Presentation to the Medicaid Care Management Oversight Council
February 18, 2011

A New Strategy for Health Care Purchasing

Announcement by the Malloy/Wyman Administration, February 8, 2011

- Streamlining administration of health care services for nearly 600,000 residents
- Moving to administrative services organization (ASO) structure
- Goals of reduced overhead costs, improved service delivery, readiness for national health care reform

“This will bring together the best parts of two parallel systems whose current structure makes it difficult to run an economical program that also delivers quality services.”

--**Lt. Gov. Nancy Wyman**

“With this change, Connecticut will be able to bring vital assistance and coordination to the care of senior citizens and adults…”

--**OPM Secretary Ben Barnes**

System Change Overview

Implementation date: January 1, 2012

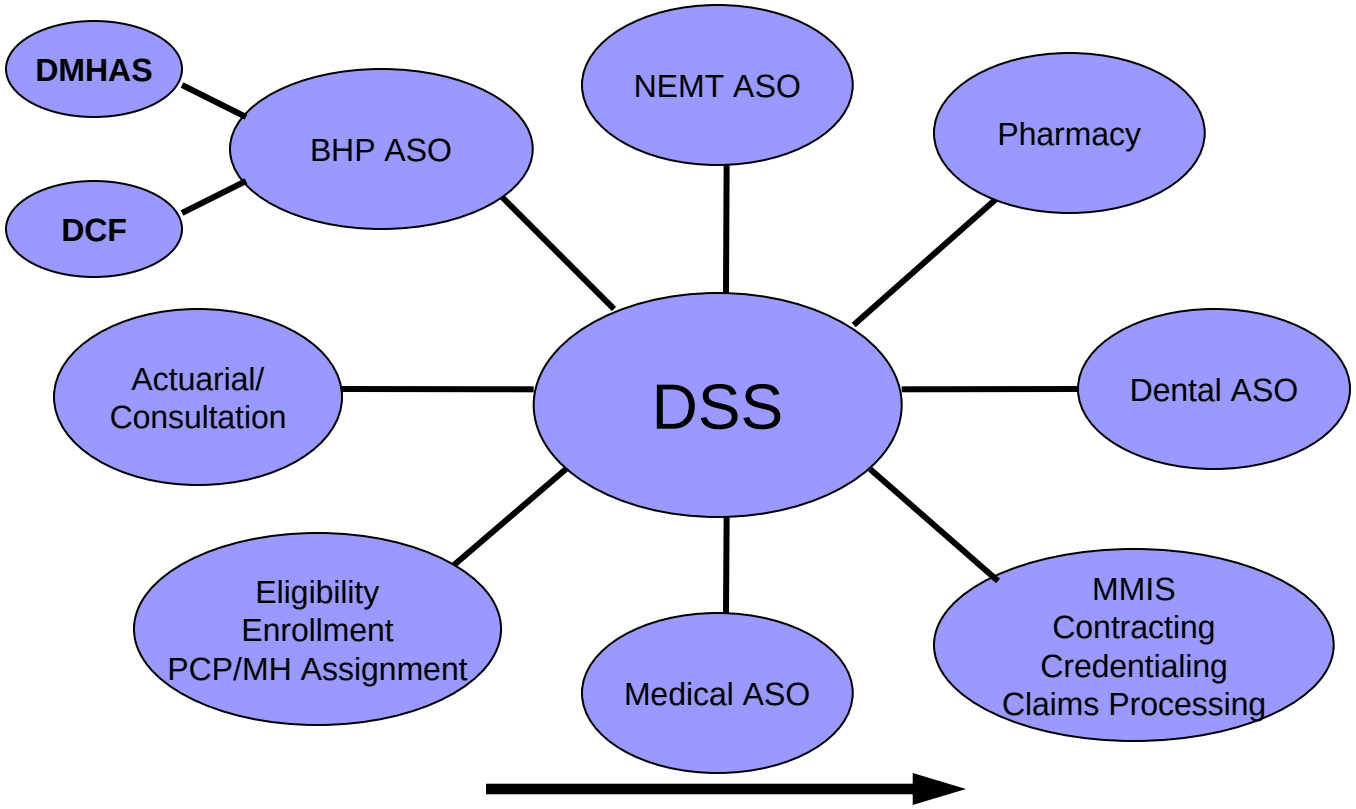
- Elimination of capitated managed care
- New medical Administrative Services Organization structure to manage benefits for all medical assistance populations (HUSKY A/B, Medicaid for Aged/Blind Disabled, Medicaid for Low-Income Adults, Charter Oak Health Plan)
- Single ASO for all Non-Emergency Medical Transportation

