Co-Chairs: Howard Drescher, Heather Gates, Alicia Woodsby

Meeting Summary
Tuesday May 1, 2012
2:30 – 4:30 p.m.
Value Options
500 Enterprise Drive, 4th Floor Huntington Conference Room
Rocky Hill, CT

Next Meeting: Tuesday June 5, 2012 @ 2:30 PM at Value Options, Rocky Hill

Attendees: Co-Chair Howard Drescher, Co-Chair Heather Gates, Co-Chair Alicia Woodsby, Sheila Amdur, Teodoro Anderson-Diaz, Jill Benson, Alyse Chin, Elizabeth Collins, Susan Coogan, Marilyn Cormack, Letha Deck, Kate Galambos, Terri DiPietro, Ronald Fleming, Sara Frankel, Bill Halsey, Colleen Harrington, Juan Hernandez, Charles Herrick, Jennifer Hutchinson, Colleen Kearney, Sabina Lim, Steven Moore, Marie Mormile-Mehler, Mary Anne O’Neill, Ann Phelan, Kelly Phenix, James Pisciotta, Debra Struzinski, Hillary Teed, and Laurie Van Der Heide

Opening Remarks and Introductions

Co-Chair Heather Gates commenced the meeting by welcoming everyone and introductions were made.

DSS Presentation on Medicare/Medicaid Eligibles Integrated Care Initiative
Kate McEvoy from DSS presented an overview on Health Neighborhoods otherwise known as the Medicare/Medicaid Eligibles (MME) Integrated Care Initiative. She said that individuals have historic barriers in getting care and the “Triple Aim” of this program is to:

- Improve the health of the population
- Enhance the individual’s experience of care (quality, accessibility, reliability)
- Control the rate of increase in, and where possible reduce, the per capita cost of care

There are several State models of care, most notably, North Carolina’s 646 Demonstration programs based on a physician/hospital integrated care and pay-for-performance initiative has had a good success rate and Connecticut’s initiative is one example of this. This Net Medicare/Medicaid savings will be shared with MDs and a broad array of providers with CT stakeholders defining value and will have a Passive enrollment with an opt-out option. **Goals** of this Program: Through the Medicare Medicaid Eligibles (MME) Initiative, stakeholders and the Department of Social Services seek to create and reward innovative local systems of care and supports that provide better value over time by:

- Integrating medical, behavioral, and non-medical services and supports
  - Intensive care management
  - Contracts and care coordination
  - Electric communication tools and utilization data
- Providing financial incentives to achieve identified health and client satisfaction outcomes

**The Profile** of the CT Population to be served is based on 57,569 people who are MMEs with complex, co-occurring health conditions:

- Roughly 88% of individuals age 65 and older have at least one chronic disease, and 42% has three or more chronic diseases
- 58% of younger individuals with disabilities have at least one chronic disease
- 38% have 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 57,569 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
- 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 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.

The question was asked, where are the MME population getting primary care? Kate answered, of the 19-64 year olds, 62% from a Primary Care Physician, 22% from outpatient services, 5% from psychiatrists, and 11% had no identifiable source of a PCP.

**Structure**

- CMS model alternatives:
  - CMS has permitted States to choose between two financial alignment models in support of integrating care for Medicare-Medicaid enrollees:
    - A Capitated Approach
    - A Managed Fee-For-Service (FFS) Approach
  - Connecticut has selected the FFS Approach
- Connecticut’s Demonstration will feature three key elements:
  - An enhanced ASO model
  - Expansion of the Person Centered Medical Home (PCMH) pilot to serve MMEs
  - Procurement of 3-5 “Health Neighborhoods” (HNs) – “Heal and Practice”
- Enhanced 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
- Expansion of PCMH pilot to serve MMEs
  - Under the Demonstration, the Department will extend the enhanced reimbursement and performance payments to primary care practices that serve MMEs (This should help divert people from going to the EDs for care.)
- 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, LTSS providers, hospitals, nursing facilities, home health providers, and pharmacists
Each HN will identify a “Lead Agency” and also a “BH Lead Agency” that will provide administrative oversight, performance monitoring, coordination of provider members, identification of the means through which ICM and care coordination will be provided, and distribution of shared savings.

