

### Comparison of Medicaid Integration Initiatives (5/10/15)

Feature	Duals Demonstration Health Neighborhood (HN) Model	DMHAS Behavioral Health Home	Medicaid Quality Improvement Shared Savings Program (MQISSP)
<b>Overall statement of purpose</b>	Connecticut’s Demonstration to Integrate Care for Medicare-Medicaid Enrollees seeks to enable person-centered, multi-disciplinary care coordination that will impact both Medicare and Medicaid services and programs by reducing unnecessary areas of over-treatment and/or duplication, addressing areas of unmet need, <i>and</i> integrating medical, behavioral, supplemental and social services in a person-centered manner to promote a healthier population of Medicare-Medicaid Enrollees (MMEs).	The Department of Mental Health & Addiction Services, Department of Children and Families and the Department of Social Services have partnered to develop the health home initiative, which will aim through a care team model based in Local Mental Health Authorities (LMHA) and their affiliates to integrate the beneficiary’s behavioral health, medical and community services and supports through a person-centered care plan, leading to better patient experience and improved health outcomes	The Connecticut Medicaid Quality Improvement and Shared Savings Program (MQISSP) aims to improve health outcomes and care experience of single-eligible Medicaid beneficiaries through arrangements with competitively selected, participating providers (FQHCs and "advanced networks") that will receive care coordination payments (FQHCs only) and a portion of any savings that are achieved (FQHCs and advanced networks), on the condition that they meet benchmarks on identified quality measures.
<b>Population served</b>	<p>All Connecticut individuals who 1) are dually eligible for Medicare and Medicaid (older adults, individuals with physical disabilities, individuals with serious and persistent mental illness, individuals with intellectual disabilities), except those served by a Medicare Advantage plan or a health home; and 2) have received their primary care from a HN participating provider in the twelve months preceding implementation.</p> <p>The most recent available data indicate that there are approximately 52,000 individuals who meet the criteria for participation in the duals demonstration. A subset of these would be assigned to a HN based on where primary care has been received. Each HN is anticipated to serve a minimum of 5,000 individuals.</p>	Individuals with an identified serious and persistent mental illness (SPMI) who are either eligible for Medicaid only, or eligible for Medicare and Medicaid, and who have Medicaid claims in excess of \$10,000 in the calendar year immediately preceding participation in a health home.	Individuals who are eligible for Medicaid only, not Medicare. TBD whether to target more specifically by age range or other criteria. The "first wave" of MQISSP must be implemented effective July 1, 2016 (please note that this reflects an assumption that CMS will approve a six-month extension of the original January 1, 2016 implementation date) and must include 200,000 to 215,000 Medicaid beneficiaries.

<b>Method of attribution</b>	<p>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.</p> <p>Individuals who have not received their primary care from an HN participating provider within the twelve months preceding implementation of the Demonstration will be enrolled in Model 1 (medical Administrative Services Organization support).</p>	<p>Connecticut will utilize the State’s Medicaid Information System to identify individuals who have Medicaid claims in excess of \$10,000 during the previous calendar year and who are engaged in services with the identified LMHA and its affiliates. These service users will be auto-assigned to the provider from which they are currently receiving behavioral health services. Upon enrollment and notification of such, individuals will have the opportunity to choose another Behavioral Health Home provider or opt out of the Behavioral Health Home program completely without jeopardizing their existing services.</p>	<p>MQISSP will utilize the same attribution method that is currently being used by the Department of Social Services for its Person-Centered Medical Home (PCMH) initiative.</p>
<b>Provider composition</b>	<p>Broad range of medical, behavioral health, and long-term services and supports providers.</p>	<p>15 statewide Local Mental Health Authorities (LMHA) and contracted LMHA affiliate providers (Affiliates) will serve as designated providers of behavioral health home services.</p>	<p>FQHCs and “advanced networks” (e.g. Accountable Care Organizations, advanced physician practices). The composition of the care team is to be determined.</p>
<b>Care coordination model</b>	<p>Proposes to permit participants to select a Lead Care Manager from among a list of qualified participating members of the HN. This Lead Care Manager will be the single point of contact for a multi-disciplinary team of providers, whose goal it is to integrate the beneficiary’s medical, behavioral and long-term services and supports through a person-centered care plan.</p>	<p>The care team will include a Director, Primary Care Nurse Care Manager, Primary Care Physician Consultant, Administrative Systems Specialist, Hospital Transition Coordinator, Licensed Behavioral Health Clinician, Psychiatrist, Behavioral Health Home Specialists, and Peer Recovery Specialist.</p>	<p>To be determined.</p>
<b>Quality measures</b>	<p>All Cause Hospital Readmissions  Ambulatory Care-Sensitive Condition Hospital Admissions  ED Visits for Ambulatory Care-Sensitive Conditions  Follow-Up after Hospitalization for Mental Illness  Depression Screening and follow-up  Care transition record transmitted to health care professional  Screening for fall risk  Initiation and engagement of alcohol and other drug dependence treatment: (a) initiation, (b) engagement  Care Plan Health Action Plan/Plan of Care</p>	<p><b>Plan All-Cause Readmissions:</b> Decrease the readmission rate within 30 days of an acute hospital stay for individuals aged 18 years of age and older.  <b>Ambulatory Care-Sensitive Conditions Admissions:</b> To decrease the rate of Ambulatory Care- Sensitive Admissions for conditions where appropriate ambulatory care prevents or reduces the need for inpatient admission to a hospital.  <b>Emergency Department Visits:</b> To reduce ambulatory care-sensitive emergency room visits.  <b>Tobacco Cessation Intervention:</b> Increase the number of tobacco users who received cessation intervention.  <b>Initiation and Engagement of Alcohol and Other Drug</b></p>	<p>To be determined, using the current PCMH measures as a starting point.</p>