Statutory Authority

Public Act 10-179, Section 20 (budget legislation) included permissive authority, stating that the Department of Social Services:

"may contract with one or more administrative services organizations to provide care coordination, utilization management, disease management, customer service and review of grievances for recipients of assistance under Medicaid, HUSKY Plan, Parts A and B, and the Charter Oak Health Plan. Such organization may also provide network management, credentialing of providers, monitoring of copayments and premiums and other services as required by the commissioner. Subject to approval by applicable federal authority, the Department of Social Services shall utilize the contracted organization's provider network and billing systems in the administration of the program."

Health Purchasing Model



PCP - Medical Home - Health Home - Integrated Care Organization

CT Medical Assistance Program (CMAP) Provider Network

Current Challenges

Current Challenges

Fee for Service

- Services are 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

Current Challenges

Fee for Service

- Difficulty accessing 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

Current Connecticut 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 all medical assistance recipients
- UCONN medication management and dementia care initiatives
- Centers of care focused on geriatrics

Current Connecticut 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)
- Progress on medical homes in commercial sector

No System to Measure Value

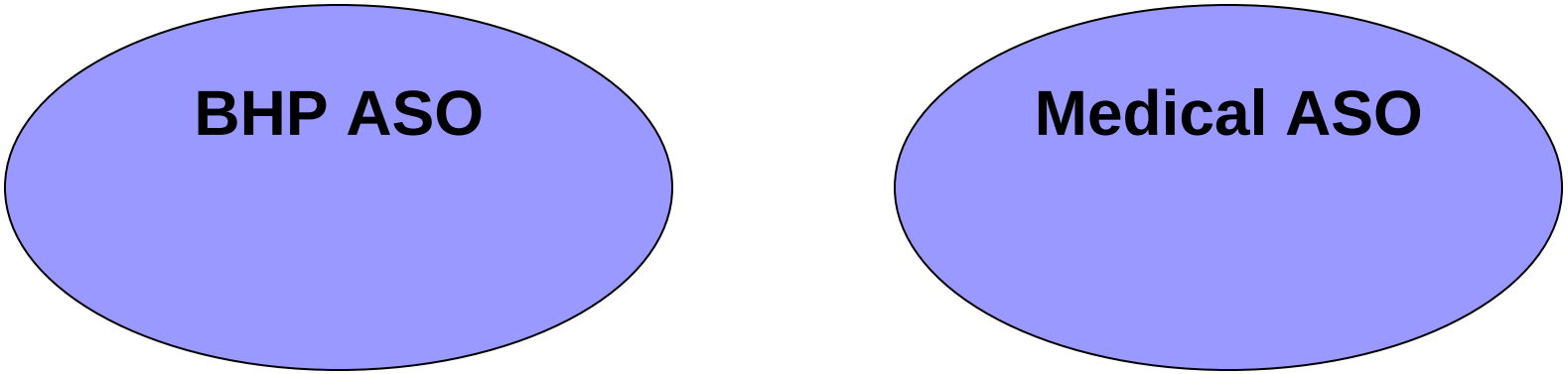
- Isolated initiatives cannot overcome the fragmentation inherent in the way that services are organized and delivered
- No system of providers in any part of the state can measure the value they provide to Medicaid recipients
- No system of providers can tell you whether they are providing better overall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

Overarching Goal

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

Care Management Delivery System

Health Purchasing Model



CT Medical Assistance Program (CMAP) Provider Network

Medical ASO

Functions

- call center services (i.e., referral assistance, appointment scheduling, benefit information),
- utilization management
- *possible* assignment to PCP or Medical Home to foster use of a usual source of care (not a gatekeeper)
- routine *Care Coordination* for all members
- *Intensive Care Management* services for members with complex needs (communicating with multiple involved providers to try to resolve problems, ensure access to necessary services, assistance with care transitions, etc.)

