Healthcare Service Delivery and Purchasing Reform in Connecticut

Presentation to National Association of Medicaid Directors
November 9, 2011

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Director, Medical Care Administration
Medical ASO: Program Goal

- Near term
  - Improve access, quality, health outcomes
  - Better manage high risk/high cost individuals
  - Reduce unnecessary and inappropriate service use

- Long term
  - Administrative support for service delivery and purchasing reforms
  - Support migration of resources and accountability to local providers and systems
Medical ASO

Functions

☐ Call center services (i.e., referral assistance, appointment scheduling, benefit information),

☐ Attribution to usual source of care (PCP or Person Centered Medical Home)
  ■ Prospective to support provider/member connection, outreach, and engagement
  ■ Retrospective to support performance payments
Medical ASO

Functions

- Utilization management
- Routine *Care Coordination* for all members
- *Intensive Care Management* services for those with complex needs
Medical ASO

Functions

- Coordination with dental, behavioral health, pharmacy, transportation, and waiver programs
- Health informatics such as health risk stratification and predictive modeling to support population health management and disease management
- Cost and quality data aggregation and analysis to support profiling of state, providers and local systems
- PCMH practice support
- Not responsible for provider network (contracting, credentialing or claims)
Promoting Change in Service Delivery and Organization

- ASO provides uniform structure for reporting, customer service, and care management.
- Changes in the delivery and organization of services at the local level are of equal or greater importance.
- New model moves beyond PCP assignment to promote the emergence of medical homes and health homes.
PCMH to ICO/Health Homes

BHP ASO
- Intensive Care Management

Medical ASO
- Intensive Care Management

Medical Home

Assigned PCP

CT Medical Assistance Program (CMAP) Provider Network
PCMH to ICO/Health Homes

BHP ASO
- Intensive Care Management

Medical ASO
- Intensive Care Management

Medical Home

Assigned PCP

CT Medical Assistance Program (CMAP) Provider Network
PCMH to ICO/Health Homes

BHP ASO

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Intensive Care Management

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CT Medical Assistance Program (CMAP) Provider Network
PCMH to ICO/Health Homes

BHP ASO

Medical ASO

Intensive Care Management

ICO/Health Home

Medical Home

Assigned PCP

CT Medical Assistance Program (CMAP) Provider Network
PCMH Reimbursement Model

Intensive Care Management (ICO/Health Home)

Office Visits

Measurable Performance

Blended Hybrid Payment Model that Expands Upon the Existing Fee-for-Service Paradigm

Dedicated Nurse Care Managers with an organized team of health care professionals. Focus on persons with multiple chronic conditions, care coordination, transitions, self-management, home and community supports

PCMH practices, recognized based on NCQA standards, utilize systems to improve all aspects of care delivery. Practices focus on patient engagement, prevention, wellness, self-management, and the promotion of health equity.

Measure and reward:
- Use of PCMH processes including disease education, care coordination, transition management, self-care
- Improved access including mail/phone
- Improved care experience
- Improved health outcomes.
Questions?
Managing Medicaid: Managed Care Trends, Challenges, and Opportunities

November 9, 2011
About MHPA

Leading association solely representing Medicaid health plans. MHPA is a nonprofit, tax-exempt organization formed in 1993 and incorporated in 1995.

91 members in 33 states and DC representing nearly 14 million Medicaid/CHIP enrollees

The mission of MHPA is to develop and advance public policy that controls costs and improves access and delivery of quality health care to Medicaid members.
35 States and DC Have Medicaid Health Plans
### State Medicaid Managed Care Expansions
#### Pre-2014

