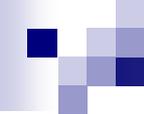


Medical Assistance Program  
Oversight Council  
October 12, 2012





# Today's Agenda

- Redetermination Update
- Duals Demonstration
- Eligibility and Enrollment Report

# Redetermination Update

- On June 22, the Department issued letter guidance to the regional offices establishing requirements for timely processing of Medicaid redeterminations. Under this guidance, the regional offices are required to do the following:
  - designate operations managers responsible for providing oversight, serving as the point of contact for emergencies, and using various sources (EMS Overdue Redetermination Report, monthly Medicaid download, other) to track progress in reducing pending overdue redeterminations

# Redetermination Update

- designate staff responsible for initiating all Medicaid redeterminations that are received in person at the office, by mail or by FAX
- implement streamlined procedures to distribute redeterminations to staff and to prioritize spend-down redeterminations for completion
- date stamp all redeterminations on the day on which they are received

# Redetermination Update

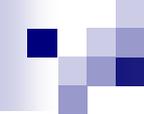
- initiate all redeterminations in EMS and update the EMS narrative within two business days of the stamped date (note that redeterminations that are received on the day before EMS month-end must be initiated the same day on which they are received)
- reinstate Medicaid in situations in which a re-determination form is received after EMS month-end but prior to the end of the calendar month

# Redetermination Update

- On June 27, the Department issued a clarification of the letter guidance stating that it is applicable to all redeterminations, including those received by regional offices prior to the issuance of the guidance
- On September 26, the Commissioner issued a memo to all staff reinforcing the June 22 guidance

# Redetermination Update

- On October 1, the Regional Administrators issued additional guidance to staff instructing them to review EMS alerts identifying clients scheduled for discontinuance due to failure to submit forms and check to see if those clients have, in fact, submitted their forms and should therefore not be discontinued
- This is the best available means, within current resources, to prevent individuals who have submitted forms as required from being discontinued



# Today's Agenda

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# Goals

Through the Demonstration, stakeholders and the Department seek to create and reward innovative local systems of care and supports that provide better value over time by:

- integrating medical, behavioral and non-medical services and supports
- providing financial incentives to achieve identified health and client satisfaction outcomes

# Key Structural Features

- Enhanced ASO Model
  - Under the Demonstration, the ASO will address the need for more coordination in providing services and supports, through such means as:
    - integration of Medicaid and Medicare data
    - predictive modeling
    - Intensive Care Management (ICM)
    - electronic tools to enable communication and use of data

# Key Structural Features (cont.)

- Expansion of Person-Centered Medical Homes (PCMH) pilot to serve MMEs
  - Under the Demonstration, the Department will extend the enhanced reimbursement and performance payments to primary care practices that serve MMEs

# Key Structural Features (cont.)

- Procurement of 3-5 “Health Neighborhoods” (HNs)
  - HNs will reflect local systems of care and support and will be rewarded for providing better value over time
  - HNs will be comprised of a broad array of providers, including primary care and physician specialty practices, behavioral health providers, long-term services and supports providers, hospitals, nursing facilities, home health providers, and pharmacists

## Key activities

- The Department submitted the final application to CMMI on May 31, 2012
- Final submission reflected revisions related to feedback received during the thirty-day public comment period
- Application is posted on Department's web site:

<http://www.ct.gov/dss/lib/dss/pdfs/mmedemo.pdf>

## Key activities (cont.)

- The Department has mapped best practices associated with other integrated care initiatives and produced white papers on:
  - care coordination
  - structure of provider networks
  - performance measures

## Key activities (cont.)

- Further, the Complex Care Committee has heard presentations from Connecticut stakeholders on existing models of care coordination (medical and behavioral health ASOs, Access Agencies, behavioral health partnerships), as well as coordination of providers across disciplines

## Key activities (cont.)

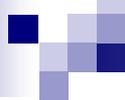
- The Department is now drafting an operations plan for the proposed “health neighborhoods”, three to five of which are expected to be procured by RFP in 2013

# Issues Pending Resolution

- CMS has not yet established minimum standards for performance (quality and care experience) that must be met to share in savings
- CMS has not yet issued its methodology for:
  - establishing cost targets or benchmarks against which performance will be measured
  - computing savings (e.g. minimum savings threshold, first dollar requirements)

## Issues Pending Resolution (cont.)

- CMS has queried Connecticut as to its intent in electing “health home” funding as a component of the duals demonstration



## Question presented:

Should Connecticut elect Affordable Care Act (ACA) health home funding within the “health neighborhood” model that will be implemented under the Demonstration to Integrate Care for Dually Eligible Individuals?

