Presentation to the Medicaid Care Management Oversight Council
April 8, 2011

Health Care Restructuring

Health Care Restructuring

Updates

- Medicaid State Technical Assistance Teams
- Statement of concept for CMS review
  - March 30, 2011
- Medical ASO RFP released
  - April 5, 2011

Health Care Restructuring

Medical ASO Procurement Timeline

Milestones	Ending Dates
RFP Released	4/06/2011
Bidders Conference	4/19/2011
Deadline for Letter of Intent 3:00 PM Local Time	4/21/2011
Deadline for Written Questions 3:00 PM Local Time	4/28/2011
Responses to Questions (tentative)	5/5/2011
Proposals Due by 3:00 PM Local Time	5/26/2011
Successful Bidder Announced	7/1/2011
Contract Negotiations Begin	7/1/2011
Execute Contract	8/1/2011
Operational Program Begins	1/1/2012

State Demonstrations to Integrate Care for Dual Eligible Individuals

Dual Eligible Demonstration

Source

- Center for Medicare and Medicaid Innovation Center (CMMI)
- Federal Coordinated Health Care Office
- Responsible for new initiatives to better integrate care for individuals who are eligible for Medicaid and Medicare…(aka “dual eligibles”)

Dual Eligible Demonstration

Purpose

- Funding to support design of innovative service delivery and payment models for dual eligibles
- Build on new approaches (e.g., health homes, accountable care organizations) to create new person-centered models that align the full range of acute, behavioral health, and long term supports and services and improve the actual care experience and lives of dual eligible beneficiaries

Connecticut Landscape

Dual Eligible Demonstration

Facts

- In 2007, dual eligible individuals represented 19% of Connecticut's Medicaid beneficiaries and 19% of its Medicare population
- However, they accounted for 58% of Connecticut's Medicaid expenditures, fully 50% higher than the national rate of 39% in the US and about 25% of Medicare's expenditures.

Dual Eligible Demonstration

Facts

- Medicaid spending per dual eligible in Connecticut is nearly twice the national average
  - $27,619 compared to $15,900 nationally,
- Connecticut has approximately 75,000 dual eligible individuals with full Medicaid coverage and about 50,000 dual eligible individuals with partial Medicaid coverage
- 60% of the full coverage duals are over 65
- 40% are disabled or chronically ill.

Dual Eligible Demonstration

Core Challenges

- Services are highly 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

Dual Eligible Demonstration

Core Challenges

- Lack of access to 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

Dual Eligible Demonstration

Current 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 ABD and dual eligibles
- UCONN medication management and dementia care initiatives
- Centers of care focused on geriatrics

Dual Eligible Demonstration

Current 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)

Dual Eligible Demonstration

Core Problem

- 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 dual eligible beneficiaries
- No system of providers can tell you whether they are providing better overall value over time

Dual Eligible Demonstration

Overarching Goal

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

The Integrated Care Organization Model

Integrated Care Organization

Program Model

- Establish local Integrated Care Organizations
- A consortium of provider partners contracted with DSS
- Broadly accountable for:
  - Primary, specialty and hospital care and other healthcare services
  - Long term care services and supports
- Includes person centered medical homes and health home(s)

Person Centered Health Home

Core Team

- Primary Care Providers (PCPs)
- APRNs for ongoing support during and between regular visits, as well as in hospital or rehab facilities to facilitate communication and discharge planning
- Care coordinators (w/ appropriate specialization)
- Access Agency Case Managers (or other waiver case manager in out years)
- Pharmacist to provide consultation for persons with multiple chronic medications, and
- Behavioral health practitioners

Patient Centered Health Home

Enhanced Services and Supports

- Comprehensive initial and annual assessments of medical, behavioral, social, transportation, medical equipment, and support needs
- Home visit upon enrollment and at subsequent annual comprehensive assessments
- Specialty care clinics including at least two specialties that meet the needs of the elderly population

Patient Centered Health Home

Enhanced Services and Supports (cont)

- Assistance with linking to services such as transportation, specialty medical services, and needed social services and supports,
- Person-centered care plans developed with and by dual eligibles and family caregivers that provide for the maximum amount of self-direction desired,
- Medication management services through an on-site consultation with the PCP and pharmacist,
- Hospital, rehab and nursing home transition coordination including medication reconciliation by the pharmacist

