Agenda

Medicaid eligibility overview
FQHC 101
Value based care 101
How HUSKY supports individuals with Autism Spectrum Disorder
Community Options – Innovation.
PACE
Medicaid Eligibility
Overview: FQHCs

FQHCs = federally qualified health centers that receive federal Public Health Service (PHS) Act, Section 330 funds, and provide primary care services in underserved, urban and rural communities. Federal designation from the U.S. Dept. of Health & Human Services, Health Resources & Services Administration (HRSA), Bureau of Primary Health Care, and the Centers for Medicare and Medicaid Services (CMS) that is assigned to private non-profit or public health care organizations that serve predominantly uninsured or medically underserved populations.

Primary purpose *

To expand access to primary health care for uninsured and underserved populations, who experience financial, geographic or cultural barriers to care and who live in or near federally designated health professional shortage areas and medically under-served areas.

Defining characteristics *

1. Located in a federally designated medically underserved area or serve a federally designated medically underserved population

2. Provide comprehensive primary care services, referrals, and other services needed to facilitate access to care, such as case management, translation, and transportation

3. Provide services to all in the service area regardless of ability to pay and offer a sliding fee schedule that adjusts according to income

4. Have nonprofit, public, or tax-exempt status

5. Have a governing board, the majority of whose members are patients of the health center

* CT Department of Public Health:
https://portal.ct.gov/DPH/Family-Health/Community-Health-Centers/Community-Health-Center-Overview
FQHCs play a key role in the HUSKY program

Scope

Connecticut residents are served by 17 in-state FQHCs and 3 border-state clinics in Rhode Island and Massachusetts.

In Connecticut, there are over 300 different FQHC locations ranging from stand-alone clinics to mobile clinics to school-based centers.

Statistics about our members*

Among our continuously enrolled members in 2021, ~28% of our members visited an FQHC at least once in the 12-month period.

Of the members with a primary care attribution, ~32% were attributed to a FQHC. During this period, FQHC total expenditure was $1.6b.

Among our continuously enrolled members who reported racial data, FQHC attributed members were 1.4x more likely to identify as Black non-Hispanic and 1.3x more likely to identify as Hispanic.

* Technical notes: Attribution methodology includes members enrolled at the time the report was run with a 15 month look back period attributed to an eligible PCP who the member had a plurality of visits with.

The data on the first two paragraphs is on non-dual members in 2021. The data in the third paragraph, on race and ethnicity, is an identical population, refreshed as of March 2023.
FQHCs financing – high level overview

**Summary**

- Federal law dictates how Medicaid programs pay FQHCs; **FQHCs are paid under a prospective payment system (PPS)**
- Under PPS, FQHCs are paid a **fixed rate** for each visit; the PPS rate is the same, regardless of the exact mix of services delivered. There are separate rates for medical, dental, and behavioral health visits
- Other than **alternative payment models (APMs)**, the state does not have discretion over the details of the PPS payment

**History**

- Pre-2001, FQHCs were paid based on costs
- The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (P.L 106-554) (“BIPA”) created the PPS for Medicaid FQHCs in all states and territories
- **Initial** PPS rates, back in 2001, were set based on FQHCs 1999 and 2000 cost reports in accord with BIPA
- Rates are increased annually by the **Medicare Economic Index (MEI)** – details on future slide
- Rates may be adjusted to account for a **change in scope** as defined in 17b-262-995. “Change in the scope of service” means a change in the type, intensity, duration or amount of services provided by an FQHC. A change in the cost of the service alone is not considered a change in the scope of service.
Backup: Additional details on FQHC payments

- **Medical** rates are clinic specific and range from $153.60 to $178.28 per visit
- **Dental** rates are clinic specific and range from $140.38 to $167.79 per visit
- **Behavioral health** rates are clinic specific and range from $169.49 to $218.35 per visit

Additional details on PPS rate

- Each FQHC has a **specific encounter rate for medical, dental, and behavioral health**
- In general, FQHCs can bill for one medical, one behavioral health, and one dental visit each on the same day. Allowance for second visit in case of emergency
- Federal law: rates may be adjusted based on change in scope of services provided by an FQHC. See 42 USC § 1396a (bb)(3)(B),
- All FQHC PPS rates are posted to the Department website:

Legal basis

- Rates are **increased annually by the Medicare Economic Index** (MEI). See 42 USC § 1396a (bb) (2) & (3)
- CMS approved SPA 16-015 on October 17, 2018, effective March 1, 2016; this SPA clarified that FQHCs are reimbursed an all-inclusive encounter rate per client in accordance with a prospective payment system, and delineated the process by which an FQHC may apply for an adjustment of its encounter rate based upon a change in scope of service
- Regulations were approved by the Legislative Regulation Review Committee of the Connecticut General Assembly on April 28, 2015, effective May 13, 2015

In Fiscal Year 2001, PPS rates were set in accordance with the following federal requirement:

*Subject to paragraph (4), for services furnished on and after January 1, 2001, during fiscal year 2001, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center or clinic of furnishing such services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1395l(a)(3) of this title*
Medicare Economic Index (MEI)

Background
MEI is a federal index overseen by the Secretary of Health and Human Services under 42 U.S.C. §217a. It is updated annually and applied each year to the FQHC PPS rate at the start of the federal fiscal year (on 10/1).