Medical ASO

Functions

- coordination with dental, behavioral health, pharmacy, transportation, and waiver programs
- health informatics such as predictive modeling, health risk stratification, and health risk assessment to support population health management and disease management
- development and production of member handbooks
- cost and quality data aggregation to support profiling of ASO, providers and local provider entities (medical homes, health homes, integrated care organizations)
- Not responsible for provider network (contracting, credentialing or claims)

Promoting Change in Service Delivery and Organization

- ASO provides uniform structure for reporting, customer service, and care management
- Changes in the delivery and organization of services at the local level are of equal or greater importance.
- New model moves beyond PCP assignment to promote the emergence of medical homes and health homes

Patient Centered Medical Home

Definition

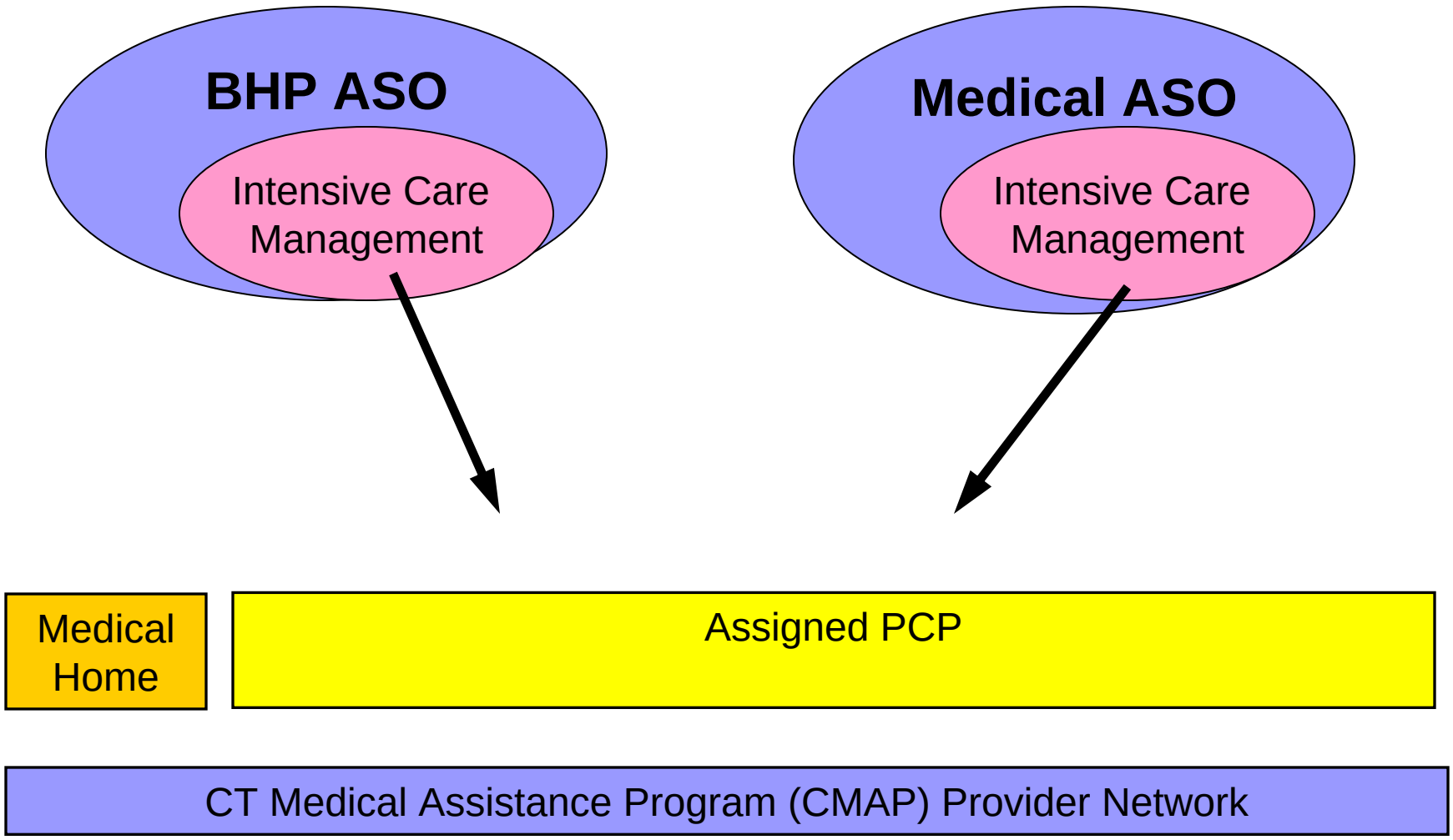
- An approach to providing accessible, continuous, coordinated and comprehensive primary care that facilitates partnerships between individual patients and their personal providers, and when appropriate, the patient's family
- The provider receives supplementary payments for coordinating patient care**.** The provider is required by terms of the agreement to provide this coordination and is encouraged to improve practice infrastructure in order to qualify as a medical home