## Background:

- ACA built upon existing efforts to **integrate medical, behavioral and social services and supports for individuals with behavioral health and chronic conditions** by permitting states to seek approval of state plan amendments to implement such coverage
- ACA “health home” amendments qualify states to receive eight quarters of **enhanced Federal Medical Assistance Payment (FMAP)** in support of this work
- By contrast to the typical Connecticut FMAP of 50% FMAP for health homes is at **90%**

# Background:

- To be eligible for the health home option, beneficiaries must have:
  - two or more chronic conditions
  - one chronic condition and risk of developing a second or
  - a serious and persistent mental health condition
  
- Chronic conditions are defined as including behavioral health conditions, substance use disorders, asthma, diabetes and heart disease

## Background:

- States have the option to elect health home funding for all beneficiaries with these conditions, or to limit the set of conditions that are included
- States may define the level of severity that is required to qualify

## Background:

- CMS has stated that electing health home funding in support of one population tolls the eight quarters only for that group, and does not foreclose electing successive 90% FMAP periods for other populations

## Background (cont.):

- DMHAS has been partnering with a work group of the CT Behavioral Health Partnership (BHP) since enactment of the ACA health home option to assess how this model could be implemented in support of the needs of individuals with Serious and Persistent Mental Illness (SPMI)

# DSS/DMHAS Working Agreement:

- Connecticut should not elect health home funding within the health neighborhood model that will be implemented under the duals demonstration
- Connecticut should elect health home funding outside the context of the duals demonstration and implement a number of condition-specific health homes for both dually-eligible and single-eligible individuals with Serious and Persistent Mental Illness (SPMI)
- Health neighborhoods should include a behavioral health partner

# Rationales:

- Incorporating health home funding under the health neighborhood would introduce a level of complexity to the funding model that is undesirable:
  - creates challenges with attribution
  - potentially confusing for beneficiaries
  - potentially burdensome for providers (tracking of data, reporting)
  - difficult to partialize APM II payments and to isolate outcomes for purposes of performance payments

## Rationales (cont.):

- Individuals with SPMI should be prioritized for participation in the health home model because they face serious access barriers in receiving integrated medical and behavioral health care
  - no identified source of regular and consistent primary care
  - high utilization of hospital emergency departments
  - inadequate attention to co-morbid conditions
  - lack of trust basis with providers
  - stigma

## Rationales (cont.):

- Implementing health homes in this way supports best practices demonstrated in other states that have already done so:
  - smaller scale of participation and number of providers
  - leadership by behavioral health entities
  - an orientation that regards the behavioral health condition as the driver for purposes of care coordination

## Rationales (cont.):

- This also permits Connecticut to build on lessons learned from both health home and health neighborhood models in developing additional types of health homes without having “run the clock” on the enhanced federal match by broadly incorporating health home funding for all types of chronic conditions within the health neighborhoods
  - individuals with other qualifying chronic conditions
  - individuals in other geographic areas, should the state elect to pilot this model only in certain geographic areas

# Comparison of models:

Feature	Health Neighborhood (3-5 to be procured)	Health Home (number to be determined)
Provider composition	Broad range of medical, behavioral health, and long-term services and supports.	Care team selected from among three options identified in State Medicaid Director letter.

# Comparison of models:

Feature	Health Neighborhood (3-5 to be procured)	Health Home (number to be determined)
Population served	All Connecticut individuals who 1) are dually eligible for Medicare and Medicaid except those served by a Medicare Advantage plan; and 2) have received their primary care from a HN participating provider in the twelve months preceding implementation. Each HN is anticipated to serve a minimum of 5,000 individuals.	Individuals with an identified SPMI who are either eligible for Medicaid only, or eligible for Medicare and Medicaid. The population may further be limited by the severity of the chronic condition and potentially by geography.

# Comparison of models:

Feature	Health Neighborhood (3-5 to be procured)	Health Home (number to be determined)
Method of attribution	Individuals who have received their primary care from an HN participating provider within the twelve months preceding implementation of the Demonstration will be passively enrolled with that HN and will have the opportunity to opt out.	To be determined, but a typical means is to attribute participants based on their source of behavioral health care.

# Comparison of models:

Feature	Health Neighborhood (3-5 to be procured)	Health Home (number to be determined)
Care coordination model	Proposes to permit participants to select a Lead Care Manager (LCM) from among a list of qualified participating members of the HN. This LCM will be the single point of contact for a multi-disciplinary team of providers, whose goal it is to integrate the beneficiary's services and supports through a person-centered care plan.	Care team composition is determined by the option that is selected. The health home care team's goal is to integrate the beneficiary's behavioral health, medical and community services and supports through a person-centered care plan.

# Comparison of models:

Feature	Health Neighborhood (3-5 to be procured)	Health Home (number to be determined)
Means of paying for care coordination	Connecticut proposes to make a PMPM payment that will incorporate the costs of care coordination as well as supplemental services including medication therapy management, nutrition counseling, falls prevention, recovery assistant and peer support.	States that have implemented health homes have typically made a PMPM payment to the behavioral health entity in support of the costs of care coordination.



**Questions or comments?**