A Précis of the Connecticut Medicaid Program

Department of Social Services

Executive Summary

The Connecticut Department of Social Services (DSS) is the single state agency for the administration of Connecticut Medicaid and the Children's Health Insurance Program (CHIP). Medicaid and CHIP are collectively described as the HUSKY Health Program. The DSS Division of Health Services as well as Eligibility Policy and field staff support access to and utilization of HUSKY Health. These programs provide person-centered health care coverage to over 768,000 individuals (21.3% of the Connecticut population). Our vision for Medicaid and CHIP is that they represent an effective health care delivery system for eligible people in Connecticut that promotes 1) well-being with minimal illness and effectively managed health conditions; 2) maximal independence, and 3) full integration and participation in their communities. HUSKY Health serves eligible children, their caregivers, older adults, individuals with disabilities and single, childless adults. HUSKY also provides limited coverage to a number of additional small groups (e.g. for family planning and tuberculosis coverage), and helps keep older adults and people with disabilities independent at home through Medicaid "waivers".

Medicaid Financing

Medicaid is a cost-sharing partnership between the federal government and Connecticut. With the exception of services for childless adults under HUSKY D, which are now reimbursed at 100%, the federal government generally pays 50% of the costs for covered services. This is known as Federal Medical Assistance Payment (FMAP) ("match"). The Medicaid budget represents 13.0% of the state budget, and totals over $6 billion annually (including federal and state shares). Medicaid also receives FMAP for the Children's Health Insurance Program (CHIP). The federal government pays 65% of the cost of covered services in CHIP. Connecticut Medicaid has administrative costs (including all eligibility-related costs) of only 5.2%.

Key Strategies:

The Department of Social Services Division of Health Services is employing diverse strategies to achieve improved health outcomes and cost efficiencies in the Medicaid program. Strategies include:

1) use of an administrative services organization (ASO) platform to promote efficient, cost-effective and consumer/provider responsive Medicaid medical, behavioral health, dental and non-emergency medical transportation (NEMT) services;
2) use of data analytics to improve care;
3) activities in support of improving access to preventative primary care;
4) efforts to support integration of medical, behavioral health, and long-term services and supports (LTSS);
5) initiatives designed to "re-balance" spending on LTSS; and
6) efforts to promote the use of health information technology.

Medicaid and CHIP at a glance:

- Medicaid and CHIP are federal-state partnerships.
- The federal government generally covers 50% of the costs of Connecticut's Medicaid program and 65% of the costs of Connecticut's CHIP.
- Medicaid eligibility and coverage rules are governed by State Plan and Home and Community-Based Services waiver documents that represent agreements between Connecticut and the

Administrative Structure

The Connecticut Department of Social Services is the federally identified "single state agency" for management of the Medicaid program. Medicaid and CHIP are administered by the Department's Division of Health Services. All attributes of the Medicaid program (e.g. eligibility standards, covered services, limitations on coverage, payment for services) are captured in the Connecticut Medicaid State Plan. Federally, Medicaid is overseen by the Centers for Medicare and Medicaid Services (CMS). Further, the Division administers a range of federal grants, including, but not limited to, Money Follows the Person and Rewards to Quit.

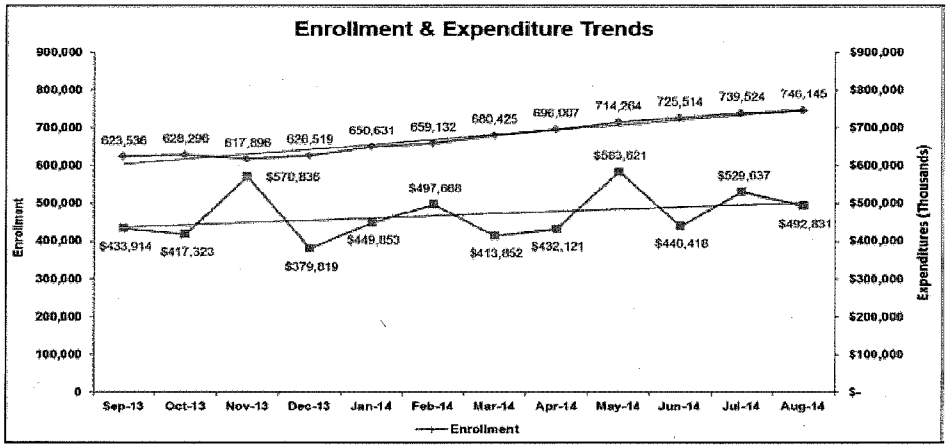
Additionally, the Division has pursued diverse opportunities under the Affordable Care Act, including the Demonstration to Integrate Care for Medicare-Medicaid Enrollees, the Medicaid Adult Quality Measures Grant and the Balancing Incentive Program (BIP).