Patient Centered Health Home

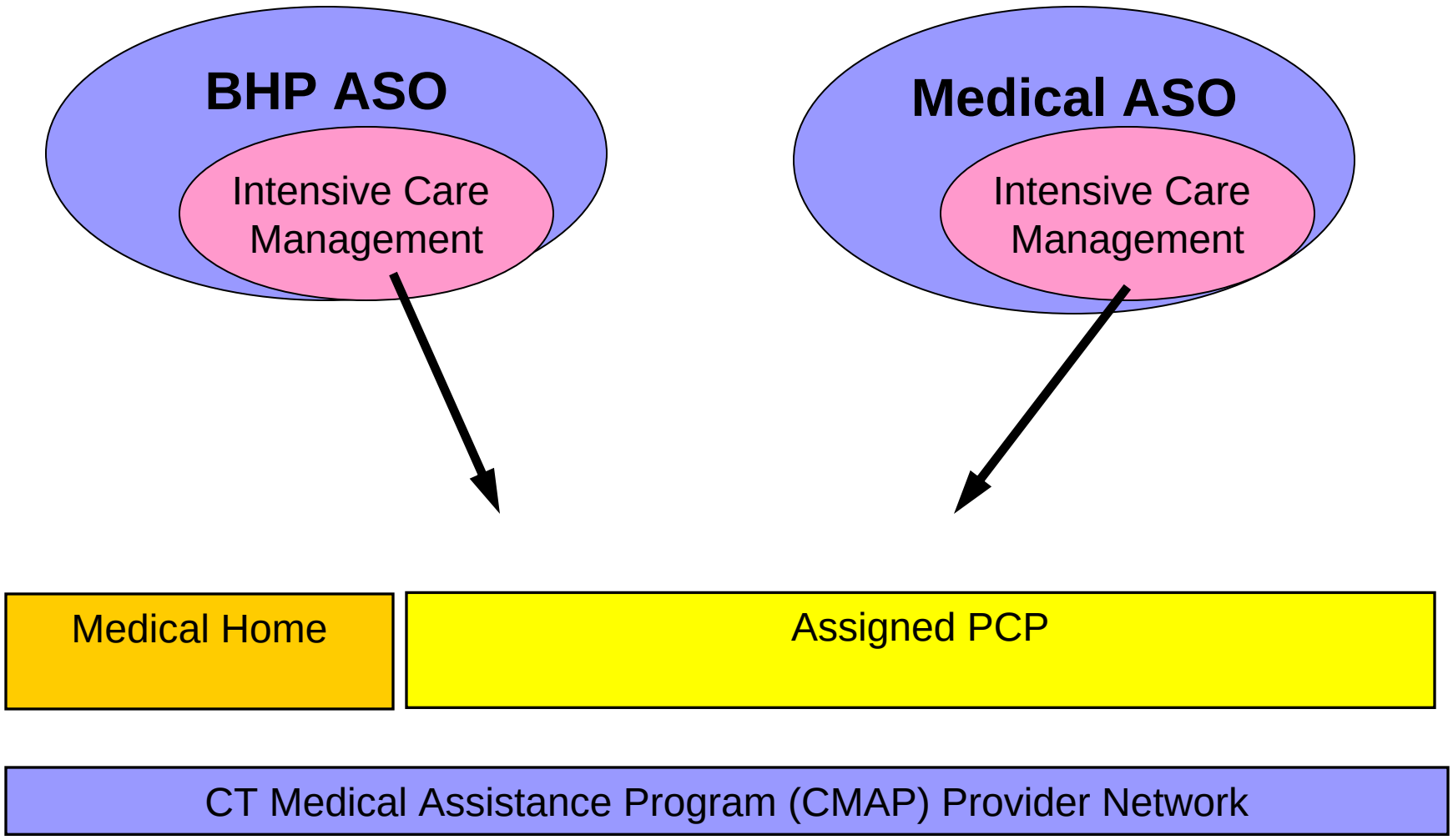
Definition

- As defined in the Affordable Care Act, “health home” means a designated provider (including a provider that operates in coordination with a team of health care professionals) *or a health team* selected by an eligible individual with chronic conditions to provide health home services.
- Health home services include (i) comprehensive care management; (ii) care coordination and health promotion; (iii) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; (iv) patient and family support (including authorized representatives); (v) referral to community and social support services, if relevant; and (vi) use of health information technology to link services.