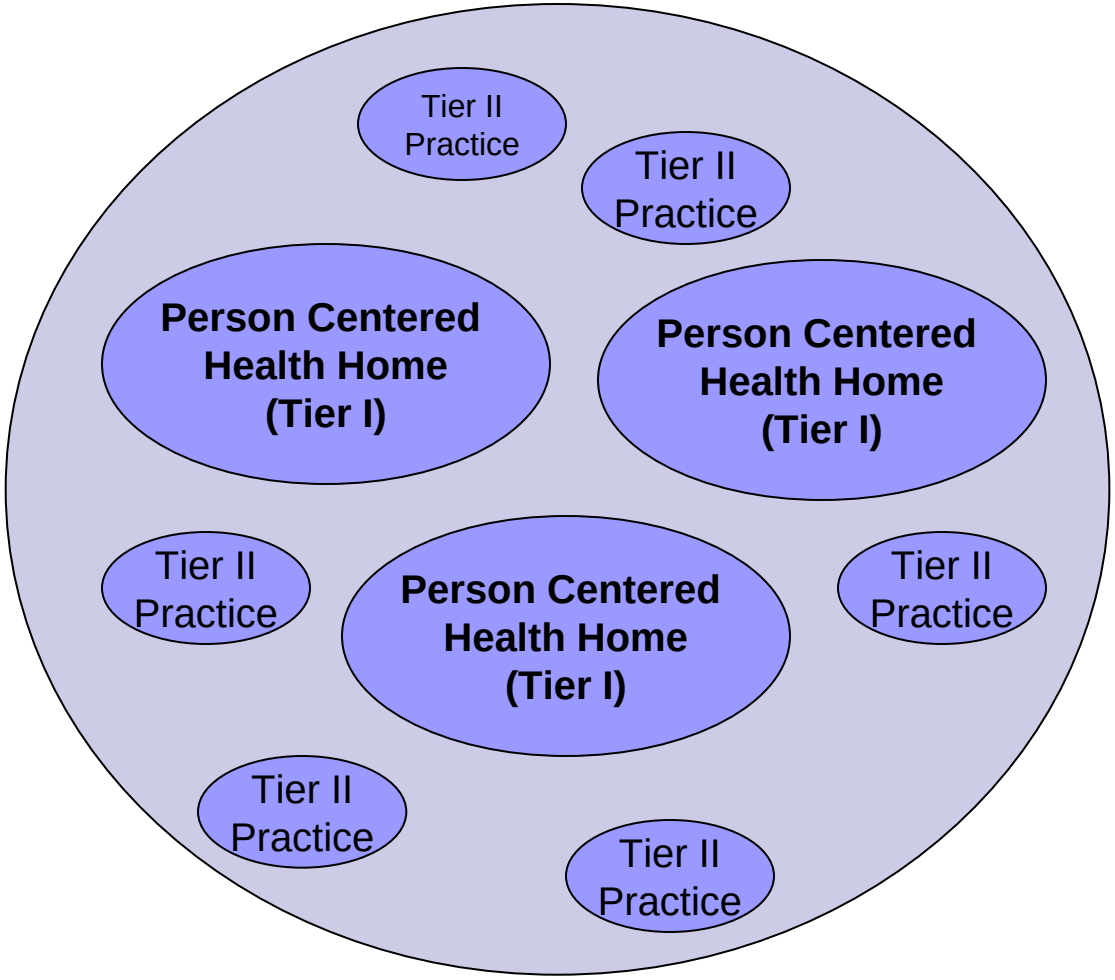
Patient Centered Health Home

Enhanced Services and Supports (cont)