<table>
<thead>
<tr>
<th>State</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>FL</td>
<td>Recently approved statewide expansion (from pilot) for managed care and LTC; CMS approval still needed</td>
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<tr>
<td>IL</td>
<td>Moving half of Illinois’s beneficiaries into health plans by Oct 2015</td>
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<tr>
<td>KY</td>
<td>Opening managed care program to multiple plans</td>
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<tr>
<td>LA</td>
<td>Medicaid managed care program beginning in June 2012; New to capitated Medicaid managed care</td>
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<tr>
<td>MI</td>
<td>Added foster care children, adding special needs children</td>
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<tr>
<td>MS</td>
<td>Enrolled special populations into health plans (SSI, Disabled Children, Working Disabled, others)</td>
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<tr>
<td>NY</td>
<td>Long history with Medicaid health plans; Moving Medicaid out of FFS in three years</td>
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<tr>
<td>SC</td>
<td>Required managed care for most beneficiaries</td>
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<tr>
<td>TX</td>
<td>Expanding Medicaid managed care to 38 new counties</td>
</tr>
<tr>
<td>VA</td>
<td>Planning to expand in 2012</td>
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Health Reform’s Medicaid Expansion will build off of an existing shift away from fee-for-service towards managed care.
Health Reform’s Medicaid Expansion
Growth Opportunities

• The best opportunities for growth will be in
  1. South
  2. West
  3. Midwest

• Based on...
  – Current Medicaid managed care penetration
  – New eligible population size
  – Current operating margin

Best Individual States
• California
• Florida
• Illinois
• Indiana
• Michigan
• Minnesota
• New Jersey
• Ohio
• Pennsylvania
• South Carolina
• Texas
• Virginia

Source: Conning Research Consulting
Health Reform’s Medicaid Expansion

• Increases minimum eligibility to 133% FPL
• Includes childless adults
• Medicaid will be covering 16 million more people by 2019
  – some estimates up to 30 million
• Challenges
  – States will experience -1% (Mass.) to 84% (Utah) increase in enrollment by 2019
  – State share of the costs range from -$5 million (Vermont) to $4.2 billion (Texas)
  – Slightly unknown population
Health Reform’s Medicaid Expansion Population Expectations

• Mix of healthy beneficiaries and individuals with multiple comorbidities

• Differing participation rates will drive Medicaid costs, sickest likely to enroll first

• Expansion population costs will be
  – Greater than costs for currently enrolled parents
  – Less than cost for currently enrolled disabled adults

Source: CHCS Policy Brief
Cost of the Newly Eligible

• $2,541
• Annual cost per non-disabled adult in Medicaid, 2007*

• $3,775
• Estimated annual cost per newly-eligible enrollee**

*Kaiser Family Foundation
Dual Eligibles

• Providing integrated care to dual eligibles is an opportunity to control costs and improve quality in the Medicaid program
• Only 10% of the 8.9 million duals receive integrated care
• Estimated $14 billion in annual savings by enrolling duals into Medicaid health plans
Strike a Balance between...

**Innovation**
- Quality improvement and best practices
- Health information technology
- Delivery and payment system reforms
- Options for integrated care for dual eligibles

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**Overload**
- Are we asking states to do too much?
- Without adequate provider networks, there is little room for innovation
- Is the Medicaid program prepared for a drastic overhaul and new requirements?
Strike a Balance between... 

**Standardization**
- Health plans and other stakeholders long for more consistency state-to-state
  - Quality measures
  - Rate-setting processes
  - Data reporting requirements

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**Flexibility**
- Health plans and stakeholders need flexibilities in serving differing markets
- States are calling for increased flexibility in managing their Medicaid programs
Federal Requirements

- New federal rules
- New federal players at CMI, Office of Coordinated Care, MACPAC, etc.
- States continually seek guidance from CMS

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State Responsibilities

- States will have to implement new requirements
  - Medicaid expansion
  - State exchanges
  - CHIP changes
  - Basic health option
  - Coordination of all of the above
Strike a Balance between...

