals with complex care needs.

Anticipated outcomes and challenges - Connecticut expects that participation in the policy academy will provide benefits including, but not limited to, consideration of peer state perspectives on implementation of community health workers (CHW) as navigators within high utilizer interventions, as well as dedicated time to conceptualize the definition of and means of covering the CHW service under the Medicaid State Plan. By the end of the policy academy, Connecticut expects to have assessed whether and how Project Access New Haven's (PA-NH's) model of patient navigation could be paired with Connecticut Medicaid's Intensive Care Management (ICM) interventions to further improve outcomes, including, but not limited to, rates at which Medicaid beneficiaries fail to fulfill primary care and specialty visits (no-show rates). Further, Connecticut expects to have developed a plan for implementation of this model.

Connecticut approaches this initiative from a position of strength, with respect to availability of data, data analytic capability, and an existing community-based model of patient navigation (PA-NH) that is intensely data-focused in its analysis of outcomes. Risks and challenges associated with this project include difficulty in settling the terms of a definition of the community health worker role, need for guidance from the Centers for Medicare and Medicaid Services (CMS) on covering such services under the preventative services Medicaid State Plan option, and process through which a State Plan Amendment will be reviewed.

Implementation prospects - Connecticut Medicaid is committed to framing the patient navigation initiative (including definition of the service; credentials/training of those providing the service; and projection of potential improvements to care experience and health outcomes, as well as cost savings associated with timely and appropriate utilization of primary and specialty care, in lieu of hospital emergency department and inpatient care) and presenting a proposal to the Office of Policy and Management, Connecticut's budget office. Connecticut Medicaid anticipates that, if the Office of Policy and Management approves the patient navigation proposal, it will be necessary to prepare and seek approval from the Centers for Medicare and Medicaid Services (CMS) for a State Plan Amendment to Connecticut's Medicaid State Plan.

Participation in the policy academy, and more specifically, development of a proposal to augment Connecticut's existing Administrative Services Organization (ASO)-based Intensive Care Management (ICM) intervention with local, community-health worker oriented patient navigation supports, will neatly complement Connecticut Medicaid's existing reform efforts. Connecticut's Medicaid agency, the Department of Social Services, is employing diverse strategies to achieve improved health outcomes and cost efficiencies in the Medicaid program. These strategies include: 1) use of an ASO platform to promote efficient, cost-effective and consumer/provider responsive Medicaid services; 2) use of data analytics to improve care; 3) activities in support of improving access to preventative primary care; 4) efforts to support integration of medical, behavioral health, and long-term services and supports (LTSS); 5) initiatives designed to "re-balance" spending on LTSS through diverse strategies including the

Balancing Incentive Program, TEFT, workforce and nursing home “rightsizing” initiatives; and 7) efforts to promote the use of health information technology.

Further, Connecticut Medicaid is instrumentally involved in Connecticut’s State Innovation Model Test Grant initiative, notably, as lead agency for development of the proposed Medicaid Quality Improvement and Shared Savings Program (MQISSP). MQISSP will build on Connecticut Medicaid’s existing, successful Person-Centered Medical Homes (PCMH) by incorporating new requirements related to integration of primary care and behavioral health care, as well as linkages to the types of community supports that can assist beneficiaries in utilizing their Medicaid benefits. Partnering with providers on this will begin to re-shape the paradigm for care coordination in a direction that will support population health goals for individuals who face the challenges of substance abuse and behavioral health issues, limited educational attainment, poverty, homelessness, and exposure to neighborhood violence.

MQISSP will focus on Medicaid beneficiaries served by Federally Qualified Health Centers and “advanced networks” (e.g. Accountable Care Organizations). Connecticut’s proposed policy academy patient navigation project will be informed by model design for MQISSP, but will also give the Department of Social Services (DSS) the capacity to expand community health worker interventions to the Medicaid population at large and to do so via local, community-based means.

Further, Connecticut Medicaid anticipates that the patient navigation approach will act as an effective complement to two other emergency department diversion initiatives, implementation of which DSS will be evaluating over the course of the next year. First, DSS will partner with the Connecticut Department of Public Health (DPH) to review and assess the need for changes in the scope of practice for Connecticut Emergency Medical Technicians (EMTs) in support of performing additional home health, hospital discharge-related and/or hospice functions (a “community paramedicine” approach). Further, DSS is considering implementation of Utah’s “Safe to Wait” initiative, under which Medicaid beneficiaries are educated to assess whether a presenting health concern necessitates a trip to the emergency department, as well as equipped with information on alternate sources of care (e.g. urgent care, primary care).

- **Description of the complex care needs population that will be served**

Connecticut Medicaid proposes to focus upon individuals who risk stratify through the CareAnalyzer® tool at highest level of need. Further, Connecticut Medicaid proposes to consider tailoring patient navigation, on a local basis, to populations that face particular challenges of access and coordination, including, but not limited to, individuals who have experienced corrections involvement.