CT Medicaid options for Medicare and Medicaid eligible individuals
Agenda

• CT dually eligible individuals’ needs
• Federal options
• Other states’ experience
• Health neighborhoods
• PCMH Plus
• Other resources
Jen analysis of CT dual eligibles

- CY 2013 data, reported to CC Comm 2015
- 58,864 individuals with full data, not excluded categories
- 4 populations
  - All dual eligibles
  - Minus community well members (84%)
  - Also minus SNF members (64%)
  - Just SNF members
- Includes both Medicare and Medicaid claims
- Includes pharmacy
By eligibility

Numbers of people

$ PMPY

all MMEs, minus community well, minus SNF

HUSKY A, HUSKY C, HUSKY D

$0, $20,000, $40,000, $60,000, $80,000, $100,000, $120,000

SNF
Percent by risk bands

- All MMEs
- Minus community well
- Minus SNF
- SNF

Band 3 | Band 4 | Band 5
--- | --- | ---

Top medical conditions

Hypertension
Musculoskeletal signs and symptoms, disorders, other
Lipid metabolism disorders
Depression
Anxiety, neuroses
Diabetes
Gastroesophageal reflux
Low back pain
Connecticut Health Neighborhood Data
State Overview: 2013

Eligible Population by County

Age-Sex Distribution

Long Term Supports & Services
% of eligible population by use status

Select Chronic Conditions

Select Disabilities

Access to Care

<table>
<thead>
<tr>
<th>Condition</th>
<th>% of Total Eligible Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>47%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>36%</td>
</tr>
<tr>
<td>Asthma-COPD</td>
<td>29%</td>
</tr>
<tr>
<td>CHF</td>
<td>10%</td>
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</table>

<table>
<thead>
<tr>
<th>Disability</th>
<th>% of Total Eligible Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Disability</td>
<td>80%</td>
</tr>
<tr>
<td>Serious Mental Illness</td>
<td>41%</td>
</tr>
<tr>
<td>Neurological Disability</td>
<td>34%</td>
</tr>
<tr>
<td>Physical Disability</td>
<td>31%</td>
</tr>
<tr>
<td>Developmental Disability</td>
<td>15%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>% of Population Who Received Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Specialist</td>
<td>86%</td>
</tr>
<tr>
<td>Primary Care Visit</td>
<td>68%</td>
</tr>
<tr>
<td>Flu Vaccination</td>
<td>38%</td>
</tr>
<tr>
<td>Mammogram *</td>
<td>20%</td>
</tr>
<tr>
<td>Acute Care Hospitalization</td>
<td>23%</td>
</tr>
</tbody>
</table>

* for women over 45 yrs old
Federal options

- State Medicaid Director letter April 2019
- "Today’s letter opens new ways to address [members’] complex needs, align incentives, encourage marketplace innovation through the private sector, lower costs, and reduce administrative burdens for dually eligible individuals and the providers who serve them."
- Feds will share savings with states
- 3 options
  - Capitated Financial Alignment Model – three way contracts between state, CMS and MCOs, currently in 9 states
  - Integrating care through the managed fee-for-service model – WA, CO
  - New models for integration
Federal options

• Option 2 – Managed Fee for Service
• WA (promising) and CO (not working according to letter)
  – WA used health home authority, no state funding
  – CO added duals to existing managed fee-for-service ACO model, has ended
• Lesson learned – most effective if target highest risk members and high-intensity interventions
• CMS recognizes that retrospective shared savings may not work for state budgets that must be balanced, so want to engage with states
Federal options

• Option 3 – Test new state-developed models, come with our ideas, concept papers and/or proposals
• Can be broad or targeted, e.g. younger people with disabilities, rural areas, people using LTSS
• Important to address SDOH
Federal options

• Special interests:
  – Promote member empowerment and independence
  – Expand access to care coordination, both Medicare and Medicaid services
  – Enhance quality, especially outcomes
  – Reduce costs for both Medicare and Medicaid
  – Preserve
    • Access to all covered Medicare benefits
    • Cost sharing protections for full-benefit duals
    • Provider choice
  – Expect robust stakeholder engagement throughout design and implementation
Washington program