HUSKY Health enrollment is growing, care and satisfaction outcomes are improving, and costs are holding constant.

Current Participation in HUSKY Health

Coverage Group	Description	Participation as of Sept. 2014
HUSKY A	Connecticut children and their parents/relative caregivers as well as pregnant women, all based on income	484,792
HUSKY B (Children's Health Insurance Program or CHIP)	Uninsured children under age 19 in higher-income households	14,341
HUSKY C	Individuals age 65 and older, individuals who are blind, individuals who have disabilities	98,160
HUSKY D	Childless individuals age 19-64 who do not otherwise qualify for Medicaid	170,875

Connecticut Medicaid is one of the very few Medicaid programs whose expenditures have remained fairly constant.



Connecticut's Unique ASO Arrangement

By contrast to almost all other Medicaid programs throughout the nation, Connecticut Medicaid is not using any managed care arrangements and is structured as a managed, fee-for-service program. Each of the four Administrative Services Organizations (ASOs) are contracted to administer services and to achieve improved health and satisfaction outcomes for beneficiaries, as well as improved experience for providers enrolled in the Medicaid program. See below for contact information for the ASOs as well as for pharmacy services.

Connecticut's Medical Expenditure Trends

	FY 12 to FY 13 Change	FY 13 to FY 14 Change
U.S. Total Spending	7.6%	12.2%
DSS Expenditures (Gross) *	4.3%	9.4%
Enrollment (Average)	5.1%	7.5%
PMPM (Average)	-0.7%	1.8%

** Expenditures are net of drug rebates and include DMHAS' behavioral health costs claimable under Medicaid.*

Important Contact Information for Medicaid and CHIP

Type of coverage:	Contact:	Telephone Number:	Web Site:
Medical coverage (CHN)	HUSKY Health Member Services	1-800-859-9889	www.huskyhealthct.org
Behavioral health coverage (Value Options)	Connecticut Behavioral Health Partnership (CTBHP)	1-877-552-8247	http://www.ctbhp.com/
Dental coverage (BeneCare)	Connecticut Dental Health Partnership (CTDHP)	866-420-2924 855-CTDENTAL (855-283-3682)	www.ctdhp.com
Non-emergency medical transportation (NEMT) (Logisticare)	Logisticare	1-888-248-9895 Reservations: 1-866-684-0409	http://www.logisticare.com/members-riders.php
Pharmacy coverage (DSS with Hewlett Packard, HP)	DSS Division of Health Services Pharmacy Unit/HP	Member services: 1-866-409-8430 Prior authorization assistance: 1-866-409-8386	www.ctdssmap.com

Our Mission

The Department of Social Services' Division of Health Services works in partnership with stakeholders (beneficiaries; the Departments of Mental Health & Addiction Services, Children & Families, Developmental Services and Public Health; Administrative Services Organizations; legislators; providers; and advocates) across the health care delivery system to ensure that eligible people in Connecticut receive the supports and services they need to promote self-sufficiency, improved well-being and positive health outcomes. We ensure that the delivery of these services is consistent with federal and state policies.

Key Elements of Medicaid Law

The purpose of Medicaid is to enable states "to furnish rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." Further, the Medicaid Act requires that each state medical assistance program be administered in the "best interests of the recipients." Participation in Medicaid is voluntary, but states that have chosen to participate must administer their programs consistent with the requirements of the Medicaid Act. Further, each participating state must draft and gain approval from the Centers for Medicare and Medicaid Services [CMS] for a Medicaid State Plan. Each State Plan must include a description of how the program is administered, covered groups, and all covered services. Federal law identifies some services as mandatory for all participating states, and others as optional. Connecticut has elected to cover many optional services. Note that each State Plan is an evolving document. To modify any element of a State Plan, such as which services are covered, a state must submit a detailed State Plan Amendment (SPA) request to CMS for its approval. Approval of SPAs is governed by requirements for timeliness of review, and often involves receipt by states of formal Requests for Additional Information (RAI). In most cases, approval of a SPA means that the amendment is approved retroactive to the date of its submission to CMS. Medicaid services must generally be offered on a statewide basis and be provided to all recipients in the same amount, duration and scope.