Current Medicaid
• States have made headway in improving care for this population
• Many will continue to receive current benefit package

& Newly Eligibles
• New population childless adults, others
• New outreach mechanisms
• New health statuses and behaviors
• New benefits Essential benefits
Medicaid Expansion Challenges

- Rebranding Medicaid – how can plans play a role in promoting the “new Medicaid”? 
- The availability of Medicaid health plans has laid the groundwork 
- Ease of enrollment and renewal
AARP Perspectives on Managed Long Term Services and Supports

Susan C. Reinhard, RN, PhD
Senior Vice President
AARP Public Policy Institute
Medicaid Managed Long-Term Care: State Action

- Managed Care in Development: 18 states
- Implemented or Expanded MC in 2010: 1 state
- Plan to Implement or expand MC in 2011: 5 states
- MC area expanded 2010: 1 state
- Will expand MC area 2011: 0 states
- Changed to mandatory enrollment 2010: 0 states
- Change to mandatory enrollment 2011: 0 states
- Expand # of PACE sites 2010: 5 states
- Expand # of PACE sites 2011: 7 states
- Other Program 2010: 0 states
- Other Program 2011: 1 state
What are the Important Considerations with Managed LTSS?

Focus on Quality

- Are policy goals aimed at building a better LTSS system? If so, these take time to build. Are state goals and timelines compatible with the delivery of high quality services?

- Are the interim efforts to ensure quality sufficient until we are able to develop evidence-based, well-tested quality measures for the delivery of LTSS?
Update on LTSS Quality Initiatives

AARP, the Commonwealth Fund, and the SCAN Foundation

- Raising Expectations: A State Scorecard on LTSS
  - A multidimensional approach to measure state-level performance of LTSS systems that provide assistance to older people and adults with disabilities.

- Examines state performance across four key dimensions of LTSS system performance: 1) affordability and access; 2) choice of setting and provider; 3) quality of life and quality of care; and 4) support for family caregivers.
Update on LTSS Quality Initiatives, cont’d.

National Quality Forum

- Initiative to identify quality performance measures that are appropriate for use with dual eligibles.

- Phase 1: Understanding the unique qualities of the population, identifying deficits in quality that affect the group, defining a strategic approach to measurement, and characterizing appropriate measures. October 2011 interim report: http://www.qualityforum.org/Setting_Priorities/Partnership/Dual_Eligible_Beneficiaries_Workgroup.aspx

- Phase 2: Identify gaps in available measures and propose modifications or concepts for measure development by June 2012.
Update on LTSS Quality Initiatives, cont’d.

NCQA and the SCAN Foundation

- Project to develop measures for dual eligible
- Environmental scan: meetings with key stakeholders
- Developed primary domains
  - individualized care plan
  - coordinated service delivery
  - comprehensive needs assessment
  - outcomes assessment where possible
NCQA and the SCAN Foundation: Next Steps

- Convene stakeholder panel, identify states/models to evaluate feasibility

- Develop draft standards/measures

- Test draft measures in 3-5 organizations with different service delivery models
What are the Important Considerations with Managed LTSS?

Focus on Consumers

- Are consumers adequately informed and represented throughout the process (e.g., contract development, implementation, oversight)?

- To what extent are states ensuring a continuum of settings and choice by including HCBS in their managed LTSS contracts?

- How do states provide incentives for integration (e.g., for consumers to choose Medicare managed care)?
Focus Groups Project with Dual Eligibles in Various Care Coordination Models

- Goal: To learn if there are differences in dual eligible’s experience of health care by type of service delivery model

- Programs: PACE, Fully-Integrated Medicare Special Needs Plan (SNP); Partially-Integrated SNP, North Carolina Primary Care Case Management Model; and, Fee-For Service

- Report and findings to be released at Alliance Meeting this December.
What are the Important Considerations with Managed LTSS?

Focus on Improving State Capacity

- Does the state have the resources (human and experiential) to ensure that plans are in compliance with all contract requirements related to the delivery of LTSS?

- What steps does the state take to ensure that plan performance in delivering LTSS is transparent to the public?
AARP Public Policy Institute Activity

State Capacity to Oversee Medicaid Managed LTSS Contracts

- Goal: To learn more about the resources it takes to adequately oversee and managed Medicaid managed care contracts to provide LTSS to beneficiaries.

- Interviews with key informants in 8 states.

- PPI hosting a Roundtable in December to bring together experts to consider the feasibility of developing objective measures to determine the adequacy of state capacity.
Questions?

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