A Snapshot of the Connecticut LTSS Rebalancing Agenda
Agenda

- Medicaid context and vision

- State Rebalancing Plan

- Major elements of rebalancing agenda
  Money Follows the Person, Nursing Home Rightsizing, Demonstration to Integrate Care for Medicare-Medicaid Enrollees, State Balancing Incentive Program (BIP), TEFT, Community First Choice, MyPlace

- Rebalancing Results
Medicaid Context and Vision
Medicaid Context

- By contrast to most other states, Connecticut is not using any managed care arrangements.

- Instead, Connecticut Medicaid is self-insured and has entered into contracts with single, statewide Administrative Services Organizations (ASOs) for each of the four major service types – medical, behavioral health, dental and Non-Emergency Medical Transportation (NEMT).
Medicaid Context (cont.)

This is our hypothesis:

Centralizing management of services for all Medicaid beneficiaries in self-insured, managed fee-for-service arrangements with Administrative Services Organizations, as well as use of predictive modeling tools and data to inform and to target beneficiaries in greatest need of assistance, will yield improved health outcomes and beneficiary experience, and will help to control the rate of increase in Medicaid spending.
Medicaid Context (cont.)

- Medicaid is a major payer of health services and currently serves over **670,000** beneficiaries (over 21% of the state population)

- **4 out of 10 births in Connecticut** are to mothers who are Medicaid beneficiaries

- Through early and ACA eligibility expansion, Connecticut is now serving almost **171,000** childless adults
Medicaid Context (cont.)

As of September, 2014, Medicaid was serving:

- **484,792** HUSKY A adults and children
- **14,119** HUSKY B children
- **98,160** HUSKY C older adults, blind individuals, individuals with disabilities and refugees
- **170,875** HUSKY D low-income adults age 19-64
- **~ 2,700** limited benefit individuals (includes behavioral health for children served by DCF, tuberculosis services, and family planning services)
Connecticut has:

- the fourth highest level of health care expenditures at $8,654 per capita, behind only the District of Columbia, Massachusetts, and Alaska [2009 data]
- the ninth highest level of Medicare costs at $11,086 per enrollee [2009 data]
- the highest level of Medicaid costs at $7,561 per enrollee [2010 data]

[Kaiser State Health Facts]
Medicaid Context (cont.)

Please note the following per capita break-out of Medicaid costs by recipient group:

- $16,955 Aged
- $25,393 Disabled
- $ 3,533 Adult
- $ 3,339 Children

[Kaiser State Health Facts, 2010 data]
Medicaid Vision

An effective, person-centered health care delivery system for eligible people in Connecticut that promotes:

- well-being with minimal illness and effectively managed health conditions;
- maximal independence; and
- full integration and participation in their communities.
Current Connecticut LTSS Milieu

- Connecticut has an active Money Follows the Person (MFP) Demonstration

- Connecticut is covering thousands of older adults, individuals with physical disabilities, individuals with behavioral health disabilities, individuals with acquired brain injury, and individuals with intellectual disabilities under 1915(c) waivers

- Connecticut has also used a small, limited scope 1915(i) State Plan Amendment to augment participation in its elder waiver
Why focus on LTSS rebalancing?

- Consumers overwhelmingly wish to have meaningful choice in how they receive needed long-term services and supports.

- Connecticut’s Medicaid spending remains weighted towards institutional settings, but re-balancing is shifting this. In 2013:
  - 58% of long-term care clients received care in the community
  - 45% of spending supported home and community-based care
Only 7% of the Medicaid population receives long-term services and supports (LTSS) but 51% ($3.1 billion) of the SFY’13 Medicaid expenditures ($6.1 billion) were made on the behalf of these beneficiaries
Connecticut Plan to Rebalance Long-Term Services and Supports
The Concept

- **Rebalancing** refers to reducing reliance on institutional care and expanding access to community Long-Term Services and Supports (LTSS)

- A rebalanced LTSS system gives Medicaid beneficiaries greater choice in where they live and from whom they receive services

- It also delivers LTSS that are integrated, effective, efficient, and person-centered
The Plan

- Of foundational importance is a Governor-led, statewide LTSS rebalancing plan, an integrative approach across departments and an intense stakeholdering process.