- Began July 2013, paused 6 months in 2015
- Built on previous Chronic Care Management program
- Used ACA health home authority – 90% match, 8 quarters
- Integrate across primary care, LTSS, behavioral health
- Based on robust analysis of duals’ needs, costs
- Managed Fee-for-Service
  - Pmpm – based on intensity of encounters, not risk
  - Quality bonuses from savings pool
- Emphasis on helping members keep themselves healthy
- Health Homes create a network of CCOs (ACOs)
  - CCOs have primary care, LTSS, specialists, behavioral health
  - Must include local agencies that authorize Medicaid LTSS, behavioral health care
Washington program

• Competitive RFP – chose provider consortium, two AAAs, a mental health regional support network, and 2 MCOs (but <5%)
• Program pause 2015 due to uncertainty about federal support, whether it saved – stopped new enrollment but continued with current members -- lost care coordinators
• Coordinators – some at health home, some at CCO
  – Focus on needs of the whole person not necessarily related to one service
  – “Engage enrollees to set health action goals and increase self-management skills”
  – Nursing homes not allowing care coordinators access
  – Hard to engage members – less than half could be found, only 14% are ”actively engaged” (have a care plan and involved with a care coordinator)
  – Hard to hire and retain care coordinators
Washington program

• 21,050 enrolled out of 24,543 eligible (12/31/16)
• Members are auto-enrolled, can opt-out formally or just refuse services
• Payment is pmpm, 3 tiers based on intensity of encounters
  – 1st payment for outreach/engagement, health screening, care plan $252.93
  – Monthly after that, high intensity ($172.61) or low intensity ($67.50)
  – Most payments are for intensive care coordination
  – Rates are inadequate – health homes lose 20%
  – Sustainability question
• Overall savings 11.8% savings
  – Over 18% gross
<table>
<thead>
<tr>
<th>Quality impact</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Inpatient admissions</td>
<td>decreased</td>
</tr>
<tr>
<td>SNF admissions</td>
<td>decreased</td>
</tr>
<tr>
<td>ER visits</td>
<td>no change</td>
</tr>
<tr>
<td>Physician E&amp;M visits</td>
<td>no change</td>
</tr>
<tr>
<td>Long-term stay SNF use</td>
<td>decreased</td>
</tr>
<tr>
<td>Readmissions</td>
<td>increased</td>
</tr>
<tr>
<td>Follow up after hospitalization for mental illness</td>
<td>no change</td>
</tr>
<tr>
<td>Preventable ER visits</td>
<td>no change</td>
</tr>
<tr>
<td>Preventable hospital admissions, all</td>
<td>no change</td>
</tr>
<tr>
<td>Preventable hospital admissions, chronic composite</td>
<td>no change</td>
</tr>
</tbody>
</table>
## Washington program

<table>
<thead>
<tr>
<th>CAHPS survey item</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor or other provider talked to them about specific things they could do to prevent illness</td>
<td>81%</td>
</tr>
<tr>
<td>Someone on their health team talked with them about specific goals for their health</td>
<td>79%</td>
</tr>
<tr>
<td>Satisfied with the shared decision making for their health care with their doctor or other provider</td>
<td>92%</td>
</tr>
<tr>
<td>Satisfied with the shared decision making for their prescriptions with their doctor or other provider</td>
<td>82%</td>
</tr>
</tbody>
</table>
Washington program

• Challenges cited
  – Hiring, training and retaining enough care managers
  – Finding and engaging members
  – Care coordination rates are not sufficient
    • Health homes have to subsidize, losing 20%
  – No separate state funding
    • Start with health home ACA funds
    • Sustain with savings

• Strengths
  – Built on prior program
  – Targeting high-need, high-cost members for care coordination
  – HH/ACO care coordinators pull everything together, consider the whole person, including SDOH
Colorado

