

Connecticut Medicaid Care Management Oversight Council

Legislative Office Building Room 3000, Hartford CT 06106
(860) 240-0321 Info Line (860) 240-8329 FAX (860) 240-5306

www.cga.ct.gov/ph/medicaid

January – November 2011 Council Report

*This report of the Medicaid Council is submitted to the General Assembly for the time period of **January through November 2011**. The Medicaid Medical Assistance Program Oversight Council reports are submitted to the General Assembly as required under CGS 17b-28. The Medicaid Medical Assistance Program Oversight Council previously called the Medicaid Managed Care Council, is a collaborative body established by the General Assembly in 1994 to initially advise the Department of Social Services (DSS) on the development and implementation of Connecticut's Medicaid Managed Care Program (HUSKY A), in 1998 the State Children's Health Insurance Program (CHIP)- HUSKY B and in 2006 the managed care portion of the state funded State General Assistance (SAGA) program that in July 2009 became the new Medicaid expansion group called the Medicaid low income adults (MLIA) program and the state subsidized Charter Oak Health Program (uninsured adults 19-64).*

*Legislation in 2011 revised 17b-28 to include Council oversight of the Medicaid HUSKY Health Program that encompasses all Medicaid enrollees' health care. The statute charges the Council with monitoring and advising DSS on matters including, but not limited to, program planning and implementation of the new delivery system under the Administrative Service Organization (ASO), transitional issues from managed care to this model, eligibility standards, benefits, health care access and quality measures. In addition the Council advises DSS on the development and implementation of the provider-level Person -Centered Medical Home model. The Council consists of legislators, consumers, advocates, health care providers, representatives of managed care plans (through 12-31-11), the medical ASO and state agencies. The Council has five Committees: **Consumer Access, Quality, Care Management/ PCMH, Women's Health and Complex Care Committee.***

The Council and Committees have met monthly during 2011 with the exception of August. The primary focus of meetings involved the public health system change processes from a capitated managed care model to a non-capitated model with a medical Administrative Service Organization (s), development of a provider-level Person-Centered Medical Home practice and financial model and development of a plan for submission to Centers for Medicare & Medicaid (CMS) that integrates care for Medicaid/Medicare (dual eligible) adults over 65 years.

Medicaid Medical Health Delivery System

Since 1995, DSS has contracted with multiple managed care organizations to manage the health care of enrollees in the HUSKY A (children/families) and HUSKY B (children only) and the state subsidized (2007) Charter Oak Health Plan for uninsured adults. In 2006 mental health services were 'carved-out' of Medicaid managed care plans and administered by a single Administrative Service Organization with defined performance measures associated with financial incentives. Dental services were removed from the MCO responsibility in Sept. 2009 and managed dental services for all Medicaid clients through the selected ASO called the CT Dental Health Partnership. Pharmacy services, previously managed by the MCOs (HUSKY Program) were 'carved -out' to a single

Preferred Drug List system managed by DSS. Beginning in Jan. 2012, DSS plans to streamline Medicaid transportation services under one transportation contractor.

February 2011 Governor Malloy announced a plan to streamline administration of health services for all Medicaid enrollees (~600,000 members) by moving to a non-captiated Administrative Service Organization (s) to achieve the goals of reduction of overhead cost, service delivery improvement and ensure the State's readiness to participate in federal health care reform. The plan also included the development of a primary care 'medical home' model that incorporates practice-based care coordination and creation of federally defined 'health homes' that will provide comprehensive care coordination for individuals (adults and children) with chronic illness.

Process for stakeholder input and development of the streamlined Medicaid system model outlined by the Governor included:

- The CT Health Foundation funded a consultant, Meryl Price, Health Policy Matters, from Massachusetts to work with the Medicaid Council and a Council work group to provide information on other states' health care delivery system models, the pros and cons of these approaches and the efficacy of provider level models such as primary care case management and medical homes. The Council chairs were interested in ensuring that CT Medicaid systems were compatible with federal health care reform in the Affordable Care Act (*Jan.*).
- The Consultants, again funded by CT Health Foundation provided the Council with information for a discussion with DSS on key considerations for the new ASO system that included goals for valued purchasing, accountability, cost effectiveness, quality measures, and quality improvement process. The council stressed the importance of accountability achieved by clearly identified state expectations in contract, close monitoring of performance and use of a purchasing mechanism that rewards 'value-purchasing'. (*Feb.*)
- DSS developed and released a Request for Proposal (RFP) for an ASO April 6, 2011. DSS agreed to include two Council members in the RFP application review; Sen. Harp appointed Mary Alice Lee and Sheila Amdur as Council representatives.
- October Council meeting DSS announced that Community Health network of CT (CHNCT) has been offered the right to negotiate a contract with DSS as the medical ASO for all Medicaid members health care in the ***HUSKY Health Program***, effective Jan. 1, 2012.