Details
Designed to measure inflation faced by physicians with respect to their practice costs and general wage levels. The MEI includes a bundle of inputs used in furnishing physicians’ services such as physicians' time, non-physician employees' compensation, rents, medical equipment, capital costs, etc. The MEI measures year-to-year changes in prices for these various inputs based on appropriate price proxies.
FQHCs and alternative payment models

Under federal law, the only way for Medicaid programs to pay an FQHC outside of the PPS is though an “alternative payment model” (APM) [42 USC § 1396a(bb)]

Under an APM, the state and each FQHC may enter into an agreed APM; the APM must result in a payment that is at least equal to the Medicaid PPS rate (“upside only”)
### Examples of Alternative Payment Models (APMs) in other states

<table>
<thead>
<tr>
<th>Program</th>
<th>Oregon</th>
<th>Washington</th>
<th>Illinois</th>
<th>Minnesota</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program</td>
<td>Alternative Payment and Advanced Care Model</td>
<td>Alternative Payment Methodology 4</td>
<td>Medical Home Network ACO</td>
<td>FQHC Urban Health Network (FUHN)</td>
</tr>
<tr>
<td>Start Date</td>
<td>2013</td>
<td>2017</td>
<td>2014</td>
<td>2013</td>
</tr>
<tr>
<td>Participation</td>
<td>18 of the state’s 32 health centers</td>
<td>16 of the state’s 27 health centers</td>
<td>9 FQHCs</td>
<td>10 FQHCs with 30 health center sites</td>
</tr>
<tr>
<td>Payment Model</td>
<td>Health centers receive a base encounter payment from the health plan and an up-front supplemental capitated PMPM wrap payment from the state. A portion of the payment is tied to meeting five quality benchmarks.</td>
<td>Health centers receive an up-front PMPM payment from the health plan as well as a monthly “enhancement payment” from the state. The rate is then prospectively adjusted annually by the state to reflect the FQHC’s performance on five quality targets.</td>
<td>Health centers receive an up-front PMPM payment from the ACO to deliver care coordination. Health centers also receive a shared savings payment from the ACO based on each center’s total cost of care and its performance on quality measures.</td>
<td>If FUHN earns shared savings through its state contract, member health centers receive a portion of shared savings based on a total cost-of-care calculation for a core set of Medicaid services, and for achieving quality targets.</td>
</tr>
</tbody>
</table>
Payment Reform 101
HUSKY pays most* providers in one of four main ways

<table>
<thead>
<tr>
<th>Description</th>
<th>(1). Provider fee schedule (most common)</th>
<th>(2). Cost-based (generally for institutions)</th>
<th>(3). Value based payments (small but growing)</th>
<th>(4). Grant based retrospective CPE claiming</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus of today’s presentation</td>
<td>Creates provider-specific reimbursement based on a provider’s costs</td>
<td>Pay providers based on the value (clinical and financial) they deliver to members</td>
<td>Waivers operated by other agencies where costs of services are funded through grant-based payments to providers and converted to rates for federal Medicaid claiming purposes</td>
<td></td>
</tr>
<tr>
<td>HUSKY publishes a list of payments for each service and pays all providers who bill from that fee schedule accordingly</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Example provider types

<table>
<thead>
<tr>
<th>Type</th>
<th>Example provider types</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>.</td>
<td>Physicians, including specialists (e.g., cardiologists), clinics, PT, OT, SLP services, etc.</td>
<td>Nursing homes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maternity providers, starting 2023</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DDS waiver providers</td>
</tr>
</tbody>
</table>

Advantages

<table>
<thead>
<tr>
<th>Type</th>
<th>Example provider types</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>.</td>
<td>Follows Medicare</td>
<td>Matches reimbursement to costs, reducing costs</td>
</tr>
<tr>
<td>.</td>
<td>Simple</td>
<td>Avoids potential incentives to “cream or skim” healthier patients</td>
</tr>
<tr>
<td>.</td>
<td>Creates incentives for providers to be financially efficient</td>
<td>Give providers incentives to improve quality and lower costs</td>
</tr>
<tr>
<td>.</td>
<td></td>
<td>Can encourage holistic treatment of disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Grant-based funding supports greater flexibility for providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Agency / provider share responsibility for meeting federal claiming requirements</td>
</tr>
</tbody>
</table>

Main disadvantages

<table>
<thead>
<tr>
<th>Type</th>
<th>Example provider types</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>.</td>
<td>Little financial incentive to keep patients healthy</td>
<td>Dulls incentives for providers to operate efficiently</td>
</tr>
<tr>
<td>.</td>
<td>Could “overpay” some providers, paying more than costs</td>
<td>Traditionally not linked to patient acuity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Could potentially result in “stinting” or “cream skimming” if appropriate policies to mitigate are not in place</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Delay in finalization and truing up expenditures for claiming purposes</td>
</tr>
</tbody>
</table>

* There are some important provider types who are not paid according to these three buckets. For example, Federally Qualified Health Centers (FQHCs) are paid via the federally mandated prospective payment system (PPS). HUSKY pays our hospitals via an APR DRG system for inpatient services and an OPPS APC methodology for outpatient services.
HUSKY pays most* providers in one of four main ways