Pathway to Medical & Health Homes



Pathway to Medical & Health Homes



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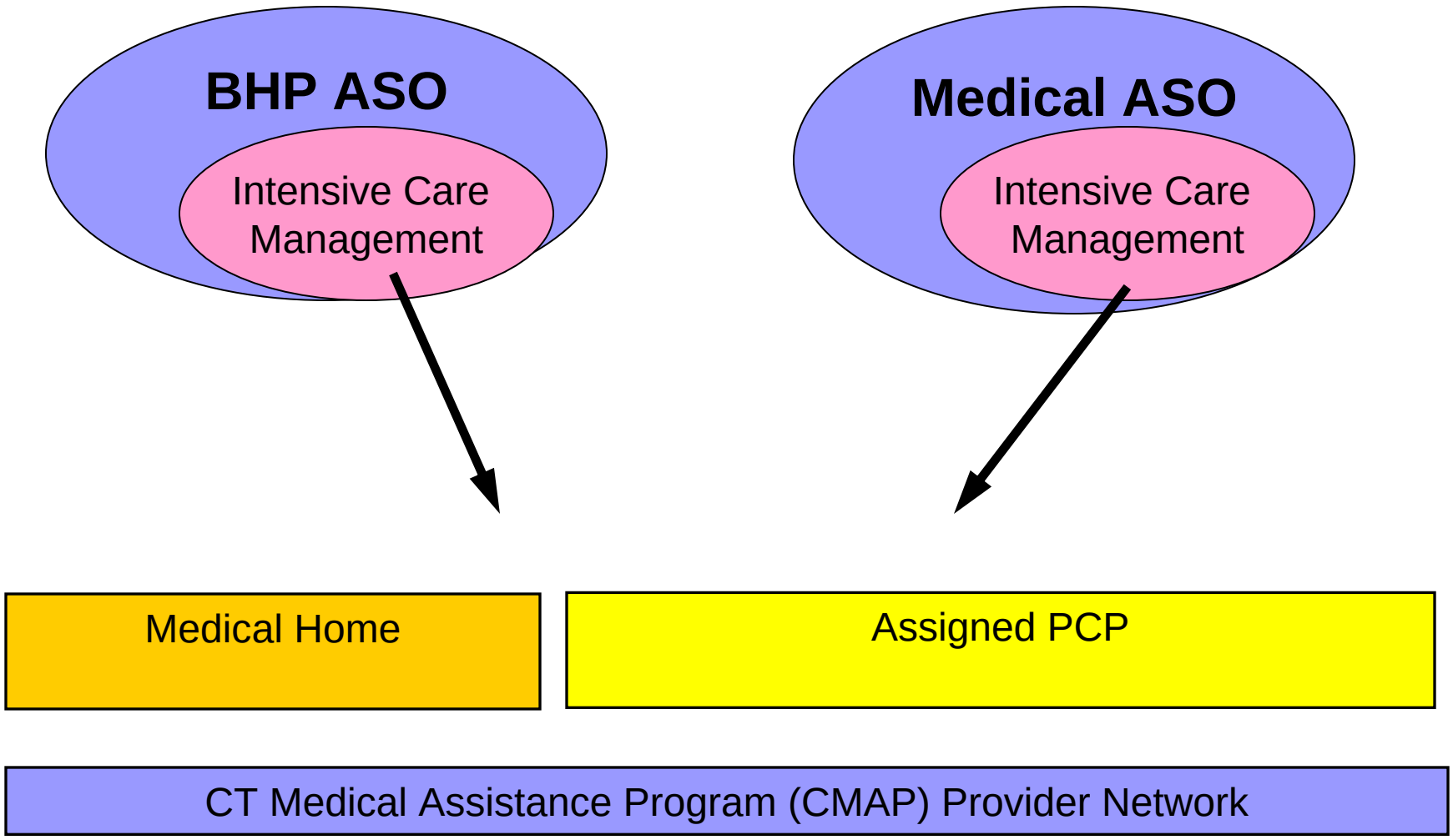