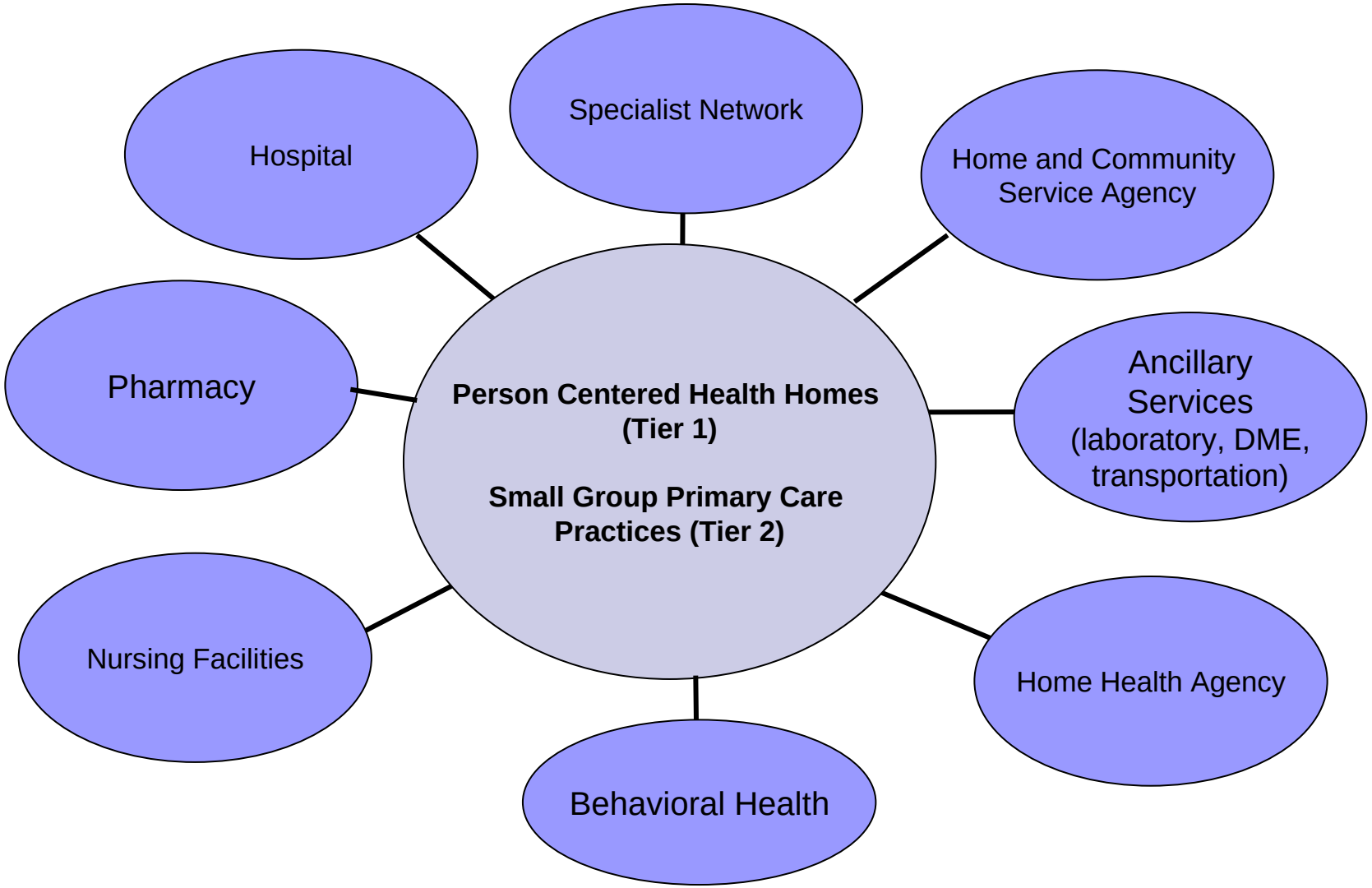
- Dementia assessment with family education and support curriculum,
- On-site assessments of activities of daily living and level of care,
- Enhanced communication through use of electronic health records and an electronic person-centered care plan,
- Warm line access to a nurse practitioner, care coordinator, case manager, or other team member as a way to ask questions about health, treatment, housing, family, transportation, safety, or other issues