Meet a Medicaid Beneficiary . . .

Mrs. W. was referred to the CHN Intensive Care Management (ICM) for assistance locating providers after years of having no insurance coverage. She needed help choosing a primary care provider, gynecologist, dentist, vision specialist and needed all of her preventative screenings. Mrs. W. developed an acute infection that required intravenous antibiotic treatment. ICM assisted her with locating a new Primary Care Physician (PCP). The PCP diagnosed Mrs. W with hypertension and she is now taking medications for her high blood pressure. The CHN ICM nurse also arranged for a home health nurse, who with the help of Mrs. W's family monitors her blood pressure. These blood pressure readings are reported to her doctor weekly by her home care nurse. ICM is continuing to assist Mrs. W. with care coordination needs for other specialists.

Connecticut Medicaid ASO Platform

Department of Social Services

Administrative Services Organizations (ASOs)

By contrast to almost all other Medicaid programs throughout the nation, Connecticut Medicaid no longer utilizes managed care arrangements, under which companies receive capitated payments for serving beneficiaries. Instead, Connecticut has adopted a self-insured, managed fee-for-service approach. In support of achieving better heath and care experience outcomes for beneficiaries, and engagement with Medicaid providers, the Department has entered into contracts with ASOs for each of the four major service types – **Medical (CHN), Behavioral Health (ValueOptions), Dental (BeneCare) and NEMT (Logisticare)**. The structure of each of the ASO contracts supports the Department's desired results. A percentage of each ASO's administrative payments is withheld by the Department pending completion of each fiscal year. To earn back these withholds, each ASO must demonstrate that it has achieved identified benchmarks on health outcomes, healthcare quality, and both member and provider satisfaction measures. All savings go back into the program instead of contributing to the profit of a managed care organization.

Why Did Connecticut Move to this Model?

Historically, Connecticut Medicaid used a mix of managed care and fee-for-service arrangements to provide services to beneficiaries. Important features, such as rules concerning prior authorization of services, provider networks, and reimbursement rates for services, were not uniform across the managed care entities. This caused confusion and uncertainty for beneficiaries. Further, this lack of consistency posed challenges for providers who participated in more than one managed care network, and providers often reported that it was difficult to engage with the managed care companies and to get paid on a timely basis. Finally, the Department received only incomplete encounter data from the managed care companies, which did not give a complete or accurate view of the use of Medicaid services.

Key Strategies:

The Department of Social Services Division of Health Services is employing diverse strategies to achieve improved health outcomes and cost efficiencies in the Medicaid program. Strategies include:

1. **use of an administrative services organization (ASO) platform to promote efficient, cost-effective and consumer/provider responsive Medicaid medical, behavioral health, dental and non-emergency medical transportation (NEMT) services;**
2. use of data analytics to improve care;
3. activities in support of improving access to preventative primary care;
4. efforts to support integration of medical, behavioral health, and long-term services and supports (LTSS);
5. initiatives designed to "re-balance" spending on LTSS; and
6. efforts to promote the use of health

Key Medicaid Contacts:

- **Medical services:**
  1-800-859-9889
- **Behavioral health services:**
  1-877-552-8247
- **Dental services:**
  1-866-420-2924
- **Non-Emergency Medical Transportation (NEMT) services:**
  1-866-409-8386

The 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.

Key Strategies

ASOs have centralized and streamlined the care experience for beneficiaries, and improved support for providers.

- **Member Supports:** The ASOs are responsible for more traditional services including beneficiary support, referrals to providers, utilization management (e.g. prior authorization of services when required), and grievances and appeals.

- **Predictive Modeling Tools:** Reflecting a new emphasis on the use of data to inform decision-making, and beneficiaries' need for individualized support, the medical, behavioral health and dental ASOs are now using predictive modeling tools and an integrated set of Medicaid claims data to identify both those currently in greatest need of assistance and those at risk of needing assistance.

- **Intensive Care Management:** The ASOs are serving high need individuals with a new program feature - Intensive Care Management (ICM). ICM enables attention to be given to the entire range of a beneficiary's needs - from basic needs such as housing stability and food security, to complex medical profiles including chronic disease, behavioral health and oral health conditions. In support of ICM, CHN has fully implemented a tailored, person-centered, goal oriented care coordination tool that includes assessment of critical presenting needs (e.g. food and housing security), culturally attuned conversation scripts and chronic disease management scripts. Additionally, three of the ASOs have now assigned ICM staff statewide:

    - CHN has in place geographically grouped teams of nurse care managers;
    - ValueOptions® has deployed ICM staff to high volume hospitals to meet the needs of those members who are admitted to the emergency department at higher rates than their peers; and
    - BeneCare employs a team of dental health specialists who are placed in various communities and are responsible for promoting oral health, reducing barriers to obtaining care, and providing care management for beneficiaries who have complex dental/medical conditions.