Practice level model development

- DSS organized a provider advisory work group of various provider types and a Council member to work with two consultants, Meryl Price and Steven Schramm of Schramm Associates, to create the Person-Centered Medical Home model. This Group met throughout the summer with shared work/information with the Council's PCCM Subcommittee. The Council was informed about the Subcommittee and Work Group discussions, development processes and options for the PCMH model in Medicaid. The consultants and DSS reported on the final proposed structure and financials for the model at the November PCCM meeting and Council meeting. Key components of the model included:
 - Primary care provider PCMH standard will initially be the NCQA recognition standards that include several recognition levels.
 - DSS will assess Medicaid members 'usual source of care' to primary care providers and members can remain with their PCP or choose another PCP rather than default members to a PCP panel. DSS will focus on the PCP rather than PCMH status of the provider.

- Financial model, unanimously approved by the Provider Advisory group includes:
 - *Concurrent* participation payments: *prospective* enhanced fee for specific services to PCMH providers by recognition level.
 - *Glide path* funding to those PCPs that plan to make practice changes to achieve NCQA level 2 recognition over 24 months; supplemental funding based on practice size will be paid over the first 12 months. Practices will be required to accomplish tasks in 6 month time periods.
 - *Retrospective* per member per month (PMPM) performance incentive and improvement payments.

Some advocates disagree with this financial model, strongly endorsing a prospective PMPM payment rather than concurrent enhanced fee model, asserting that providers need more on-going financial support for the PCMH costs.

The Council strongly urges DSS to plan the integration of School based health centers into the new system of care. DSS stated they will be reassessing the criteria for Medicaid PCP and will follow up with discussions at the Consumer Access Committee (per request of the Executive Committee). Key issue is that SBHC be identified as the ‘usual source of care’ for the child/youth as (some) SBHC may not wish to become a PCP.

DSS expects to launch the PCMH practice level model with the release of a request for application (RFA) for interested PCPs and will update the Council in December on PCMH.

- The Women’s Health Committee is working with Obstetrical practitioners to develop process performance measure provider incentives for July 1, 2012 that will lead to improved birth outcomes.
- The Executive Committee has encouraged DSS work with the Quality Committee to design PCP/PCMH asthma performance incentives to reduce asthma-related ED and hospitalizations.
- The Medicaid delivery system change under a Medicaid State Plan Amendment rather than a waiver necessitates DSS creating uniform rates under the FFS system. This process could result in lower reimbursement rates for large practices that leveraged higher service rates under managed care. Hospital rates could also revert to the FFS case rate rather than the MCO per diem rate. Separate to the system rate adjustment issue is the rate changes for Medicaid obstetrical services effective July 1, 2011 that reduce overall Medicaid revenues that jeopardize the independent practitioners continued participation in Medicaid. The Council Executive Committee has met with DSS on this issue and the overall rate issues. DSS will continue to work with Medicaid providers and dialogue with the Executive Committee.

Integrated Health Care Model for the Dual eligible enrollees.

DSS, with varied stakeholder input, submitted a plan to CMS and received \$1M for a planning grant to develop an integrated care system for Medicaid/Medicare (dual) eligible members 65 years and over. DSS is working with the Council’s newest Committee, Aged, Blind & Disabled (now called the Complex Care) Committee that has, under the leadership of Sheila Amdur and Rep. Villano, recruited a broad representation of consumers and advocates to work with State Agencies and DSS consultants to create an integrated care plan due to CMS April 2012. Key components of the model were outlined

at the May Council meeting that included:

- Integrated Care Organization (ICO) model, similar in some ways to the federal Accountable Care Organizations (ACOs), is a partnership of multiple health care services (outpatient and institutional) in a community. The ICO is the lead entity in a geographic area that is responsible for managing overall costs and attaining performance standards for this population.
- Health Homes will take the lead for comprehensive care coordination of clients with chronic illness, co-morbidities or serious chronic mental health illness, facilitating this coordination as the individual moves from the community to a facility and back to the community.
- Financial models associated with integrated care models have the potential for shared savings from efficient, evidenced-based, coordinated care that would be distributed to the ICO for direct provider performance incentives and/or reinvestment in the area program.
- The expectation is the 3-6 ICOs selected by review of RFA responses will begin operation in the 4th Quarter of 2012.
- The Committee and their work groups will continue to work with DSS on the design, the consultant will do focus groups in December and DSS will have several work groups to work with DSS and consultants as well.

Reports to the Council

✓ In January the MCOs provided data on MCO HUSKY performance improvement projects for CY 2009 (MCOs - Aetna Better Health, AmeriChoice and CHNCT- began managing HUSKY and Charter Oak member health care in Feb. 2009).