The Beneficiary’s Perspective
- Advantages of joining a Health Neighborhood (HN)
  - HN will integrate Medicare and Medicaid benefits, including medical, behavioral and non-medical supports
  - HN will use a person-and family centered, personalized, team-based approach that is consistent with the MME’s needs and preferences
    - MME will select his/her preferred care coordinator
    - A consistent team of providers will support the MME and his or her family member/caregiver in planning and coordinating care
  - HN will provide specialized supports to identified populations (e.g. individuals with serious and persistent mental illness, individuals with developmental disabilities)
  - HN will provide additional benefits and services:
    - Chronic illness self-management education
    - Nutrition counseling
    - Falls prevention Medication therapy management

Who Will Benefit
An older adult with COPD who lives alone and who has experienced multiple unexplained falls and associated hospitalizations within the past six months will be able to work with her waiver care manager and a team of providers (e.g. primary care physician, cardiologist, pharmacist, home health nurse and OT) to examine the reasons for the falls and implement interventions that will reduce or eliminate her need to go to the hospital.

A younger individual with diabetes and bipolar disorder will be able to enlist his behavioral health care manager and a multi-disciplinary team to work on strategies for understanding his conditions and effectively manage them.

Providers that have historically had few opportunities and tools to do so will have the means and opportunity to be in direct contact and to collaborate.

The Next Steps
- The draft application has been posted on both the MAPOC and DSS website: http://www.ct.gov/dss/cwp/view.asp?a=2345&pm-1&Q503056
- A 30-day comment period commenced on Wednesday, April 25 – the Department will review and inventory comments
- The Department plans to submit the final application on or about May 29, 2012
Discussion
There was discussion on sharing net savings with providers. Sheila Amdur said no programs in the country have shown any savings. Some will get less; some will get more (shared savings to providers). Person centered management might provide savings. After the first year, if there are savings, it should be distributed evenly to all of the providers and after two years, bonuses should be provided where the savings are coming from. Shared savings must reach performance measures. Kate said that participants in the demonstration can go out of network for care but ultimately, the network is still responsible for care. There was mention of a co-occurring initiative; Money Follows the Person which is a shared savings methodology. Co-Chair Heather Gates asked what is the payment mechanism to support initial care? Kate replied that it is a fee for service (FFS) program. Kelli Phenix said that there was no spend down for MMEs. Jill Benson wanted to know what is the relationship between Behavioral Health and medical needs?

Update on Health Homes

Jennifer Hutchinson of DMHAS gave a presentation on Health Homes and passed out a chronological timeline that the Department has developed for this demonstration (attached). She said that a lot more work needs to be done and so far, a lot of work has been done in a very short time. It is a work in progress. Sheila replied that the process has been extraordinary inclusive. She, Jen, and Heather all agreed that a special work groups needs to convene with DMHAS, the MAPOC Complex Care Committee and the BHP OC Adult Quality, Access & Policy Committee to work on design plan discussions. After a discussion, it was decided this meeting will take place on Tuesday, May 8, 2012 at VO on the 4th Floor in the Crandall Room. Co-Chair Howard Drescher said that the Adult QAP Committee will keep up with the outcome of this new work group and will give Health Homes a high priority for its agenda. Kelli Phenix wanted to know how this will be different from what is happening currently. It was said that the inclusion of electronic health records (EHRs) would make for better quality care and control and Care Managers would give suggestions to clients for better health outcomes. Co-Chair Alicia Woodsby wanted to clarify the view DSS took on the differences between a Financing Mechanism vs. a Quality Care Program for clients.

New Business and Announcements
Hearing no new policy items, Co-Chair Alicia Woodsby adjourned the meeting at 4:29 PM.

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