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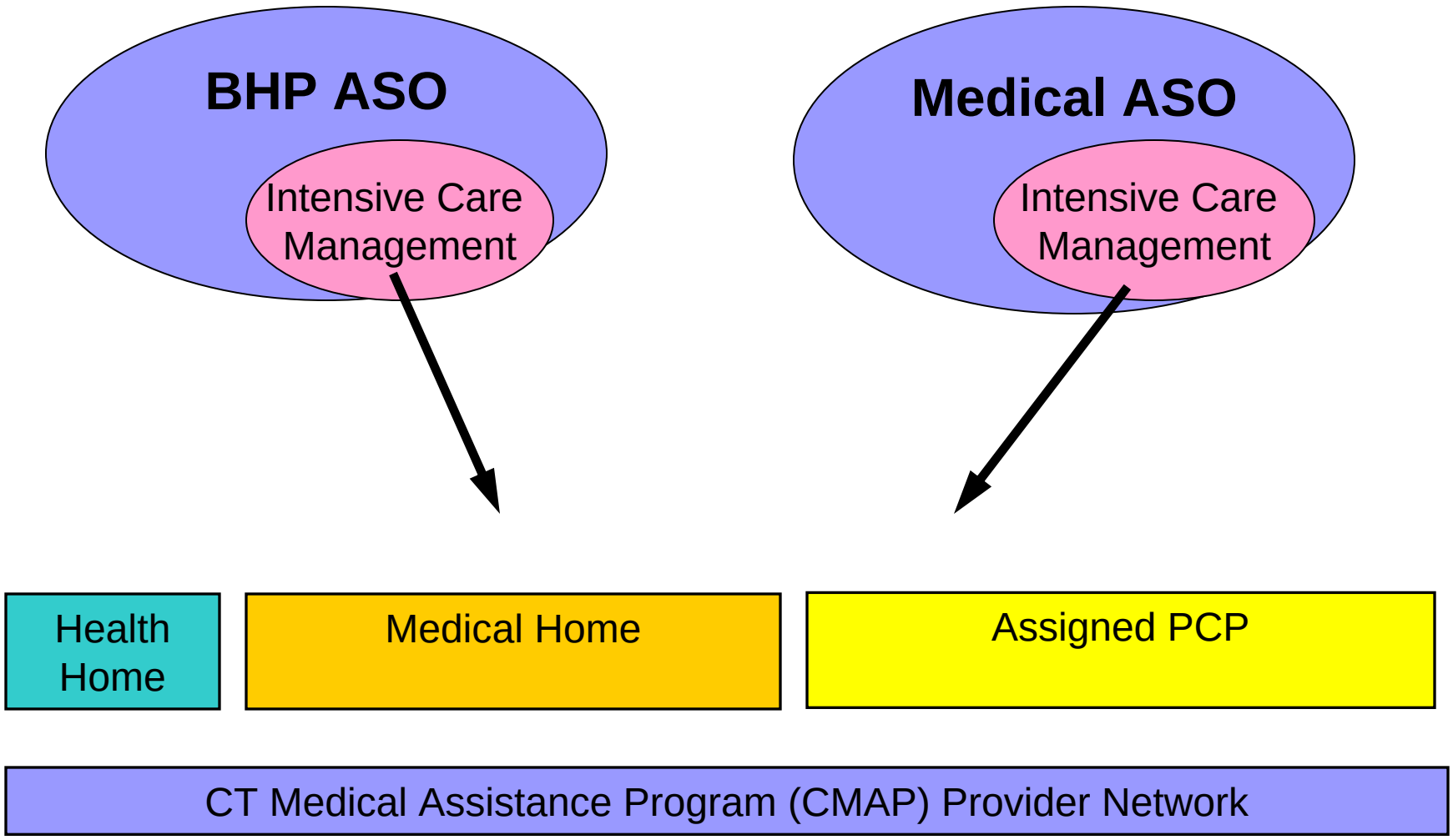