	<p>State delivery of training for Lead Care Management Agencies</p> <p>Percent of patients discharged from inpatient facility to home or any other site of care for whom a transition record was transmitted</p> <p>Discharge Follow-Up</p> <p>Real Time Hospital Admission Notification</p> <p>Percentage of providers with agreement to receive data from beneficiaries' Medicare D plans</p> <p>Access to Primary Care</p> <p>Follow up with any provider within 14 days of emergency room visit</p> <p>Number of enrollees who were discharged to community setting from nursing facility and did not return to nursing facility during measurement year</p>	<p><b>Dependence Treatment:</b> Increase the percent of adolescents and adults with a new episode of alcohol or other drug dependence (AOD) who initiated AOD treatment or engaged in AOD treatment.</p> <p><b>Transition Record Transmitted to Health Care Professional:</b> Increase the percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.</p> <p><b>Follow-up After Hospitalization for Mental Illness :</b> Increase the percentage individuals who have a follow up visit within 7 days of discharge from an acute hospitalization for mental health.</p> <p><b>Adult Body Mass Index (BMI) Assessment:</b> Improve BMI education and health promotion for enrolled individuals.</p> <p><b>Screening for Clinical Depression and Follow-up:</b> Early intervention for individuals diagnosed with depression</p> <p><b>Adult Asthma Control:</b> Decrease the admission rate of for individuals between the ages of 18 and 40 individuals diagnosed with asthma to inpatient facilities.</p> <p><b>Controlling High Blood Pressure:</b> Increase the percentage of individuals 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (&lt;140/90) during the measurement year</p> <p><b>HbA1c Level Screening:</b> Increase the percentage of adults, age 18 to 75, with diabetes whose Hemoglobin HbA1c was within a normal range during the measurement period.</p> <p><b>Improve Cardiovascular Care for Individuals with CAD:</b> Increase the percentage of adults, over age 18, with coronary artery disease (CAD) whose LDL was within a normal range during the measurement</p>	
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<b>Means of paying for care coordination</b>	Connecticut proposes to make a risk stratified PMPM payment to each Lead Care Management Agency that is providing care coordination for a dually eligible participant of the demonstration.	PMPM payment to the behavioral health entity in support of the costs of care management and coordination, assistance with transitions, and referrals to community supports.	Supplemental payment to FQHCs only in support of newly implemented care coordination and community integration activities (to be specifically determined).
<b>Financial model</b>	<p>Under the duals demonstration:</p> <p>In year one, the Department of Social Services will establish a Performance Payment Pool that will be funded based on the actuarially determined savings in aggregate amongst all participating HNs. Payments from the pool will be based solely on HN performance on quality measures.</p> <p>For the second and third years, the Department of Social Services will establish a Quality Bonus Pool and a Value Incentive Pool. The state will calculate the actuarially determined savings in aggregate amongst all participating HNs and allocate a portion of the savings to each pool. The Quality Bonus Pool will be distributed based on HN-specific performance against benchmarks (performance incentive payment) and improvement (performance improvement payment) over time. The Value Incentive Pool will be distributed to each HN proportionate to its achieved cost savings.</p>	PMPM payment only; no shared savings arrangement.	<p>Under MQISSP, DSS will select a number of FQHCs and advanced networks by RFP. DSS will then enter into upside-only shared savings contracts with the providers (FQHCs and advanced networks) that are selected. There will be no downside risk on providers.</p> <p>Additionally, DSS will be making supplemental care coordination payments ONLY to the FQHCs that are selected (not to the advanced networks).</p>

<b>State departments involved</b>	DSS, DMHAS, DDS	DMHAS, DCF, DSS	DSS
<b>Stakeholder group</b>	Medical Assistance Program Oversight Council (MAPOC) Complex Care Committee	Behavioral Health Partnership Oversight Council Health Home Workgroup	MAPOC Care Management Committee
<b>Procedural status</b>	Negotiations with CMMI on hold pending settlement of recommendation to rescind state share of care coordination payments from biennial budget.	Pending approval of State Plan Amendment.	Planning process is just being launched.