- **Provider Supports:** ASO arrangements have substantially improved engagement with providers, who now have a single set of coverage guidelines for each service, and a uniform fee schedule from which to be paid. Providers can bill every two weeks, and 'clean claims' are paid completely and promptly through a single fiscal intermediary – Hewlett Packard Enterprises (HP). This promotes participation and retention of providers, and enables monitoring of the adequacy of the networks needed to support a growing population of beneficiaries.

The Results

Access to Care

- Increased the number of Primary Care Providers (PCP) enrolled in Medicaid by **14.6%** and increased the number of specialists enrolled in Medicaid by **11.4%.**
- Recruited and enrolled 25 new practices into DSS' Person-Centered Medical Home (PCMH) program.
- Increased the number of participating dentists in the CTDHP network to over 1,900, which is a **12.7% increase** over the previous year.
- Connecticut Medicaid beneficiaries have the best access to dentists of any program in the country. A geo-access analysis shows that **100% of beneficiaries** have the choice of at least two dentists within a 20 mile radius of their home; 99.7% have 2 providers available within a 10 mile radius; and 97.7% have 1 dentist available within a 5 mile radius.

Utilization Management and Cost Effectiveness

- Overall admissions per 1,000 member months decreased by 3.7%.
- Utilization per 1,000 for emergent medical visits decreased by 0.9%
- Utilization per 1,000 for non-emergent medical visits decreased by 13.7%.
- Utilization of dental restorative services has decreased by 2.5%.

Care Coordination, Outcomes and Quality – all figures are for year 2013

- **Reduced** emergency department (ED) usage for members engaged in the CHN Intensive Care Management (ICM) program by 15.1% and **inpatient admissions by 50.7%.**
- **Reduced** overall readmission rate within 30 days decreased by 2.9%.
- **Reduced** readmission rate by 44.4% for those members receiving CHN's intensive discharge planning.
- Increased well child visits in the first 15 months of life (6 or more visits) by nearly 11% and the well child visits in the third, fourth, fifth and sixth year of life by over 5%.
- Increased children's and adolescent's access to primary care practitioners by 8%.
- Increased immunization rate for adolescents (Tdap/Td Total) by nearly 6%.
- Increased lead screening in children by nearly 6%.
- Increased Breast Cancer Screening by 4%.
- Increased the number and percent of children age 3 to 19 who received preventive dental care to 69% (HUSKY A) and 73% (HUSKY B).
- Improved outcomes for individuals served by the ValueOptions ICM program, including: a **72.7% reduction** in total days in a confined setting; **73.5% reduction** in psych days; a **69.2% reduction** in inpatient detoxification days; and a 10.5% increase in total days in the community.
- Improved outcomes for individuals served by the BeneCare ICM program, including: a reduction in use of the Emergency Department for dental care to less than 5%; and an increase in utilization of preventative dental services by children served by HUSKY A and B from 36% in 2008 to 58% in 2013.

How Has Increased Enrollment Affected Medicaid Network Adequacy?

- Participation of medical and dental providers in Medicaid is increasing:
    - Participation of primary care practitioners is **up 21.3%** since 2012 to a current total of 3,534
    - Participation of specialists is **up 23.3%** since 2012 to a current total of 22,562
    - Total medical provider participation is **up 31.7%** since 2012 to a current total of 27,950
    - Total dental provider participation is also up dramatically to a current total of 1,951
- 97.4% of primary care practices and over 75% of all specialty practices (with the exception of dermatology) have open panels (i.e. have indicated that they are accepting new Medicaid beneficiaries)
- Geo-mapping indicates that there is good incidence of provider access at 15, 20 and 25 mile distances from where beneficiaries are located
- Data from a "mystery shopper" survey indicates that a majority of callers:
    - could get a timely appointment (63.8%)
    - were not told that their insurance coverage affected the availability of an appointment (68.2%)
    - were treated courteously (93.0%)

Meet A Medicaid Beneficiary . . .