<table>
<thead>
<tr>
<th>Description</th>
<th>(1). Provider fee schedule (most common)</th>
<th>(2). Cost-based (generally for institutions)</th>
<th>(3). Value based payments (small but growing)</th>
<th>(4). Grant based retrospective CPE claiming</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Focus of today’s presentation</strong></td>
<td>Focus of today’s presentation</td>
<td>Creates provider-specific reimbursement based on a provider’s costs</td>
<td>Pay providers based on the value (clinical and financial) they deliver to members</td>
<td>Waivers operated by other agencies where costs of services are funded through grant-based payments to providers and converted to rates for federal Medicaid claiming purposes</td>
</tr>
<tr>
<td><strong>Example provider types</strong></td>
<td>Physicians, including specialists (e.g., cardiologists), clinics, PT, OT, SLP services, etc.</td>
<td>Nursing homes</td>
<td>Maternity providers, starting 2023</td>
<td>DDS waiver providers</td>
</tr>
<tr>
<td><strong>Advantages</strong></td>
<td>. Follows Medicare</td>
<td>. Matches reimbursement to costs, reducing costs</td>
<td>. Gives providers incentives to improve quality and lower costs</td>
<td>Grant-based funding supports greater flexibility for providers</td>
</tr>
<tr>
<td></td>
<td>. Simple</td>
<td>. Avoids potential incentives to “cream or skim” healthier patients</td>
<td>. Can encourage holistic treatment of disease</td>
<td>Agency / provider share responsibility for meeting federal claiming requirements.</td>
</tr>
<tr>
<td><strong>Main disadvantages</strong></td>
<td>. Little financial incentive to keep patients healthy</td>
<td>. Dulls incentives for providers to operate efficiently</td>
<td>. Could potentially result in “stinting” or “cream skimming” if appropriate policies to mitigate are not in place</td>
<td>Delay in finalization and truing up expenditures for claiming purposes.</td>
</tr>
</tbody>
</table>

*Most providers*
**Value-Based Payment (VBP):** “Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.”¹

A VBP model might be referred to as an **Alternative Payment Model (APM):** “A payment approach that gives added incentive payments to provide high-quality and cost-efficient care.”²

Value-based payments are now integral to public payor’s strategy to improve outcomes and reduce inequality

**CMS Innovation Center Strategic Priorities**

**Innovation Center Strategic Objective 1: Drive Accountable Care**

*A health system that achieves equitable outcomes through high quality, affordable, person-centered care*

**Aim:** Increase the number of people in a care relationship with accountability for quality and total cost of care.

**Measuring Progress:**
- All Medicare beneficiaries with Parts A and B will be in a care relationship with accountability for quality and total cost of care by 2030.
- The vast majority of Medicaid beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030.

**Presidential COVID-19 Health Equity Task Force**

**Health Care Access and Quality**

Everyone has equitable access to high-quality health care.

**Improve health equity through measurement and incentives.**

*By:
- Developing a health equity framework, inclusive of formal metrics, equity impact statements and process to monitor [...]*
- Supporting the development of reimbursement models that encourage data- and community-driven approaches focused on improving equity-centered health care delivery for communities of color and other underserved populations where they live and work.
- Providing payment incentives to providers that improve metrics of health care quality and patient experience in communities of color and other underserved populations.*

(Left) CMS, Innovation Center Strategy Refresh, 2021
(Right) Presidential COVID-19 Health Equity Task Force, Final Report and Recommendations, October 2021

CT Department of Social Services
Value-based payment has been adopted in Medicare and Medicaid, and continually advanced by the CMS Innovation Center

CMS Innovation Center: established in 2010. Goal: transition health system to value-based care by developing, testing, and evaluating new payment and service delivery models. Over the last decade, the CMS Innovation Center has launched over 50 model tests.¹

<table>
<thead>
<tr>
<th>Examples in Medicare²</th>
<th>Examples in Medicaid³</th>
</tr>
</thead>
<tbody>
<tr>
<td>End-Stage Renal Disease Quality Incentive Program</td>
<td>State Medicaid programs are increasingly implementing a variety of VBP models that aim to drive system change towards greater efficiency and improved health outcomes.</td>
</tr>
<tr>
<td>Hospital Value-Based Purchasing Program</td>
<td>States have implemented a variety of approaches, using various authorities and strategies.</td>
</tr>
<tr>
<td>Hospital Readmission Reduction Program - details next slide</td>
<td></td>
</tr>
<tr>
<td>Hospital Acquired Conditions Reduction Program</td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility Value-Based Purchasing Home Health Value-Based Purchasing</td>
<td></td>
</tr>
</tbody>
</table>

² CMS, Medicare Value-Based Programs. [https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs)
**A non-HUSKY Example:**
**Medicare’s Hospital Readmissions Reduction Program (HRRP)**

### Context

**Why discuss Medicare at MAPOC?**

1. One of the largest “pay for performance” systems in US healthcare history
2. Well studied
3. We have fewer HUSKY specific examples
4. Program may have implications for HUSKY members (dual eligible + non-Medicare HUSKY members via spillovers)

*Here, we are not proposing any policy changes in Medicaid; just describing a Medicare program for illustration*

Readmission rates are important. Pre-Affordable Care Act, ~20% of Medicare hospitalizations had a readmission within 30 days;¹ in 2013, 30-day readmissions across all payors cost more than $50b.²

**HRRP:** If a hospital has higher risk-adjusted payment than a benchmark, hospital receives a penalty. Penalties up to 3% of hospital’s base Medicare inpatient payments;³ current fines estimated ~$520m⁴

### Evidence

**Key result:**

- **Program substantially reduced Medicare admissions for targeted conditions:** results varied across studies, but typically show on the order of ~5 – 10% reduction in readmissions; other papers find a reduction in one-year mortality
- **While there is some evidence of “gaming” on the part of hospitals, there appears to be no evidence that this harmed patient care and, in fact, evidence points to a reduction in one-year mortality⁴**

**How we know:**

- **Method #1.** Compare hospitals that, due to the patients they serve, would likely be subject to the penalty to other, similar, hospitals unlikely to be subject to the penalty…before and after
- **Method #2.** Exploit a policy discontinuity in formula for penalty, comparing hospitals that face greater penalties to those that face smaller penalties

**Implications:** In this program for this population, “paying for value” appears to have improved patient care and decreased spending

---

¹. [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9113654/#cit0007](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9113654/#cit0007)
². [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5710454/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5710454/)
What kinds of payment models are considered VBP?