Integrated Care Organization

Small Group Primary Care Practices



Integrated Care Organization



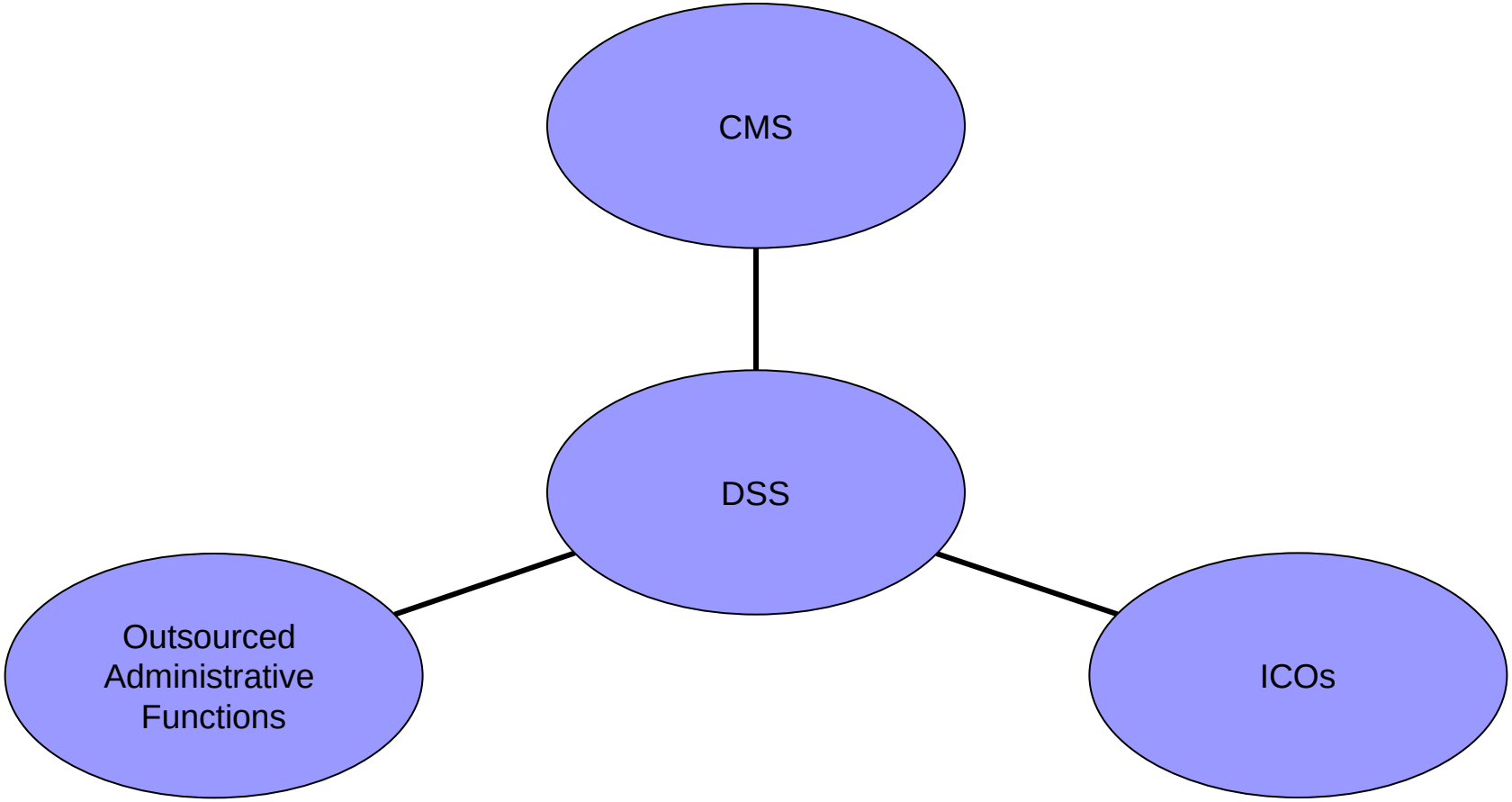
Integrated Care Organization

Hub and Spoke

- Partnership “spokes” will extend from the health home and small practice “hub”
- Extended service team partners comprised of hospitals, nursing homes, and extended primary, acute, specialty, rehabilitation, behavioral health, HCBS services, and pharmacy providers connected as a virtual team through electronic communications or in-person as needed
- Agreements with existing Area Agencies on Aging, Aging and Disability Resource Centers and Independent Living Centers

Integrated Care Organization

Role of DSS



Integrated Care Organization

Role of DSS

- Set overall program objectives in consultation with Care Management Oversight Council
- Contract with CMMI to administer demonstration
- Receive Medicare gain share distributions and distribute to ICOs
- Establish ICO qualifications
- Administer ICO contracts
- Existing Medicaid administrative activities including state plan, policy, contracting, credentialing, claims, administrative hearings, HIT incentive payments, federal claiming, etc.

