Connecticut's Demonstration Initiative Regarding Medicare Medicaid Eligible's (MMEs)

Connecticut's Demonstration Initiative

- Connecticut, like many other states, is in the process of restructuring and transitioning their Medicaid program by rejecting the former managed care model, capturing federal funds to develop new models of care, and developing a statewide strategic plan to reduce the number of nursing home beds and increase the capacity for home and community based services. The following is a brief summary of Connecticut's demonstration initiative regarding Medicare Medicaid Eligible's (MMEs).
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Connecticut's Demonstration Initiative

- Connecticut was one of several states to receive a Center for Medicare and Medicaid Innovation Center (CMMI) planning grant to develop a plan for a three year pilot demonstration program to coordinate the care of the clients who are eligible for both Medicare and Medicaid (MMEs). A plan design was developed and submitted to CMMI for approval in May of 2012. Our Department of Social Services has since been in plan design discussions with CMMI and submitted a revised final design on April 22, 2013.

Connecticut's Demonstration Initiative

- Connecticut's overall vision for the Demonstration is "to create and enable value-based systems through which MMEs will receive integrated, holistic, person-centered services and supports that address the entirety of their needs (physical, behavioral, and non-medical)."
- The Demonstration will include all MME individuals age 18 and over who are not in a Medicare Advantage Plan or an Accountable Care Organization. There are 64,000 individuals in Connecticut who are MME and 57,568 MMEs would be eligible for the Demonstration. However, at least four Accountable Care Organizations have been recently approved by CMS for operation in the state and this may reduce the number of MMEs that will be eligible.

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- The Demonstration will integrate Medicare and Medicaid long term care, medical and behavioral health services and supports, promote practice transformation, and create pathways for information sharing through key strategies including:
  - Data integration and state of the art information technology and analytics;
  - Intensive care management (ICM) and care coordination in support of effective management of co-morbid chronic disease;
  - Expanded access for MMEs to Person Centered Medical Home (PCMH) primary care;
  - Electronic care plans and integration with Connecticut's Health Information Exchange to facilitate person-centered team based care, and
  - A payment structure that will align financial incentives (advanced payments related to costs of care coordination and supplemental services, as well as performance payments) to promote value.

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- **The Demonstration will be a two layered approach.** The first layer will be the development of enhanced Administrative Service Organization (ASO) services for the entire MME population.
  - 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 to allow for predictive modeling for this population, intensive care management, quality management, and electronic tools to enable communication through the Health Information Exchange.
- The state will fund the development of the enhanced ASO's functions.

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- The second layer will be the development of three or five pilot "health neighborhoods" that will incorporate all of the building blocks of the ASO model and enhance them by creating "dynamic, innovative, person-centered local systems of care and support that are rewarded for providing better value over time."
  - A health neighborhood will be an integrated service network 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 homes, home health providers and pharmacists.
  - Each health neighborhood will be organized around an Administrative Lead Agency (ALA) that will provide administrative oversight, performance monitoring, coordination of provider members, identification of the means through which intensive care management and care coordination will be provided, and the distribution of shared savings. The ALA will need to be a Connecticut based healthcare provider with a preference being given to community based providers.
  - There will also be a required Behavioral Health Partner Agency (BHPA) for each health neighborhood. DSS feels that given the high incidence of serious and persistent mental illness (SPMI) in the MME population, it is important that there should be a strong focus on behavioral health in the health neighborhoods.
  - Care coordination will be done by a system of Lead Care Managers (LCM) employed through Lead Care Management Agencies (LCMA) affiliated with the health neighborhoods. The LCMAs will also receive per member per month (PMPM) payments as reimbursement for the intensive care management and care coordination.
  - The health neighborhood will also be required to provide supplemental benefits including chronic illness self-management education, fall prevention, nutrition counseling, mediation therapy management, and case management.
  - The state will fund a portion of the initial startup costs.

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- The Demonstration design will utilize a **shared savings incentive model** where the state will receive from the Center for Medicare and Medicaid Services (CMS) a portion (most likely 50%) of the Medicare savings that are realized through the Demonstration. The state will also hopefully achieve Medicaid savings. The state will then share a portion of these savings with the neighborhoods retrospectively based on the neighborhood achieving cost savings and meeting quality measures.

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- It was originally anticipated that the implementation of the enhanced ASO model would have been on January 1, 2013 and for the health neighborhood model on April 1, 2013 or later. *However, DSS has been in ongoing discussions with CMMI regarding the design of the health neighborhood since the application submission and this has caused a delay in the implementation schedule.* The state's design is unique compared to other states and if approved, implementation of both phases now may not occur until January 1, 2014.
- The health neighborhood RFP which is expected to be released sometime *in the second half of 2013 has yet to be released.*
- Further work will be done on the health neighborhood design including the performance measures. (DSS has produced white papers on care coordination and performance measurements, both concepts that will be incorporated into the MME initiative.)