- Connecticut’s plan, entitled, “Strategic Rebalancing Plan: A Plan to Rebalance Long-Term Services and Supports” is available from this link:

Money Follows the Person
Money Follows the Person: Overview

- Money Follows the Person is not just about transitioning individuals from nursing facilities to the community.

- Money Follows the Person has:
  - led overall systems change efforts in LTSS
  - included a diverse array of stakeholders (consumers, caregivers, advocates, providers)
  - resolved barriers to choice
  - helped institutional providers to conceptualize new roles for themselves
Money Follows the Person: Overview

Key Demonstration services include:

- care planning specialized in engagement and motivation strategies
- alcohol and substance abuse intervention
- peer support
- informal caregiver support
- assistive technology
- fall prevention
- recovery assistance
- housing coordination
- self-directed transitional budgets including housing set-up
- transportation assistance and housing modifications
Money Follows the Person: Overview

Systems focus areas for MFP include:

- housing development
- workforce development
- LTSS service and systems gap analysis/recommendations
- hospital discharge planning interventions
- development of improved LTSS quality management systems
Money Follows the Person: Overview (cont.)

- In FY 2014, CT MFP transitioned 552 individuals from nursing facilities to community-based settings.

- Since its inception in December, 2008, CT MFP has transitioned over 2,300 individuals from nursing facilities to community-based settings, towards an ultimate goal of 5,000.
Nursing Home Rightsizing
Nursing Home Rightsizing

- $40 million in grant and bond funds through FY 2017 has been dedicated to nursing facilities that are interested in diversifying their scope to include HCBS

- DSS has issued town-level projections of need for LTSS and need for workforce

- This data has informed applicants and selection of facilities through a Request for Proposals process
Applicant nursing facilities are required to work collaboratively with the town in which they are located to tailor services to local need.

In early 2014, the administration awarded $9 million in grant funds to seven entities.

Another Request for Proposals is in process of being issued.
Demonstration to Integrate Care for Medicare-Medicaid Enrollees
Demonstration to Integrate Care: Overview

Through the Demonstration, stakeholders and the Department seek to create and reward innovative local systems of care and supports that provide better value over time through a managed fee-for-service model by:

- integrating medical, behavioral and non-medical services and supports
- providing financial incentives to achieve identified health and client satisfaction outcomes
Demonstration to Integrate Care: Profile of population to be served

- Connecticut dual-eligibles (“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.
Demonstration to Integrate Care: Profile of population to be served (cont.)

- 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**
comparatively high spending alone on MMEs has not resulted in better health outcomes, better access or improved care experience

illustratively, in SFY’10 almost 29% of MMEs were re-hospitalized within 30 days following a discharge, and almost 10% were re-hospitalized within 7 days following a discharge
MMEs have reported in Demonstration-related focus groups that they have trouble finding doctors and specialists that will accept Medicare and Medicaid, and often do not feel that the doctor takes a holistic approach to their needs.
Demonstration to Integrate Care: Key Structural Features

- **Enhanced Administrative Services Organization (ASO) Model**

  - Under the Demonstration, the ASO will address the need for more coordination in providing services and supports, through such means as:
    - integration of Medicaid and Medicare data
    - predictive modeling
    - Intensive Care Management (ICM)
    - electronic tools to enable communication and use of data
Demonstration to Integrate Care: Key Structural Features (cont.)

- Expansion of Person-Centered Medical Homes (PCMH) pilot to serve dual eligible individuals ("MMEs")

  - Under the Demonstration, the Department will extend the enhanced reimbursement and performance payments to primary care practices that serve MMEs
Demonstration to Integrate Care: Key Structural Features

- Procurement of 3-5 “Health Neighborhoods” (HNs)
  - HNs will reflect local systems of care and support and will be rewarded for providing better value over time
  - HNs will be comprised of a broad array of providers, including primary care and physician specialty practices, behavioral health providers, long-term services and supports providers, hospitals, nursing facilities, home health providers, and pharmacists
Demonstration to Integrate Care: Status

- Currently negotiating Memorandum of Understanding (MOU) with CMMI

- For more information on this project, see this link:

State Balancing Incentive Program (BIP)
effective October 1, 2011 through September 30, 2015, CMS offered enhanced Federal Medical Assistance Payments (FMAP) to states that agree to increase the proportion of Medicaid spending on home and community-based services (HCBS)
BIP: Overview

- Connecticut submitted its application October 31, 2012

- Connecticut’s award is $72.8 million
BIP: Requirements

- BIPP requires that states:
  - in which 25% or greater of Medicaid spending is on HCBS (as opposed to institutionally-based long-term care) commit to increase that percentage to a target of 50% by September 14, 2015; and
within six month of applying, have implemented the following:

- a “no-wrong door single entry point system” to facilitate consumer access to information on LTC services and to assess their financial and functional eligibility for available programs
"conflict-free" case management (e.g. of the kind provided by the Access Agencies for the Connecticut Home Care Program for Elders; neutral in relationship to providers)

a core, statewide, standardized assessment instrument
BIP: Achievements to Date

- Diverse efforts are underway to streamline and standardize access to LTSS across the state within the structure of the Department’s replacement Eligibility Management System (EMS), which will be called ImpaCT:

  - in support of the Core Standardized Assessment (CSA), all involved agencies have agreed to implement a standardized assessment across programs, supporting the State’s goal of linking standard levels of needs to standard budget allocations.
BIP: Achievements to Date (cont.)

- in support of streamlined intake processes (No Wrong Door), DSS drafted and submitted an Advanced Planning Document (APD) outlining the funding and information technology architecture required to support standardization of functional eligibility processes and assessments across LTSS programs
Testing Experience and Functional Tools in Community-Based Long Term Services and Supports (TEFT)
TEFT Overview

- In March, 2014, CMS awarded TEFT planning grants to Connecticut and eight other states to test quality measurement tools and demonstrate e-health in Medicaid community-based long term services and supports (LTSS)

- TEFT is designed to:
  - Field test an experience survey and a set of functional assessment items
  - Demonstrate personal health records
  - Create a standard electronic LTSS record
TEFT Overview

- State grantees will have an opportunity to extend the grant period to a total of four years

- Connecticut has received a $500,000 grant, and contingent upon successful completion of the planning phase, has requested an additional $3,772,385

- The DSS Division of Health Services Money Follows the Person and Alternate Care Units are partnering on these initiatives with the UConn Center on Aging and UConn Health Center Biomedical Informatics
Community First Choice
Community First Choice

- Connecticut is planning to implement a 1915(k) State Plan Amendment to elect the Community First Choice option

- Connecticut will focus upon use of this option to cover Personal Care Assistance
My Place
My Place Campaign

- My Place is a web-based, No Wrong Door platform that aims to coordinate seamlessly with both the Department’s Eligibility Management System (EMS) and Connecticut’s health insurance exchange (Access Health CT).

- My Place is also a campaign designed to share information and to promote awareness.
My Place Campaign

- My Place is intended to convey different messages to a range of stakeholders:
  - My home
  - My role in person-centered care planning
  - My role as a caregiver
My Place Resources

http://www.myplacect.org/
Rebalancing Results
So, how are we doing?

We have:

- increased the percentage of hospital discharges to home and community care rather than nursing facility care from 47% in 2007 to 52% in 2013

- increased the percentage of LTSS expenditures to home and community rather than nursing home care from 33% in 2007 to 43% in 2013
So, how are we doing?

- increased the percentage of nursing facility admissions returning to the community within six months of admission from 30% in 2007 to 36% in 2013

- increased the percentage of people receiving LTSS in the community versus in institutions from 52% in 2007 to 58% in 2013
What impact has this had for people served?

We have increased the percentage of people who:

- are happy with the way they live their lives - from 62% while institutionalized to 79% after their move to the community
- report that they are doing fun things in their communities - from 42% while institutionalized to 60% after their move to the community
- increased the percentage of people who report that they are being treated the way in which they wish to be - from 82% while institutionalized to 93% after their move to the community
Appendix:
Overall Synopsis of
Connecticut Medicaid
Health Care Reform Agenda
For more information on Connecticut’s Medicaid reform strategies, please see “A Precis of the Connecticut Medicaid Program”, which is available at this link:

Questions?