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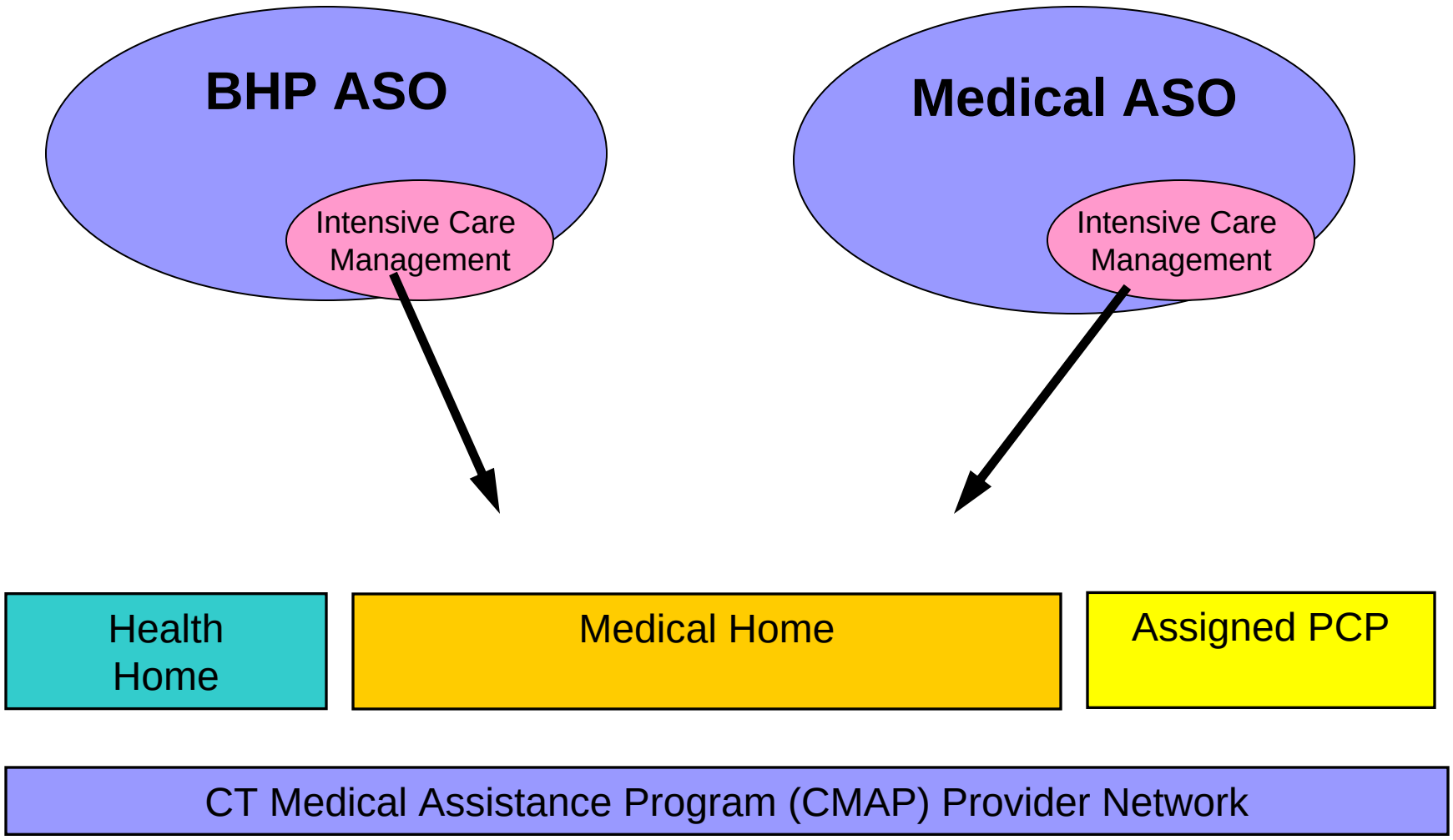