VBP models range from models that include some link to quality or value, to population-based payment models that pay per member, instead of per service.

The widely referenced HCP-LAN Framework categorizes payment models on a spectrum that moves from purely volume-based payment to more value-based payment.

**Note: higher category does not necessarily mean “better”**

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Category 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee for Service – No Link to Quality &amp; Value</td>
<td>Fee for Service – Link to Quality &amp; Value</td>
<td>APMs Built on Fee-for-Service Architecture</td>
<td>Population-Based Payment</td>
</tr>
</tbody>
</table>

**Degree of value-based**

- **Category 1**: Payments are based on volume of services and not linked to quality or efficiency.
- **Category 2**: At least a portion of payments vary based on the quality or efficiency of health care delivery.
- **Category 3**: Some payment is linked to the effective management of a segment of the population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk.
- **Category 4**: Payment is not directly triggered by service delivery so payment is not linked to volume. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., 1 year).

Source: Health Care Payment Learning & Action Network, APM Framework, 2017
CT DSS Payment Models

Where do CT DSS’ provider payment models fall on the VBP spectrum now?

<table>
<thead>
<tr>
<th>Volume-based</th>
<th>Value-based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
<td>Category 2</td>
</tr>
<tr>
<td>Fee for Service -</td>
<td>Fee for Service -</td>
</tr>
<tr>
<td>No Link to Quality</td>
<td>Link to Quality</td>
</tr>
<tr>
<td>&amp; Value</td>
<td>&amp; Value</td>
</tr>
<tr>
<td></td>
<td>Category 3</td>
</tr>
<tr>
<td></td>
<td>APMs Built on</td>
</tr>
<tr>
<td></td>
<td>Fee-for-Service</td>
</tr>
<tr>
<td></td>
<td>Architecture</td>
</tr>
<tr>
<td></td>
<td>Category 4</td>
</tr>
<tr>
<td></td>
<td>Population-Based</td>
</tr>
<tr>
<td></td>
<td>Payment</td>
</tr>
</tbody>
</table>

- **DSS Payment Models**
  - Most HUSKY Payments
  - PCMH
  - Nursing home quality payment*
  - Home and Community-Based Service (HCBS) VBP
  - PCMH+
  - Maternity bundle*

* Indicates that slide is coming

Source: Health Care Payment Learning & Action Network, APM Framework, 2017
Maternity Payment Bundle

Implementation trigger (first indication of pregnancy)

Claims analysis trigger for Global maternity episode

Discharge from facility

Pregnancy

Delivery

Postpartum

Newborn

Look back period: 280 days (9 months) from Delivery

Look forward
First 30 days (reporting only)

Birthing Person

Look forward period: 90 days (3 months) after discharge from facility

Pregnancy:
• Monthly prenatal visits
• Routine ultrasound
• Blood testing
• Diabetes testing
• Genetic testing

Labor and Birth:
• Vaginal or C-section delivery

Postpartum:
• Breastfeeding support
• Depression screening
• Contraception planning
• Ensuring link from labor and birth to primary and pediatric care providers occurs for birthing person and baby

Doulas
• Care navigators
• Group education meetings
• Childhood education classes
• Preventive screenings (chlamydia, cervical cancer, etc.)

Look forward period: 280 days (9 months) from Delivery

First 30 days (reporting only)

Look forward period: 90 days (3 months) after discharge from facility
Example: Value-based payment in nursing homes

Pressure ulcers

Clinical context

Pressure ulcers (bed sores) impact an estimated 2+ million people per year... and can cause severe pain...
...and, if hospitalized, can cost tens of thousands of extra dollars (source) and death

How homes can help

Strong evidence, via randomized control trials, that homes can take steps to reduce pressure ulcer incidence rate

---

<p>| Table 1. Intervention Effect and Quality of Supporting Randomized Controlled Trials (RCTs) |</p>
<table>
<thead>
<tr>
<th>Strategy</th>
<th>Description of Preventive Interventions</th>
<th>Participant Population</th>
<th>No. of RCTs/No. of Participants</th>
<th>Pressure Ulcers, RR (95% CI)</th>
<th>Randomization</th>
<th>Allocation Concealment</th>
<th>Blinding Of Outcome Assessment</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pressure redistribution foam (e.g., cubed foam, visco-elastic foam, and high-density foam vs standard hospital mattresses)</td>
<td>Medical, surgical, and rehabilitation patients</td>
<td>5/2016</td>
<td>0.40 (0.21-0.74)</td>
<td>4 RCTs</td>
<td>2 RCTs</td>
<td>None</td>
<td>McIntyre et al</td>
</tr>
<tr>
<td>2</td>
<td>Oral nutritional supplements (e.g., daily drinks of 25 g, 2 kcal/ml, and standard hospital diet vs standard hospital diet)</td>
<td>Elderly hospital patients</td>
<td>4/124</td>
<td>0.85 (0.73-0.99)</td>
<td>4 RCTs</td>
<td>None</td>
<td>1 RCT</td>
<td>Stratton et al</td>
</tr>
<tr>
<td>3</td>
<td>A hyperosmolar taffy and regimen for skin dryness, applied twice per day to the sacrum, trochanters, and heels (Meadjohn Laboratories, Bama-Geve SA, Barcelona, Spain) vs matched group placebo</td>
<td>Patients from home care and geriatric centers</td>
<td>1/380</td>
<td>0.42 (0.22-0.80)</td>
<td>1 RCT</td>
<td>None</td>
<td>1 RCT</td>
<td>Reddy et al</td>
</tr>
<tr>
<td>4</td>
<td>A foam cleanser: combining an emollient, a water-repellent barrier, and a water-repellent deodorant (Clinsan; Shisei Health Care, Waltham, England) vs soap and water for incontinence care</td>
<td>Residents of long-term care facilities</td>
<td>1/93</td>
<td>0.32 (0.13-0.82)</td>
<td>1 RCT</td>
<td>None</td>
<td>1 RCT</td>
<td>Hodgkinson et al</td>
</tr>
</tbody>
</table>

https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1106015
**HUSKY pays most providers in one of four main ways**