✓ March meeting Mercer presented their EQRO report mandated by CMS for the 2nd year (2010) of the three cycle. The review focused on 3 dimensions, access to care, timeliness to care and quality of care including the performance improvement projects. There are contract sanctions if a MCO does not remediate low or non-compliant performance. DSS plans to review the EQRO reports and determine which measures should be included in the ASO model and use the same methodology to ASO measure performance/compliance. Sen. Harp cautioned that the new system must capture data/claims to identify performance and service delivery; it is unacceptable to 'not know' reasons for care issues.

✓ The MCO HEDIS reports were reviewed by the Quality Committee and the Council. Compared to 2009 (base year with 2 new MCOS) the 2010 reports showed improvement related to improved data management vs. internal quality management. Two plans' performance on some HEDIS indicators was significantly lower than the national HEDIS 50% range. The Council recommended DSS establish in the ASO contract acceptable HEDIS performance ranges at or above 50%, which DSS will do.

- ✓ April meeting Dr. Donna Balaski (DSS) provide an update on:
 - Dental provider network that now has 1,252 enrolled practitioners, less than 10% have a closed panel (not accepting new patients) and CTDHP has a 100% success rate of connecting callers requesting dental appointments to providers.
 - Mystery Shopper Survey 2010: showed 93% of call to dental office resulted in an appointment time, 88% of scheduled appointment were made within 4 weeks of the call.
 - The 2011 summer survey will add referrals for treatment for practices not accepting appointment requests and identify geographic location of surveyed practices.

✓ May meeting Mary Alice Lee, CT Voices, reported on the incidence of loss of HUSKY coverage for one-year olds; 42% of children were not enrolled the month following their 1st birthday. Part of the reason for eligibility loss was related to confusing notices sent to families. DSS has drafted a plan based on the report recommendations to address regional office issues, change family notices, targeted outreach to families and advocates to alert families to the one-year HUSKY renewal process. DSS followed up with specific changes to address this eligibility loss at the June meeting that include use of the 4 page HUSKY application, member notice revision, analyze the use of the pre-filled form used for other HUSKY renewals, Ex Parte review of other household member's HUSKY eligibility, DSS and community partners training on one-year old HUSKY retention. DSS will continue to monitor one-year old HUSKY loss and evaluate the effectiveness of the Agency changes.

✓ Medicaid Program changes:

- *State Medical Assistance for Non-Citizens (SMANC) closure*: the courts upheld DSS dis-enrollment of adults (exceptions are pregnant women, those in nursing facility). Those that lose health coverage are informed of other programs. At the September meeting Sen. Prague asked DSS to consider adopting medical exceptions for health coverage for legal immigrant but Medicaid ineligible individual that have critical medical service need.
- *LTC Medicaid eligibility* changes effective July 1, 2011: changes in spousal assets do not apply if DSS determines the institutionalized spouse is eligible for Medicaid *before July 1, 2011*.
- Evelyn Dudley explained *ConnPACE changes* effective July 1, 2011; program is no longer available to individuals with Medicare. Those individuals not participating in Medicare Savings Plan (MSP) should do so for pharmacy coverage. 211 Info line, CHOICES and other Aging Service networks have been asked to assist these individual with transition from ConnPace.
- *Charter Oak Health Plan state subsidy changes* were discussed by Kristin Dowty (DSS) at the Sept. meeting. The new policy:
 - Reduces state subsidized premium assistance to low income enrollees
 - Increased the premium to \$446/M effective 9-1-11
 - Limits eligibility in Charter Oak to applicants that do not qualify for the federal CT Pre-existing Condition Insurance Plan.
 - There are NO changes to deductible or co-insurance levels by income band. The 2011 legislation eliminated the annual benefit maximum (\$100,000), prescription maximum (\$7500) and medical equipment (\$4000).
- *PCIP changes*: CMS has allowed CT to eliminate premium rates based on age and adopt a flat PMPM rate of \$381. This issue and the annual benefit maximums have been raised at the Council meetings in the past.

HUSKY, Charter Oak and PCIP enrollment reports

ACS provides a quarterly verbal report and monthly paper copy to the Council that is post on the Council website within that month meeting summary. Observations related to the data:

- Charter Oak health plan enrollment had declined since June 2010 when changes to monthly premiums and low income band A individuals otherwise eligible for Medicaid were moved into

the Low income adult Medicaid expansion group when asset test was removed. By Nov. ACS reported a significant decline in Charter Oak 'lockouts for non-payment of premiums.

- Early in 2011 HUSKY A enrollment continued to increase by ~1500-2000 members/month. In late summer, early fall HUSKY A monthly enrollment increases were lessening. Pending application did increase temporarily due to loss of business days due to the hurricane.
- PCIP enrollment has moved from a choice to eligibility structure with a gradual increase in enrollees.
- HUSKY B enrollment is declining: ACS suggested this is related to more families becoming eligible for Medicaid HUSKY A.