Integrated Care Organization

Role of DSS

- Will contract with ASO(s) for:
  - Call center services
  - ICO attribution
  - Measurement of ICO quality and outcomes
  - Health informatics including predictive modeling, population health management, health risk stratification, health risk assessment as needed to support ICO performance
- Will contract with actuary for:
  - Cost aggregation by ICO
  - Actuarial services
  - Provider profiling

Other Program Features

Program Features

Administration

- RFA to select 3 to 6 ICOs to begin operation in fourth quarter CY2012
- Administrative PMPM to ICOs to support service enhancements
- Medicare pays all claims for Medicare funded services
  - Current rates and methods
  - Existing due process rights
- Medicaid pays all claims for Medicaid funded services
  - Current rates and methods
  - Existing due process rights

Program Features

Population, Freedom of Choice

- Stage 1 focus on dual eligibles over 65, in communities and institutions
- Stage 2 focus on expansion to under 65 with disabilities
- Freedom to change PCPs and/or ICOs
- Freedom to go to any other Medicare or Medicaid provider
- Attribution process (opt in, opt out) to be determined

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

Quality and Outcomes

- Develop new measures consistent with program goals
- Compile measurement set from existing tools:
  - Member Satisfaction: CAHPS
  - Effectiveness of Care Measures: HEDIS
  - Outcomes Measures: AHRQ Prevention Quality Indicator Measures and HEDIS Use of Services
  - Gaps in care: Rand's Assessing Care of Vulnerable Elders (ACOVE-3)
  - MDS for Nursing Facility
  - QBAI/OASIS data for home health

Financing and Reimbursement

State and CMS
Medicare Program

- Medicare currently pays and would continue to pay for physician, hospital, lab, home health, medial equipment and supplies and other services
- Under demonstration, state would measure Medicare savings (if any) for the demonstration population
- Medicare and state would share Medicare savings net of administrative costs
- Sharing of savings may be contingent on achieving statewide quality and outcome targets

State and ICO
Medicaid & Medicare Programs

- Medicaid currently pays and would continue to pay cost-share for Medicare covered services (cross-over), and the full range of home health, behavioral health, dental, medical equipment and supplies, home and community based services, skilled nursing facility services and other Medicaid state plan services
- Under demonstration, state would measure Medicaid and Medicare savings (if any) for each ICO's enrolled demonstration population
- State would share Medicaid and Medicare savings net of administrative costs
- Sharing of savings would be contingent on achieving statewide quality and outcome targets

ICO and Provider Partners
Medicaid & Medicare Programs

- ICO would reinvest a portion of savings to support continued innovation and improvement in value
- ICO would also distribute a share of the savings to its provider partners, or
- Alternatively, a direct distribution of share of savings by state to providers

Method for Determining Savings
Medicare

- Savings measured against a projected per member per month (PMPM) budget target
- PMPM budget target calculated based on approach used by the CMS Medicare Advantage program for the dual eligible special needs plans
- Includes risk adjusted payments and adjustments for Medicare program changes and fee schedule changes that are outside of the control of the state
- Additional adjustments may be needed to reflect any risk characteristics not currently reflected in the CMS Medicare Advantage program methodology such as differentiation by nursing home versus community

Method for Determining Savings

Example

	PMPM	Enrollment	Budget
Risk Cell 1	$ 700	45	$ 31,500
Risk Cell 2	$ 800	60	$ 48,000
Risk Cell 3	$ 900	56	$ 50,400
Risk Cell 4	$ 1,000	35	$ 35,000
Risk Cell 5	$ 1,100	45	$ 49,500
Risk Cell 6	$ 1,200	25	$ 30,000
Risk Cell 7	$ 1,300	98	$ 127,400
		364	$ 371,800
Monthly PMPM	$ 1,021		

Budget

Contractual Services	**Estimate**
Project design and management support	$175,000
Data validation and analyses, risk adjustment review and budget projections	$325,000
Assessment/recommendations to develop performance measurement tools	$350,000
Medicare/Medicaid data set integration	$150,000
Total Services	**$1,000,000**

Dual Eligible Demonstration

Summary

- Connecticut's Dual Eligible Demonstration will align financial incentives to promote value – the enhancement of quality of care, the care experience and health outcomes at lower overall cost to the Medicare and Medicaid programs.
- Quality and outcome measures will focus both on medical service outcomes, as well as the effectiveness of home-and community-based services (HCBS) and supports, emphasizing individual satisfaction with the person-centered and disability competent care process.
- Risk-adjusted global budgets will be used to assess the ICO's effectiveness in managing overall cost, while retaining existing Medicare and Medicaid benefits and FFS reimbursement

Questions?