<table>
<thead>
<tr>
<th>Description</th>
<th>Focus of today’s presentation</th>
<th>Creates provider-specific reimbursement based on a provider’s costs</th>
<th>Pay providers based on the value (clinical and financial) they deliver to members</th>
<th>Waivers operated by other agencies where costs of services are funded through grant-based payments to providers and converted to rates for federal Medicaid claiming purposes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example provider types</td>
<td>Physicians, including specialists (e.g., cardiologists), clinics, PT, OT, SLP services, etc.</td>
<td>Nursing homes</td>
<td>Maternity providers, starting 2023</td>
<td>DDS waiver providers</td>
</tr>
<tr>
<td>Advantages</td>
<td>Follows Medicare</td>
<td>Matches reimbursement to costs, reducing costs</td>
<td>Gives providers incentives to improve quality and lower costs</td>
<td>Grant-based funding supports greater flexibility for providers</td>
</tr>
<tr>
<td></td>
<td>Simple</td>
<td>Avoids potential incentives to “cream or skim” healthier patients</td>
<td>Can encourage holistic treatment of disease</td>
<td>Agency / provider share responsibility for meeting federal claiming requirements.</td>
</tr>
<tr>
<td>Main disadvantages</td>
<td>Little financial incentive to keep patients healthy</td>
<td>Dulls incentives for providers to operate efficiently</td>
<td>Could potentially result in “stinting” or “cream skimming” if appropriate policies to mitigate are not in place</td>
<td>Delay in finalization and truing up expenditures for claiming purposes.</td>
</tr>
</tbody>
</table>

*There are some important provider types who are not paid according to these three buckets. For example, Federally Qualified Health Centers (FQHCs) are paid via the federally mandated prospective payment system (PPS). HUSKY pays our hospitals via an APR DRG system for inpatient services and an OPPS APC methodology for outpatient services.*
HUSKY support for members with Autism Spectrum Disorder (ASD)
# State Plan and Waiver Services

<table>
<thead>
<tr>
<th>State Plan</th>
<th>Waiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Early and Periodic Screening, Diagnostic and Treatment (EPSDT)</td>
<td>• Not an entitlement</td>
</tr>
<tr>
<td>• Entitlement</td>
<td>• Lifespan (age 3 and up)</td>
</tr>
<tr>
<td>• Services limited through age 21</td>
<td>• Offer services that are not available under the State Plan</td>
</tr>
<tr>
<td>• Unable to access waiver services unless enrolled in waiver</td>
<td>• Limits number of individuals served. Currently 219 individuals enrolled in waiver</td>
</tr>
<tr>
<td>• No cap on services</td>
<td>• Can access State Plan services through age 21</td>
</tr>
<tr>
<td>• Limited to services in the State Plan</td>
<td>• Annual $50,000 cap on services; average cost is far less</td>
</tr>
</tbody>
</table>
Overview of how HUSKY supports members with ASD:
State Plan Services

Eligibility:
How people with ASD qualify for HUSKY

- Individuals eligible for EPSDT services under Medicaid under the age of 21 with an autism spectrum disorder diagnosis. Over 5,500 individuals have accessed ASD home-based services since 2015

ASD specific State Plan services

- Comprehensive evaluation
- Behavior assessment
- Home-based services
- Direct observation and direction (this allows the technician to receive real-time feedback from supervisor)

Non-ASD specific services

- Individuals eligible for Medicaid who have been diagnosed with autism spectrum disorder are eligible for all Medicaid-covered services, if medically necessary. This includes, but is not be limited to, speech therapy, occupational therapy, physical therapy, transportation, and all other medical, behavioral health and oral health services.
Additional details: State Plan Services for ASD

• In 2015, DSS implemented ASD home-based services for youth under the age of 21 with autism spectrum disorder

• Beacon Health Options provides utilization management services for this service

• As of January 2023, over 5,500 youth have received services.

• Since 2015, Beacon Health has grown the provider network to over 800 ASD providers across the state

• Access to services has always been challenging based on the availability of licensed and experienced staff and the high demand for services
ASD Provider Enrollment as of 01/02/2023

- 750 individual providers have enrolled in Medicaid to provide ASD services.
- 185 unique practices (individuals or groups) have enrolled in Medicaid to provide ASD services.
- 889 providers are able to provide ASD treatment services.

Cumulative ASD Individual Provider Enrollment

Note: Providers may be a part of the same practice. If no individual is identified then the practice is counted as the individual.