- Sept. 2014 through Dec. 2017, phased in enrollment
- Add duals to state’s Medicaid Managed Fee-for-Service (ACOs)
- Attribute to ACOs by geography/residence
- Attribute to PCP by where they get their care
- Can opt-out/disenroll anytime
- For duals, additional ACO expectations:
  - Develop individual care plans based on members’ health goals
  - Support members progress toward those goals
  - Enter into agreements with LTSS, behavioral health providers to coordinate and avoid duplication
  - Facilitate transitions from hospitals
  - Assess, provide technical assistance to providers to deliver disability-competent care
Colorado

- **Note**: place members in risk categories at beginning of demonstration, to avoid gaming the system
- Foundation ACO program built on PCMHs, saved money, improved quality, no shared savings, modified fee-for-service, PCMH links members to social services needed, coordinate transitions
- Duals quality results – (only Medicare $$ counted yet)
Colorado

Quality, savings results
- Lowered ED visits 8% for non-disabled
- Lowered readmissions and total admissions
- Imaging down – rate varies by pop but all down
- Lower rates of exacerbated chronic health conditions such as hypertension (5%) and diabetes (9%)
- Increased preventive services for diabetics
- Increased child well visits
- Increased follow up care after hospital discharge
- (2018) pmpm down $120 for duals (only Medicare $$ yet)
Health Neighborhoods review

• CT one of 15 states awarded CMS planning grants, much of the design work happened in Complex Care Committee and workgroups, dropped

• “Establish a person-centered multi-disciplinary provider network that will coordinate services across Medicare and Medicaid”

• “Key strategies for achieving these results include multi-disciplinary care coordination and use of a provider portal to support care planning and to share data on beneficiaries”

• Eligibility – duals over age 18 except those in Medicare Advantage, MSSP, or a health home, unless they opt-out of the health home

• Providers can be in >1 Medicaid or Medicare model, but members can only be in one
Health Neighborhoods review

- 3 to 5 pilots covering >5,000 people each, base on cluster analysis of where duals are currently getting care
- Administrative Lead Agency (ALA) responsible for:
  - “establishing an integrated service network within its geographic area, linked by care coordination contracts
  - ensuring compliance with contract requirements informed by the Department
  - distributing shared savings dollars to HN providers using a pre-determined distribution methodology
  - Each HN must also identify a Behavioral Health Partner Agency (BHPA) with expertise in serving MMEs with behavioral health conditions”
- 2 controlling agencies was a Committee concern and raised in comments
• ALA and BHPA have joint responsibility for:
  • “ensuring adherence to Demonstration care coordination standards and procedures”
  • developing a quality improvement program for care coordination
  • collecting and reporting Demonstration data
  • providing or contracting for and monitoring Demonstration supplemental services
  • creating forums for core curriculum learning collaborative activities for providers
  • developing client education and outreach materials and strategies”
• Health Neighborhoods必须提供：
  • primary care providers;
  • identified specialists
  • extender staff
  • behavioral health professionals
  • Access Agency(ies) for the Connecticut Home Care Program for Elders and LMHA or LMHA affiliates
  • occupational, physical and speech/language therapists
  • dentists
  • pharmacists
  • community-based LTSS including home health agencies, homemaker-companion agencies, and adult day care centers
  • hospitals that serve the health neighborhood’s coverage area
  • nursing facilities
  • hospice providers
Health Neighborhoods review

• Health Neighborhoods may include:
  – “Durable Medical Equipment (DME) providers
  – Emergency Response System (ERS) providers
  – hearing aid providers
  – ophthalmologists
Health Neighborhoods review

• HN required information and assistance affiliates:
  – “Infoline
  – the CHOICES program that serves the health neighborhood’s coverage area
  – the Aging & Disability Resource Center that serves the health neighborhood’s coverage area”

• May also include social services affiliates, for example:
  – “housing organizations
  – home renovation/accessibility contractors
  – bill payment/budgeting services
  – employment services
  – local organizations serving minority, non-English speaking, and underserved populations”
Health Neighborhoods review