Miss. B. was referred to Intensive Care Management (ICM) at CHN for behavioral health concerns and difficulty getting care because of a lack of transportation. Miss B.'s behavioral health problems were interfering with her family life, leaving her guardian (mother) unable to leave the home. Miss B.'s mother asked for assistance to find a behavioral health clinician to prescribe medication because Miss B. hadn't been using any medication for many months. In partnership with Value Options, ICM found a behavioral health provider for therapy and medication management. ICM also coordinated transportation with Logisticare so that Miss B. could again participate in an autism program because she now had a ride. ICM also found a counselor, a psychiatrist for medication and an after school program for autism. Miss B.'s mother stated she feels she will be able to look for a job now because Miss B is getting her care again.

Connecticut Medicaid Use of Data to Improve Care

Department of Social Services

Data Analytic Capacity

Connecticut Medicaid is uniquely situated in its data analytic strength. Since 2012, Connecticut Medicaid has had the benefit of a fully integrated set of claims data across all categories of Medicaid services. The Department's medical ASO, CHN, maintains this data within the Utilization & Cost Analyzer (UCA) system, an analytical and data discovery tool that includes Medicaid claims, member eligibility, and provider data. UCA utilizes QlikView software and is uploaded monthly with claims, member eligibility, and provider data directly from CHN's data warehouse specific to the Connecticut Medicaid program. The data warehouse is populated with data that is received from the Department and its claims processing partner, HP. UCA provides a simple, rapid, and comprehensive means of assessing medical cost and utilization trends in various cuts of the claims, member eligibility and provider data with multiple layers of drillable investigative analysis, down to the claim, member and provider level.

Why Are We Focusing Here?

A key motivation for transitioning from managed care arrangements to the current ASO model was to improve the completeness and integrity of the data available to the Department and providers, and to utilize that data to improve quality. The United States Department of Health and Human Services Agency for Healthcare Research and Quality has stated that, "the rationale for measuring quality improvement is the belief that good performance reflects good-quality practice, and that comparing performance among providers and organizations will encourage better performance."

Key Strategies:

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5) initiatives designed to "re-balance" spending on LTSS; and
6) efforts to promote the use of health information technology.

Key Contacts:

- **CHN:**
  1-800-859-9889 (main number)
  1-800-440-5071 (referrals to Intensive Care Management)
  http://huskyhealthct.org/providers/providers_intensive_care_mngmnt.html

What is "predictive modeling"?

The Center for Health Care Strategies (CHCS) has defined "predictive modeling" as "data-driven, decision-support tools that estimate an individual's future potential health care costs and/or opportunities for care management." CHCS further comments that predictive modeling has three key elements: 1) the *outcome* being predicted (e.g. the relative future overall costs for an individual or expected inpatient utilization); 2) the mix of *predictor variables* used in predicting the outcome (e.g. basic demographic information as well as diagnosis and prescription claims, functional status, prior utilization data); and 3) the means by which *predictor variables are combined* to create the predicted outcome.

Connecticut is uniquely situated to use data to identify those in greatest need, equip providers with better understanding of their patients, analyze whether interventions have had their desired effect, and assess the impact of Medicaid services on individuals, families and populations.

CHN's Use of Data to Improve Support for Connecticut Medicaid Beneficiaries

- **Predictive Modeling.** CHN has extensive predictive modeling and data analytic capabilities through use of DSTHS CareAnalyzer®, a web-based tool that combines elements of patient risk, care opportunities and provider performance. The tool is updated on a monthly basis with Medicaid claims, member eligibility, provider data and lab results. CareAnalyzer® includes two main components: quality measures including NCQA HEDIS® certified measures and the Johns Hopkins ACG® (Adjusted Clinical Group) system. In addition, CareAnalyzer® contains a series of reports designed to provide information on provider effectiveness (quality of care) and provider efficiency (cost of care).

- **Tracking of Health Measures.** CHN uses the HEDIS® measures within CareAnalyzer® to monitor performance throughout the year on key measures. Performance is monitored at the population level, by setting (e.g., Person-Centered Medical Home, hospital clinic, and non-PCMH community practice) and at the individual practice level. The HEDIS® measures also allow CHN to identify individual members who have gaps in care. The Johns Hopkins ACG® system provides risk-adjusted member information and is used by CHN in identifying members who may benefit from care management or other interventions. CHN also uses the ACG® system to evaluate the disease prevalence of member populations, assess pharmacy adherence and determine current and predicted risk for the Medicaid population.