- Running Total
- Quarterly Additions
[History]: Home & Community Supports Waiver for Persons with Autism

The Home & Community Supports Waiver for Persons with Autism serves individuals with Autism through a 1915 (c) Medicaid waiver

- 2006 - legislation passed requiring the Department of Developmental Services (DDS) to establish a pilot program to provide supports and services to **adults** with autism. The pilot was established to fill a gap in services for individuals with ASD who do not have an intellectual disability
- The pilot included a feasibility study on obtaining a Medicaid waiver to serve this population. The pilot originally served individuals with ASD over the age of 18 and was later opened to those age 3 through the lifespan
- 2007 - legislation passed creating the Division of ASD Services within DDS and provided authorization to seek a waiver
- 2012 - CMS approved Autism waiver.
- 2014 - CMS approved Early Childhood Autism waiver (sunsetted 2018 and Autism waiver amended to include children ages 3 and up.)
- 2016 - legislation moves Division of ASD Services from DDS to DSS. DSS, rather than DDS, became the lead agency for coordinating state agency functions that have responsibility for ASD services. Both waivers transition to DSS
- 2023 - most recent renewal of waiver
- In his FY 2024 and 2025 biennial budget, Governor proposed transferring lead agency responsibilities from DSS to OPM with Medicaid State Plan and waiver activities remaining at DSS
[Eligibility]: Home & Community Supports Waiver for Persons with Autism

The Home & Community Supports Waiver for Persons with Autism is not an entitlement; services and access to services under the waiver may be limited, based on available funding and program capacity.

To be eligible, individuals must meet the following:

• Have a primary diagnosis of Autism Spectrum Disorder
• Be at least 3 years of age
• Have a Full-Scale IQ score of 70 or higher as indicated on a test of intelligence
• Live in their own home or family home
• Have substantial limitations in at least two of the following: self-care, understanding and use of language, learning, mobility, self-direction, or capacity for independent living
• Have had functional impairments must diagnosed before age 22
• Be eligible for Medicaid (HUSKY A, C, or D)
• Have an impairment expected to continue indefinitely
[Services]: Home & Community Supports Waiver for Persons with Autism

List of services that HUSKY offers only to waiver participants

- Live-in companion
- Respite
- Assistive technology
- Clinical behavioral supports
- Community mentor
- Individual goods & services
- Interpreter
- Job coaching
- Non-medical transportation
- Emergency response System
- Nutrition
- Social skills group
- Specialized driving assessment
- Life skills coach

Members on waiver, who are under age 21 can access State Plan services.
## [Process]: Home & Community Supports Waiver for Persons with Autism

<table>
<thead>
<tr>
<th>Step #1: Place on waitlist</th>
<th>Step #2. Wait for waiver slot</th>
<th>Step #3. Waiver slot becomes available</th>
<th>Step #4. Develop service plan</th>
<th>Step #5. Arrange services and ongoing monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Involved parties</strong></td>
<td>DSS Autism team</td>
<td>Member and/or responsible party</td>
<td>Member and/or responsible party</td>
<td>Member and/or responsible party</td>
</tr>
<tr>
<td>▪ Member and/or responsible party</td>
<td>DSS</td>
<td>▪ DSS case manager</td>
<td>▪ DDS case manager</td>
<td>▪ DDS case manager</td>
</tr>
<tr>
<td>▪ DDS</td>
<td></td>
<td>▪ All involved in member's personalized service plan</td>
<td>▪ Providers</td>
<td>▪ Community party</td>
</tr>
<tr>
<td><strong>Activities</strong></td>
<td></td>
<td>▪ Universal assessment completed</td>
<td>▪ Level of need completed</td>
<td>▪ Identify member's goals</td>
</tr>
<tr>
<td>1. Member and/or responsible party submits application to DDS for initial eligibility determination. 2. DDS determines if applicant meets diagnosis &amp; IQ requirements 3. If requirements met, member placed on waitlist</td>
<td>1. DSS Autism team identifies the next members on the waiver waitlist and updates demographic information.</td>
<td>1. If clinically eligible and Medicaid eligible, enrolled in waiver</td>
<td>2. Develop person-centered service plan based upon level of need that is within annual service plan budget cap of $50,000.</td>
<td>1. Coordinate services with service providers. 2. Monitor services to ensure they meet member's needs. 3. Maintain consistent communication with member and responsible party.</td>
</tr>
<tr>
<td><strong>Comment</strong></td>
<td>▪ &lt;21 &amp; Medicaid eligible access State Plan services  ▪ &gt;21 &amp; Medicaid eligible, access non-autism services</td>
<td>If not already completed, will need: 1. SSA disability determination 2. Medicaid eligibility determination</td>
<td>Needs reassessed annually. Services are often not reduced.</td>
<td></td>
</tr>
</tbody>
</table>

CT Department of Social Services
Rebalancing
# Overview: Community Options – Rebalancing Medicaid

## Rationale

1. Consumers overwhelmingly wish to have **meaningful choice** in how they receive needed long-term services and supports (LTSS)

2. **Average per member per month costs** are less in the community

3. In Olmstead v. L.C., 527 U.S. 581 (1999), the Supreme Court held that title II prohibits the **unjustified segregation** of individuals with disabilities.

   1. Medicaid must administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities

## Brief national history

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960s</td>
<td>Medicaid – Required nursing home benefit</td>
</tr>
<tr>
<td>1970s</td>
<td>Medicaid – Optional personal care assistance</td>
</tr>
<tr>
<td>1980s</td>
<td>Medicaid – Optional 1915(c) waivers</td>
</tr>
<tr>
<td>1999</td>
<td>Olmstead v. L.C 527 U.S.581</td>
</tr>
<tr>
<td>2005</td>
<td>Deficit Reduction Act</td>
</tr>
<tr>
<td></td>
<td><strong>Authorized Money Follows the Person</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Optional 1915(i) benefit</strong></td>
</tr>
<tr>
<td>2010</td>
<td>ACA</td>
</tr>
<tr>
<td></td>
<td><strong>New eligibility group under 1915(i)</strong></td>
</tr>
<tr>
<td></td>
<td>Optional Community First Choice</td>
</tr>
</tbody>
</table>