- Care managers
  - “Under the Demonstration, Lead Care Managers (LCMs), employed by Lead Care Management Agencies (LCMA's), will be responsible for acting as single points of contact for MMEs [duals] who participate in HNs.
  - An LCM must be an APRN, RN, LCSW, LMFT or LPC and must complete Demonstration training.
  - LCMs will be responsible for assessing, coordinating and monitoring an MME’s Demonstration Plan of Care (POC) for medical, behavioral health, long-term services and supports (LTSS), and social services.
  - The Department will make risk-adjusted PMPM care coordination payments directly to LCMAs (the APM II payment).”
Health Neighborhoods review

- State receives Medicare and Medicaid savings above a minimum floor of savings to CMS
  - Start up payments to support HN formation, proposed $250,000 each
  - APM I payment: pmpm to PCMHs, replaces current add-on rate payment
  - APM II payment: risk-adjusted pmpm to Lead Care Agencies for care coordination
  - Supplemental service payments: to ALAs for extra services such as nutrition counseling, falls prevention, medication management, peer support and recovery assistant
- Year 1 – savings into a pool, shared with HNs based on quality measures
- Years 2, 3 – savings into 2 pools – pay HNs based on savings from one, quality from the other
PCMH Plus so far

- SIM initiative taken up/accepted by Medicaid
- Promise from DSS and OPM that there would be no shared savings in Medicaid until it was prevalent in the rest of CT, with a proper evaluation of the impact, and problems addressed
  - Current state budget calls for PCMH Plus for duals
- Shared savings, with upfront payments
- Payments also for quality performance and improvement
- In Wave 2 now, evidence only for first year
- Were 9 ACOs in Wave 1, expanded to 14 for Years 2 and 3, RFP out soon for Years 4 and 5
  - FQHCs, other ACOs – slightly different services, very different upfront money
- Deep concerns about underservice, cherrypicking
  - Literature growing that cherrypicking common in shared savings
PCMH Plus so far

- Shared savings has not worked to either save money or improve quality in other states, other programs, incl. Medicare ACOs in CT
- PCMH Plus Year 1 evaluation
  - Five of nine ACOs did not save but got payments
  - PCMH+ ACOs had much higher pmpm total costs, both before and at Year 1 end
  - All but one ACO had higher ER visit rates than comparison group, both before and at Year 1 end
  - Highest and lowest quality ACO received equal payments/member
  - Indications of underservice in DME, dental – no follow up
  - Biggest ACO winner by far saw higher risk scores at end of Year 1
PCMH Plus so far

• Problems –
  • Promise to wait until more is known disregarded
  • Expanded program before any evaluation done
  • Consensus consumer notices eroded late in process, no language that ACOs benefit by reducing costs of care
  • Then lack of complaints/opt-outs used as evidence of consumer satisfaction
  • Consumer input includes three interviews/ACO of consumers chosen by ACOs
  • Cost the state at least $1.3 million MORE in Year 1
  • No underservice or cherrypicking monitoring, insist that it can’t happen
  • Ignored/reversed on 100% PCMH requirement
  • Double paying for ICM
PCMH Plus going forward

- Independent advocates’ recommendations to improve:
  - Require ACOs to have 100% PCMHs in their system
  - Fix notices so they explain risks and are understandable
  - Reject post-hoc changes to comparison group
  - Enforce no direct PCP compensation based on savings from their panels
  - Expand minimum # members/ACO from 2,500 to 5,000
  - Ensure access to ICM as appropriate, exclude those savings from payments to ACOs as they are fully state funded
  - Do not expand to any new populations – especially duals – until the impact on the current population is better understood, concerns are addressed
Other resources

• Underservice metrics, data sources for health neighborhoods
  • Complex Care Committee workgroup
• Care plan standards
  • Complex Care Committee
• Underservice/adverse selection prevention policies
  • SIM Equity and Access committee
• Palliative care needs, Advanced analytics and information management
  • UConn
• NGA high-need member project