- **Use of Data to Inform Provider Support.** CareAnalyzer® also includes several reports that the Department and CHN use to monitor provider performance based on HEDIS® quality measures. Recently, these reports have been made available to primary care practices for their attributed members. The reports allow both CHN and the primary care practices to monitor measure results on an ongoing basis and identify members with gaps in care. Additional reports are available that measure provider efficiency including the primary care physician (PCP) profile report which analyzes the relative cost efficiency of a practice and a PCP cost of care assessment that provides risk-adjusted comparison of total cost of care.

Meet a Medicaid Beneficiary . . .

Mr. T. had a serious and persistent mental illness, and struggled with cocaine abuse, diabetes, and an extensive heart disease that included a cardiomyopathy (overgrowth of the heart muscles) with heart failure and a previous heart attack. He had been hospitalized 46 times in one year, primarily for complications related to management of his diabetes and an insulin overdose.

Mr. T. was homeless and moved back and forth between Bridgeport and New Haven which made it difficult to find him after hospital discharges. CHNCT Inpatient Discharge Care Manager worked with Mr. T during a hospitalization to help him coordinate his services after discharge. ICM worked with social workers from Yale, St Vincent's Medical Center and Bridgeport Hospital, CT Valley Hospital Intake, Mr. T.'s parole office, Shelter Plus Care, Columbus House and Optimus Health Center to coordinate his care.

Since Mr. T. has been working with ICM he has cut his use of cocaine way down; has had fewer hospitalizations; obtained permanent housing and accepted home care services to help him take his medicines and insulin.

More Detail on CHN's Use of Predictive Modeling:

The CHNCT Predictive Modeling and analytics tool combines elements of patient risk, care opportunities, and provider performance to identify members requiring care management services. This tool uses the Johns Hopkins ACG® (Adjusted Clinical Group) logic to identify members' current and predicted risk and severity. Resulting scores are grouped as high, moderate, or low risk.

Predictive modeling is based on medical and pharmacy claims, member/provider records, and lab data. Factors used to determine risk include:

- overall disease burden (ACGs);
- disease markers (EDCs);
- special markers (Hospital Dominant Conditions and Frailty);
- medication patterns;
- utilization patterns; and
- age and gender.

Predictive modeling reports can be filtered to prioritize Intensive Care Management outreach efforts based on current or potential health risks, high utilization of the emergency department, frequency of inpatient admissions and 30-day readmissions, number and type of chronic conditions, gaps in care, number and type of physicians utilized, number of medications, member demographics and/or current and predicted risk score.

Connecticut Medicaid Improving Access to Primary Care

Department of Social Services

Why is Prevention Important?

The United States spends far more *per capita* on health care than any other developed nation, and yet has little or nothing to show for its efforts. Our health outcomes are poor, our lifespans shortened and our burden of chronic disease second to none. For example, the infant mortality rate in the U.S. is most similar to that of Sri Lanka;, which recently finished fighting a 40 year civil war; our current generation of children are the first in our history who are predicted to not live as long as their parent's generation, largely because of the impact of childhood obesity. Despite these grim statistics, our nation's healthcare system continues to focus on technology, facility-based care and newer and more expensive drug therapies, rather than preventing these illnesses from occurring in the first place, or at least mitigating the impacts of these illnesses before they become more catastrophic. If an ounce of prevention is worth a pound of cure, then a vaccination against hepatitis B is preferable to a liver transplant, and predictive modeling to identify and intervene with those with diabetes who are at risk of complications is better than waiting to treat their amputations, kidney failure and blindness.

Why Are We Focusing Here?

Connecticut adults do not use primary care as recommended, with 1) 12% of at-risk Connecticut residents not having visited a doctor within the two years previous to the study; 2) considerably fewer people of color having done so; and 3) only half of Connecticut adults over age 50 receiving recommended care. [Commonwealth Fund, 2009] Further, a report from the Connecticut Hospital Association indicated that one-third of all emergency department visits are for non-urgent health issues, and that 64% of visits occur between 8:00 a.m. and 6:00 p.m., suggesting that there are barriers to accessing primary care even during typical work hours. [Connecticut Hospital Association, 2009]

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Looking for help accessing Medicaid-covered primary care?

Call CHN at **1-800-859-9889** or access the PCMH page of the CHN web site (*link will be released in the near future*)

What is a Person-Centered Medical Home?

