The Affordable Care Act: Accomplishments and Future Goals

STATE OF CONNECTICUT

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Implementation Accomplishments

- Primary Care Rate Increases
- Ordering, Referring, Prescribing practitioner enrollment
- State Innovation Model
- Individuals aging out of foster care will remain eligible for Medicaid up to age of 26
- Healthcare Exchange
- Expansion of Medicaid for childless adults
Implementation of Primary Care Rate Increase

- Effective January 1, 2013, ACA requires states to increase Medicaid payments for primary care services provided by primary care doctors to 100% of the Medicare payment rate for 2013 and 2014.

- Services must be provided by a physician who specializes in family medicine, general internal medicine, or pediatric medicine.

- Higher payment will be made for primary care services rendered by practitioners (e.g. Advance Practice Registered Nurses, APRNs) working under the personal supervision of any qualifying physician.

- Affordable Care Act (ACA) rate increases were implemented July 1, 2013 for 2,277 approved providers who attested as to their eligibility.

- DSS issued an additional provider bulletin to clarify means of making both retroactive payments (to January 1, 2013) and payments ongoing.
Section 6401 of the Affordable Care Act:

- requires all providers, including *ordering*, *prescribing* or *referring* (OPR) physicians or other professionals providing services under the State Plan or under a waiver of the plan to be enrolled;
- requires the OPR provider’s NPI to be listed on every claim for services based on the order, prescription or referral; and
- establishes a similar requirement for Medicare.
State Innovation Model (SIM)

- Connecticut will collaborate with public and private stakeholders to design a transformed health care delivery system that incorporates:
  - promotion of integrated care models
  - use of the Health Insurance Exchange to inform and connect consumers to coverage
  - expanded supply of primary care physicians and other professionals
  - increased engagement among regulators, providers and consumers
The resulting payment and delivery system model will advance greater alignment across multiple payers on contracting and payment strategies that promote value over volume, greater consistency in quality and other performance metrics, and expanded primary care.
Health Insurance Exchange

- Effective October 1, 2013, Access Health CT, the CT Health Insurance Exchange, started processing applications.

- As of October 11, 2013, of those who have applied:
  - 1,544 will be eligible for Medicaid on January 1, 2014
  - 1,443 will be enrolled in a health plan effective January 1, 2014
In April 2010 Connecticut became the first state to gain CMS approval for an early expansion group.

Childless adults (aged 19-64) with income of up to 53% of the Federal Poverty Level (FPL) who were historically served by SAGA medical became eligible effective April, 2010 for new HUSKY D (Low Income Adult, LIA) group.

This is the group for which income eligibility will expand under ACA, effective January 1, 2014.
Medicaid Expansion (cont.)

- In April 2010, there were approximately 45,000 individuals eligible for HUSKY D (the Medicaid for Low-Income Adults (MLIA) program) at the time of the expansion.

- As of October 2013, there are approximately 93,000 beneficiaries currently being served by MLIA.
Medicaid Expansion (cont.)

- Effective January 1, 2014, ACA as enacted required states to expand Medicaid to all individuals not eligible for Medicare under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL

- Connecticut is estimating an additional 50,000-55,000 newly eligible individuals for HUSKY D
Innovative Healthcare Models

- Connecticut plans to implement two innovative healthcare models for specific target populations:
  - Duals Demonstration Model: Health Neighborhoods for individuals eligible for Medicare and Medicaid
  - Behavioral Health Homes for individuals with serious and persistent mental health conditions
Healthcare Demonstration Model for Individuals Eligible for Medicare and Medicaid

HEALTH NEIGHBORHOODS
Background

- As part of the Affordable Care Act, the Center for Medicare and Medicaid Innovation (CMMI) issued a procurement opportunity for states to develop innovative healthcare models and provider reimbursement strategies for those individuals who are eligible for Medicare and Medicaid (MMEs).
- Connecticut was one of 15 states to be awarded the demonstration planning grant from CMS which includes an opportunity to implement the model developed during the year long planning grant process.
- Connecticut is now preparing to implement the Demonstration Model.
In partnership with the Departments of Mental Health and Addiction Services (DMHAS) and Developmental Services (DDS), the Department of Social Services (DSS) intends to implement a Demonstration to Integrate Care for Medicare-Medicaid Enrollees (MMEs) for MMEs age 18-64, and age 65 and older

- Establish a person-centered multi-disciplinary provider network that will coordinate services across Medicare and Medicaid in order
  - Improve the care experience for the beneficiaries
  - Improve the quality of care and outcomes
  - Decrease the total cost of care for beneficiaries
Profile of Population to be Served
Population Profile

- Connecticut MMEs have complex, co-occurring health conditions
  - roughly 88% of individuals age 65 and older has at least one chronic disease, and 42% has three or more chronic diseases
  - 58% of younger individuals with disabilities has at least one chronic disease
  - 38% has a serious mental illness (SMI)
Connecticut MMEs use a disproportionate amount of Medicaid resources and Connecticut is spending much more than the national average on MMEs.