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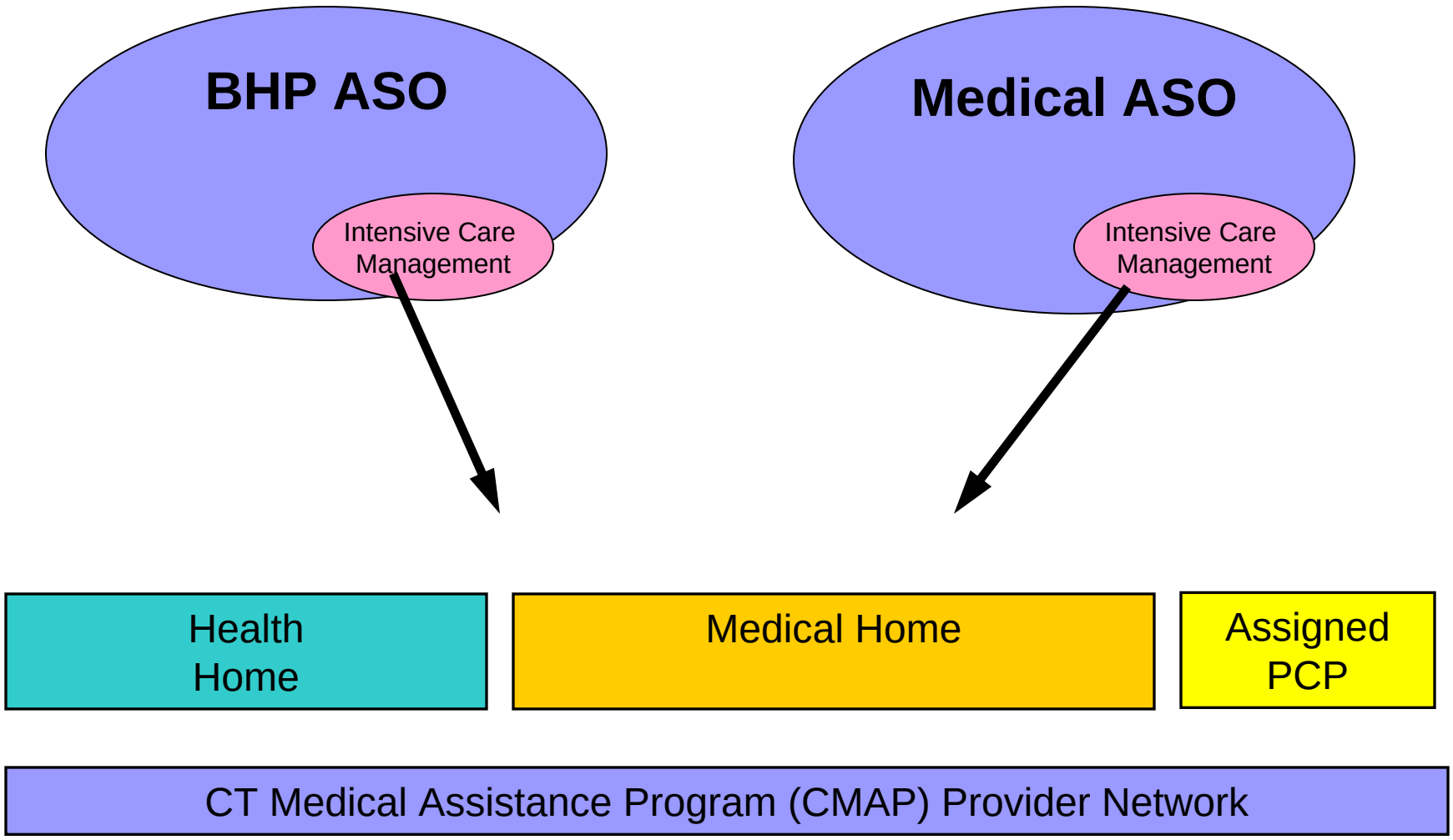

Service Delivery and Organization

Summary

- ASO positioned to support clients and improve care for all individuals
- Gradual emergence of medical homes with ability to facilitate referrals, help individuals navigate the system, and coordinate care
- More advanced medical homes will be qualified to serve as health homes for individuals with chronic illnesses
- ASO resources can be reduced as providers are better able to provide services and supports
- ASO resources will likely remain for selected functions and to address gaps in the system
- ASO can continue to provide care coordination and intensive care management for individuals without a medical or health home

Measuring & Rewarding 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 funded service costs associated with the care and support of enrolled individuals across the continuum of health services

Financial Incentives Linked to Value

- ASOs, Medical Homes and Health Homes will be eligible for financial incentives based on the value that they provide
- Incentives will be aligned so that ASOs and medical/health homes are working toward shared goals
- Medical/health home incentives not to exceed 5% of base PMPM
- Will explore similar incentives for broader provider community

Questions?