In their *Joint Principles* document, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association define a Person-Centered Medical Home as, "an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family." The premise of a PCMH is that it enables primary care practitioners to bring a holistic, person-centered approach to supporting the needs of patients, while reducing barriers to access (e.g. limited office hours) that have inhibited people from effectively using such care.

Connecticut's nationally recognized Person-Centered Medical Home (PCMH) program is now serving over a third of Medicaid beneficiaries, and has enrolled over 1,200 providers.

Connecticut Medicaid Key Strategies

- **Person-Centered Medical Homes (PCMH).** The Department implemented its PCMH initiative on January 1, 2012. Through this effort, the Department is investing significant resources to help primary care practices obtain PCMH recognition from the National Committee for Quality Assurance (NCQA). Practices on the "glide path" toward recognition receive technical assistance from CHN. Practices that have received recognition are eligible for financial incentives including enhanced fee-for-service payments and retrospective payments for meeting benchmarks on identified quality measures. Key features of practice transformation include embedding limited medical care coordination functions within primary care practices, capacity for non-face-to-face and after hours support for patients, and use of interoperable electronic health records (EHR).

- **Affordable Care Act (ACA) Primary Care Rate Increase.** The ACA required that states increase reimbursement to primary care providers to 100% of the Medicare rate in calendar years 2013 and 2014, and covered the cost of that increase. This rate increase has been extended, at a somewhat reduced level, in the biennial Connecticut budget passed in Spring, 2014.

- **Rewards to Quit.** This tobacco cessation initiative is being funded by a five-year federal grant of up to $10 million. Through the program local mental health authorities (LMHAs), federally-qualified health centers, FQHCs and primary care practices) are offering counseling and training sessions, peer coaching and other smoking-cessation techniques. Participating beneficiaries are receiving financial incentives for achieving various milestones toward quitting. This is the first time that the Department is testing use of beneficiary incentives as a means of improving outcomes.

- **Health Equity.** The Department and its partner CHN are currently examining access barriers related to gender, race and ethnicity faced by Medicaid beneficiaries. This project is focused on identifying disparities and equipping primary care practices with a toolkit outlining strategies to reduce these barriers. In addition, the Department is continuing to partner with the federal Office of Minority Health (OMH) on various efforts to improve the health of racial and ethnic populations.

How are We Doing?

- As of August, 2014, there are 87 practices (associated with 323 sites and 1,273 providers) enrolled in the Department's PCMH program. These practices are serving over 254,000 Medicaid beneficiaries. Beneficiaries are attributed to these practices based on their use of them, as opposed to the typical managed care approach of assigning beneficiaries regardless of their preference.

- On the whole, health outcomes (e.g. use of preventative visits, management of chronic conditions including diabetes) for participants of PCMH practices are better than for individuals not served by a PCMH.

Quality Measure	Statewide	PCMH Program Participants*	Non-PCMH Participants
Adolescent Well Care	52.7%	56.2%	45.6%
Well-Child Visits in the First 15 Months of Life 6 or More Visits	57.7%	63.9%	58.7%
Well-Child Visits in the Third, Fourth, Fifth & Sixth Years of Life	70.4%	76.2%	63.5%
Adult Access to Preventive Health Services	82.3%	93.7%	74.1%
Annual Dental Visit	72.6%	74.2%	70.5%
Developmental Screening in the First Three Years of Life	21.1%	19.0%	22.1%
Asthma Patients with One or More Asthma Related ED Visits	12.9%	13.3%	12.7%
Use of Appropriate Medications for People With Asthma	86.4%	86.0%	87.4%
Ambulatory Care - ED Visits per 1000 Member Months	79.7	95.6	65.0
Comprehensive Diabetes Care - Eye Exam	48.8%	49.9%	48.6%
Comprehensive Diabetes Care - LDL Screen	67.2%	73.3%	63.7%

- The ACA primary care rate increase inspired many primary care providers to enroll in Medicaid. There were 3,458 primary care providers enrolled in Medicaid at the end of July, 2014, up from 2,370 in January 2013, when the reimbursement increase became effective. In January 2012, there were only 1,622 primary care providers.