- the 57,568 MMEs eligible for the Demonstration represent less than 10% of Connecticut Medicaid beneficiaries yet they account for 38% of all Medicaid expenditures.
per capita Connecticut Medicaid spending for the 32,583 MMEs age 65 and over and the 24,986 MMEs with disabilities under age 65 is **55% higher than the national average**
The Demonstration Model
Demonstration Model

- The goal of the Demonstration is to improve MMEs’ health and care experience outcomes by integrating Medicare and Medicaid long-term care, medical and behavioral services and supports, promoting provider practice transformation, and creating pathways for information sharing.

- 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.
The Demonstration will be implemented by the Department of Social Services (DSS), in collaboration with the Departments of Mental Health and Addiction Services (DMHAS) and Developmental Services (DDS).

It will serve all MMEs who are age 18-64, or age 65 and older, who are not being served by:

- a Medicare Advantage (MA) Plan;
- a Medicare Accountable Care Organization (ACO); or
- a “health home”
The Demonstration will use two models:

- **Model 1** will build on the existing strengths of the Connecticut Medicaid medical Administrative Services Organization.

- **Model 2** will create local, multi-disciplinary networks called “Health Neighborhoods” (HNs).
This Demonstration will improve on past efforts in several important ways:

- providers will receive care coordination payments
- providers will be eligible for performance payments
- providers will have access to a provider portal that will support cross-disciplinary care coordination and will provide integrated Medicare and Medicaid data on beneficiaries
The Demonstration is a “shared savings” initiative

The federal government will share a percentage of any Medicare savings that are achieved under the Demonstration, net of an increase in Medicaid spending, with Connecticut

A portion of these shared savings payments will be paid to participating HN providers who meet identified standards on Demonstration quality measures
Key Features of Integrated Care Demonstration
Connecticut’s Demonstration will feature two key elements:

- Enhancement of the current Administrative Services Organization (ASO) model

- Procurement of 3-5 “Health Neighborhoods” (HNs)
Under the Demonstration, CHN-CT will provide extensive technical and other support to HNs, including:

- use of integrated Medicaid and Medicare data to support enrollment in HNs and to risk stratify MMEs for purposes of HN care coordination
- member services (e.g. referrals to Medicaid-participating providers, coverage questions)
- utilization management for Medicaid services
CHN-CT will also support the care coordination needs of MMEs who do not participate in the HN model by tailoring its current Intensive Care Management (ICM) service to meet the needs of MMEs.
Structure – Procurement of HNs

- Under the Demonstration, the Department plans to procure 3-5 HNs:
  - HNs will be made up of a broad array of providers, including primary care and physician specialty practices, behavioral health providers, LTSS providers, hospitals, nursing facilities, home health providers, and pharmacists
HNs will be expected to serve a minimum of 5,000 eligible MMEs.

The Department will provide “cluster analysis” information based on integrated Medicare and Medicaid data to inform formation of HNs.

The cluster analysis will show where there are groups of MMEs served by common sets of providers.
The Demonstration will not serve MMEs who are participating in:

- a Medicare Advantage (MA) plan;
- a Medicare Shared Savings Program Accountable Care Organization (ACO); or
- a health home for individuals with Serious and Persistent Mental Illness (SPMI) who are receiving their services from a Local Mental Health Authority (LMHA) or affiliate, unless that MME opts out of the health home and into a HN.
For all other MMEs, the Demonstration will use a passive enrollment method to engage participation in HNs.

- MMEs who have received their primary care or behavioral health care from an HN participating provider within the twelve months preceding implementation of the Demonstration will be passively enrolled with that HN.

- An MME who is passively enrolled will have the choice to opt out of participation.
Each HN must identify an “Administrative Lead Agency” that will be 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
Structure – HN Leadership (cont.)

- Each HN must also identify a Behavioral Health Partner Agency (BHPA) with expertise in serving MMEs with behavioral health conditions
the ALA and the BHPA will be jointly responsible for:

- ensuring adherence to Demonstration care coordination standards and procedures
- developing a quality improvement program for care coordination
- collecting and reporting Demonstration data
Structure – HN Leadership (cont.)