## Key achievements

**Informed MACPAC report to Congress:**

- March 2022 Report to Congress on Medicaid and CHIP: MACPAC

**Recognized for national leadership:**

- 2020 Affordability and Access Winner Connecticut – The SCAN Foundation

**Selected for NASHP best practice report:**

- Salom Teshale, Wendy Fox-Grage, Kitty Purington, (2022) "Paying Family Caregivers through Medicaid Consumer-Directed Programs: State Opportunities and Innovations"

**Selected for HUD best practice report:**


**U.S. Department of Housing and Urban Development** [Pending Publication]
## Community Options: Primary Home and Community-Based (HCBS) Innovation Initiatives

<table>
<thead>
<tr>
<th>Operational</th>
<th>Pilot</th>
<th>In development</th>
<th>Operational redesign</th>
</tr>
</thead>
<tbody>
<tr>
<td>My Place CT</td>
<td>Community First Choice</td>
<td>Money Follows the Person Rebalancing Demonstration (MFP)</td>
<td>Value Based Payment – HCBS</td>
</tr>
<tr>
<td>Description</td>
<td>Web-based and Social Media project for information about long-term services and supports</td>
<td>Personal Care Attendant Services for people at institutional level of care</td>
<td>Transition from institution to community</td>
</tr>
<tr>
<td>Funding Primary</td>
<td>MFP</td>
<td>Medicaid</td>
<td>MFP</td>
</tr>
<tr>
<td>Funding Secondary</td>
<td>None</td>
<td>MFP</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Outcome: Improve Quality of Life</td>
<td>Increase access to information</td>
<td>Increase access to community supports</td>
<td>Increase % of people receiving HCBS relative to people receiving long-term services and supports</td>
</tr>
<tr>
<td>Evaluation</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
# Community Options: Primary HCBS Innovation Initiatives

<table>
<thead>
<tr>
<th>Operational</th>
<th>Pilot</th>
<th>In development</th>
<th>Operational redesign</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>My Place CT</strong></td>
<td><strong>Community First Choice</strong></td>
<td><strong>Money Follows the Person Rebalancing Demonstration (MFP)</strong></td>
<td><strong>Value-Based Payment – HCBS</strong></td>
</tr>
<tr>
<td><strong>Description</strong></td>
<td>Web-based and Social Media project for information about long-term services and supports</td>
<td>Personal Care Attendant Services for people at institutional level of care</td>
<td>Transition from institution to community</td>
</tr>
<tr>
<td><strong>Funding Primary</strong></td>
<td>MFP</td>
<td>Medicaid</td>
<td>MFP</td>
</tr>
<tr>
<td><strong>Funding Secondary</strong></td>
<td>None</td>
<td>MFP</td>
<td>Medicaid</td>
</tr>
<tr>
<td><strong>Outcome: Improve Quality of Life</strong></td>
<td>Increase access to information</td>
<td>Increase access to community supports</td>
<td>Increase % of people receiving HCBS relative to people receiving long-term supports and services</td>
</tr>
<tr>
<td><strong>Evaluation</strong></td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Today’s Focus**

- Money Follows the Person Rebalancing Demonstration (MFP)
- Value-Based Payment – HCBS
Money Follows the Person Rebalancing Demonstration
Money Follows the Person - overview

Federal Goals

1. Increase home and community-based services (HCBS) and decrease institutionally-based services
2. Eliminate barriers that restrict people from receiving long-term services and supports in the settings of their choice
3. Strengthen the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions
4. Put procedures in place to provide quality assurance and improve HCBS

Brief history

The Money Follows the Person Rebalancing Demonstration, created by Section 6071 of the Deficit Reduction Act of 2005, supports states’ efforts to “rebalance” their long-term support systems so that individuals can choose where to live and receive services. States receive enhanced federal reimbursement. Connecticut was one of the first states to receive funding in 2007. Connecticut’s initial goal was to transition 700 people from institutions to the community over 5 years. The goal was exceeded within 2 years of operation. To date, Connecticut has transitioned over 7,000 people - more people per capita than any other state.
Money Follows the Person Rebalancing Demonstration

**Over 7,000 People Transitioned to Community From January 2009 - December 2022**

MFP is a ‘laboratory’ for analysis of gaps in the HCBS continuum that prevent people from having a choice to remain in or return to the community after a nursing home stay.
As a child, Claire was diagnosed with Cerebral Palsy. For many years she lived in an apartment supported by the Department of Developmental Disabilities (DDS). In 2018, she became ill and was hospitalized. After hospitalization, she moved to a nursing home to continue rehabilitation. Unfortunately, rehabilitation did not go well for her. She remained in the nursing home long term and lost her apartment.

After transfer to a different nursing home, Claire’s health and strength began to improve. Her DDS case manager told her about Money Follows the Person. Claire and her family were excited to know that a return to the community was once again possible.

Through MFP she received a new customized wheelchair and many other household goods such as toiletries, bedding, medical supplies/equipment, and groceries. In her new apartment, Claire and her roommate have a 24/7 PCA who helps them with activities of daily living activities and ensures that all their needs are met.