- 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
Structure – HN Composition

- HN must include:
  - 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 that serves the health neighborhood’s coverage area
  - occupational, physical and speech/language therapists
HN must include (cont.):

- dentists
- pharmacists
- community-based long-term services and supports 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
HN may also include:

- Durable Medical Equipment (DME) providers
- Emergency Response System (ERS) providers
- hearing aid providers
- ophthalmologists
HN membership may also include social services affiliates, non-exclusive examples of which include:

- housing organizations
- home renovation/accessibility contractors
- bill payment/budgeting services
- employment services
- local organizations serving minority, non-English speaking, and underserved populations
Providers who are part of an Accountable Care Organization or participating in the Medicare Advantage Plan may participate in the Demonstration.

MMEs cannot participate in more than one demonstration model.
The most important role of an HN will be to coordinate care for all of its MME members.

For purposes of the Demonstration, **Care Coordination** is defined as a person-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an individual’s needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an identified care coordinator following evidence-based standards of care.
Under the Demonstration, **Lead Care Managers (LCMs)**, employed by **Lead Care Management Agencies (LCMAs)**, will be responsible for acting as single points of contact for MMEs 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).
Under the Demonstration, the Department will make the following types of payments:

- **Start-up payments** to support formation of HNs
  - DSS proposal to CMS includes $250,000 for each HN

- **APM II**: risk-adjusted PMPM payments to Lead Care Management Agencies for care coordination
Supplemental service payments: payments to ALAs to contract for supplemental services including nutrition counseling, falls prevention, medication therapy management, peer support and recovery assistant.
Performance payments:

Year 1:

- a portion of actuarially determined savings in aggregate amongst all participating HNs will fund a Performance Payment Pool
- payments from the pool will be based solely on HN performance on quality measures
Structure - Payments

- **Years 2 & 3:**
  - A portion of actuarially determined savings in aggregate amongst all participating HNs will fund a Quality Bonus Pool and a Value Incentive 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.
Next Steps

- Continue technical assistance calls with CMS
  - Accountable Care Organizations/Health Neighborhoods
  - Medicare Advantage Plan Enrollment/disenrollment
- Finalize MOU with CMS
- Issue Cluster Analysis to stakeholders/providers
- Submit state plan/waiver documents to CMS
- Convene Health Neighborhood formation training
- Issue Health Neighborhood RFP
Behavioral Health Home Model for Individuals with Serious Mental Health Conditions

BEHAVIORAL HEALTH HOMES
Behavioral Health Homes

- The CT Behavioral Health Home model is being developed by the Department of Mental Health and Addiction Services (DMHAS) in collaboration with the Departments of Social Services (DSS) and Children and Families (DCF)
- The CT Behavioral Health Home model includes input from various stakeholder groups, including the Connecticut Behavioral Health Partnership (CT BHP) Oversight Council and individuals in recovery and their families
Why a Behavioral Health Homes?

- Mortality rate/age – People living with SPMI are dying 25 years earlier than the rest of the population, in large part due to preventable physical conditions
- Access to appropriate primary health care for individuals diagnosed with chronic behavioral health conditions – traditionally underserved in primary health care and often experience barriers in accessing appropriate care
- Unmanaged chronic health conditions are significant barriers to the achievement of recovery
- Many behavioral health providers historically provide care coordination
Development

- Meetings with Rhode Island and Missouri
- Stakeholder workgroup
- Build off current Local Mental Health Authority (LMHA) service system
  - 7 PNP/6 State Operated
- Technical Assistance – National Council and CHCS
- Discussions with the Governor’s Budget Office
  - Leveraged “in-kind” dollars to get new appropriation
Model

- Statewide – geographic roll-out
- Additive to current service system – treating the whole person
  - Primary Care Functions
- ASO – enrollment, HIT
- Auto-enrollment of high utilizers/high need individuals
- Designated providers
- Allow for payment of non-traditional services (e.g. peer services, wellness, health promotion)
Challenges

- SO vs. PNP
- Limited funding
- Data sharing
- Not all LMHAs look the same
- Fiscal model – rates
- Intersection with Duals Demonstration
- Culture shift – outcomes/quality measures
- Incentives?
Next Steps

- SAMHSA consult
- CMS conversations
- ASO procurement
- Data system
- Learning Community
  - Working with primary care
- State Plan Amendment
Health Home – Triple Aim

- **Improve Experience in Care** – use care coordination and universal care plans and ongoing measurement of outcomes to continually enhance integration and coordination of behavioral health, primary, acute, and long-term services and supports.

- **Improve Overall Health** – operate under a “whole-person” philosophy by providing a comprehensive array of early intervention, clinical and recovery support services across an inter-disciplinary team of primary care, behavioral health care, and community-based services and supports that promote health and recovery and improve lives.

- **Reduce Per Capita Costs of Health Care** – while delivering high quality, integrated services (without harm whatsoever to individuals, families, or communities).
Questions or Comments?