Claire reports that she is happy and looking forward to what the future holds.
MFP attempts to address some of the key barriers that members face when remaining or moving into the community

<table>
<thead>
<tr>
<th>Key challenge faced by members</th>
<th>Example of how MFP helps</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1). Service gaps</td>
<td>Workforce recruitment</td>
</tr>
<tr>
<td></td>
<td>Informal caregiver support</td>
</tr>
<tr>
<td>(2). Physical health</td>
<td>Informed Risk Agreement</td>
</tr>
<tr>
<td>(3). Mental health</td>
<td>Substance use disorder demonstration services</td>
</tr>
<tr>
<td></td>
<td>Informal caregiver training related to dementia</td>
</tr>
<tr>
<td>(4). Housing</td>
<td>Monthly training for housing coordinators</td>
</tr>
<tr>
<td></td>
<td>Access to the rental assistance program</td>
</tr>
<tr>
<td>(5). Member engagement</td>
<td>Quarterly professional development on engagement strategies</td>
</tr>
<tr>
<td>(6). Financial issues</td>
<td>Dedicated eligibility staff assigned to each person in Money Follows the Person</td>
</tr>
</tbody>
</table>

Note: Key challenges are based on data collected by field staff on each individual who participates in Money Follows the Person.
Value-Based Payment
HCBS Providers

Initiative Funded under American Rescue Plan Act Section 9817
Value Based Payment, HCBS Providers - overview

**Goals**

Increase the number of people who receive services from a person-centered care team, guided by member's goals, with accountability for quality of service and choice of community services in lieu of institutionalization.

**Context / Rationale**

Members report that health care systems, including home and community-based service systems, are fragmented. Information is not shared across all providers and members occasionally receive conflicting guidance. A value-based payment for all providers, aligned with member goals, can incentivize a team-based delivery system and improve member experience.

**What we’re measuring**

1. Reduce avoidable hospitalization
2. Reduce rate of hospital discharge to nursing home
3. Increase probability of return to community within 100 days of nursing home admission

CT Department of Social Services
## Value Based Payment – HCBS Providers

### Principles and Key Strategies

<table>
<thead>
<tr>
<th>Principles</th>
<th>Key Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Person-centered</td>
<td>• Team based culture – delivery reform guided by goal</td>
</tr>
<tr>
<td>• Equitable delivery of service</td>
<td>• Value based payment based on rebalancing metrics – HCBS Measure Set</td>
</tr>
<tr>
<td>• Choice regarding where people receive long-term services and supports</td>
<td>• Benchmark ‘capacity building’ glide path</td>
</tr>
<tr>
<td>• Fair - achievable for all providers</td>
<td>• Direct care worker training</td>
</tr>
<tr>
<td></td>
<td>• Participating in Health Information Exchange</td>
</tr>
<tr>
<td></td>
<td>• Learning collaboratives</td>
</tr>
<tr>
<td></td>
<td>• Racial equity</td>
</tr>
<tr>
<td></td>
<td>• Meaningful use of data</td>
</tr>
</tbody>
</table>
## Value Based Payment – HCBS Providers

### Addressing Challenges in Existing System

<table>
<thead>
<tr>
<th>Challenges</th>
<th>HCBS VBP Design</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Capacity</strong></td>
<td><strong>Lack of provider capacity to collect and use data</strong></td>
</tr>
<tr>
<td><strong>Standardization</strong></td>
<td><strong>Lack of standardized definition and measurement related to member (person-centered) goals</strong></td>
</tr>
<tr>
<td><strong>Data Sharing</strong></td>
<td><strong>Member data is not shared electronically across all healthcare systems</strong></td>
</tr>
<tr>
<td><strong>Measures</strong></td>
<td><strong>Lack of measures to ensure no disparity in delivery of service</strong></td>
</tr>
</tbody>
</table>
**HCBS VBP Roadmap**

**01** Milestone
State submits American Rescue Plan Act Spending Plan and receives approvals
Q4 2021

**02** Milestone
CMS approval of benchmark methodology - 200 HCBS providers meet benchmarks
Q1 2022

**03** Milestone
State submits VBP methodology - 200 providers continue to participate; 7200 direct care workers complete racial health equity training.
Q4 2022

**04** Milestone
5% Quality Infrastructure payments begin
Q2 2023

**05** Milestone
First outcome-based payment
Q2 2024

**06** Milestone
Measure for racial health equity and person-centered goals implemented
04 2024

**07** Milestone
VBP sustained beyond ARP 9817
Q3 2025
Community Options Partners for Design, Development and Implementation of Innovations

- **Steering Committee**
  - Self-advocates, advocates, Department of Mental Health and Addiction Services, Department of Aging and Disability Services, Department of Developmental Services, Connecticut Legal Rights, AARP, State Long-Term Care Ombudsman, Office of Policy and Management, ARC of CT, MS Society, etc.

- **Providers**
  - Center on Aging – UCONN Health
  - State Health Information Exchange – Connie
  - National Committee for Quality Assurance (NCQA)
  - Yale-New Haven Hospital Center for Outcomes Research and Evaluation (Yale CORE)
Program of All-Inclusive Care for the Elderly (PACE)
PACE - Program of All-Inclusive Care for the Elderly

• Medicare program for older adults and people over age 55 living with disabilities.

• Three-way partnership between the Federal government (Medicare), the State (Medicaid), and the PACE organization
  • Optional Medicaid State Plan Amendment

• Provides community-based care and medical services to people who otherwise need nursing home level of care.

• Benefits include, but are not limited to, all Medicaid and Medicare covered services, such as adult day care, dentistry, home care, and transportation.

• Providers receive monthly Medicare and Medicaid capitation payments for each enrollee.

• Operates in approximately 30 states

• Connecticut does not operate a PACE program but today we do have coordination activities in partnership with the 7 D-SNPs (Dual Eligible Special Need Plans) that operate in the state.

Note: U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation Office of Behavioral Health, Disability, and Aging Policy published this report that includes PACE in 2021: Comparing Outcomes for Dual Eligible Beneficiaries in Integrated Care: Final Report | ASPE (hhs.gov)