Meet A Medicaid Beneficiary:

Mr. M. was referred to the CHN Intensive Care Management (ICM) program for Parkinson's disease, several heart problems, severe shoulder conditions , as well as skin cancer on his scalp. Evaluation by ICM showed that Mr. M. did not attend his doctor's visits because he was uncomfortable with his Primary Care Physician (PCP). He had oozing wounds from the skin cancer on his scalp and had not seen a dermatologist. He had chronic pain in his right shoulder with limited range of motion and he had not seen an orthopedist. His shoulder pain had progressed to the point that he stopped attending cardiac rehab. The ICM evaluation also noted that he was not in the care of a neurologist or any other provider for his Parkinson's. ICM worked with Mr. M. to choose a PCP, and a dermatologist who treated his scalp wounds. ICM also assisted Mr. M. with choosing an orthopedist that completed arthroscopic surgery on his shoulder. Mr. M. has resumed cardiac rehab, and became connected to a neurologist at Yale for his Parkinson's.

The Next Generation of PCMH: Advanced Medical Homes (AMH)

Connecticut Medicaid's PCMH initiative has achieved substantial early success in improving health outcomes and care experience. Building from this base, the Department is interested in discussion that has emerged as part of development of Connecticut's application to the Centers for Medicare and Medicaid Services (CMS) for funds in support of a multi-payer health reform effort under the CMS State Innovation Model (SIM) initiative. One of the elements of this proposal is to provide funding and technical assistance to primary care practices that have not yet pursued recognition as PCMH. Also, Connecticut is interested in incorporating additional elements into a standard that will be known as "Advanced Medical Home" (AMH), including, but not limited to, the culturally and linguistically appropriate services (CLAS) standards developed by the federal Office of Minority Health. These standards are an important means of recognizing, remedying and preventing barriers to effective receipt of health services that are related to race, gender, ethnicity, disability or other immutable characteristic.

Connecticut Medicaid

Integration of Medical, Behavioral Health and Long-Term Services & Supports

Department of Social Services

Why are We Focusing Here?

Many Medicaid beneficiaries, especially those who are dually eligible for Medicare, have very complex health profiles. A high incidence of beneficiaries have both physical and behavioral health conditions, and need support in developing goal-oriented, person-centered plans of care that are realistic and incorporate chronic disease self-management strategies. A siloed approach to care for a recipient's medical and behavioral health needs is unlikely to effectively care for either set of needs. For example, a client with depression and a chronic illness such as diabetes is unlikely to be able to manage either diabetes or depression without effectively addressing both conditions at the same time. Further, historically there has been considerable division as between medical and long-term services and supports, with little coordination or communication occurring among providers. DSS believes that the mind is part of the body, and that overcoming these boundaries is essential to responding in a person-centered manner to beneficiary needs, and to achieving better outcomes.

Key Strategies:

The Department of Social Services Division of Health Services is employing diverse strategies to achieve improved health outcomes and cost efficiencies in the Medicaid program. Strategies include:

1) use of an administrative services organization (ASO) platform to promote efficient, cost-effective and consumer/provider responsive Medicaid medical, behavioral health, dental and non-emergency medical transportation (NEMT) services;
2) use of data analytics to improve care;
3) activities in support of improving access to preventative primary care;
4) **efforts to support integration of medical, behavioral health, and long-term services and supports (LTSS);**
5) initiatives designed to "re-balance" spending on LTSS; and
6) efforts to promote the use of health information technology.

How Will This Change the Current Approach?

Care coordination is an effective means of supporting integration. A number of entities already provide care coordination in Connecticut. These include:

- Access Agencies, which support individuals served by the Connecticut Home Care Program for Elders
- State and non-profit staff associated with the other Medicaid "waiver" programs
- Local Mental Health Authorities (LMHAs), both public and private, which are affiliated with the Department of Mental Health & Addiction Services and serve individuals with mental health disabilities
- Transition Coordinators affiliated with the Money Follows the Person Program
- Person-Centered Medical Homes (PCMH)

Integration activities are intended to strengthen, and not supplant, the important care coordination work that is already being done.

Looking for updates on integration?

Access meeting minutes and materials for the Medical Assistance Program Oversight Council's Complex Care Committee at this link:

http://www.cga.ct.gov/med/comm2.asp?sYear=2013

How is Integrated Care Different Than Past Practice?

The American Psychological Association (APA) has stated that what makes, "integrated health care unique is the sharing of information among team members related to patient care and the establishment of a comprehensive treatment plan to address the biological, psychological, and social needs of the patient. The interdisciplinary health care team includes a diverse group of members (e.g., physicians, psychologists, social workers, and occupational and physical therapists), depending on the needs of the patient."

Connecticut Medicaid Key Strategies

Medicaid integration efforts have focused upon the Demonstration to Integrate Care for Medicare-Medicaid Enrollees and the DSS/DMHAS health home initiative.

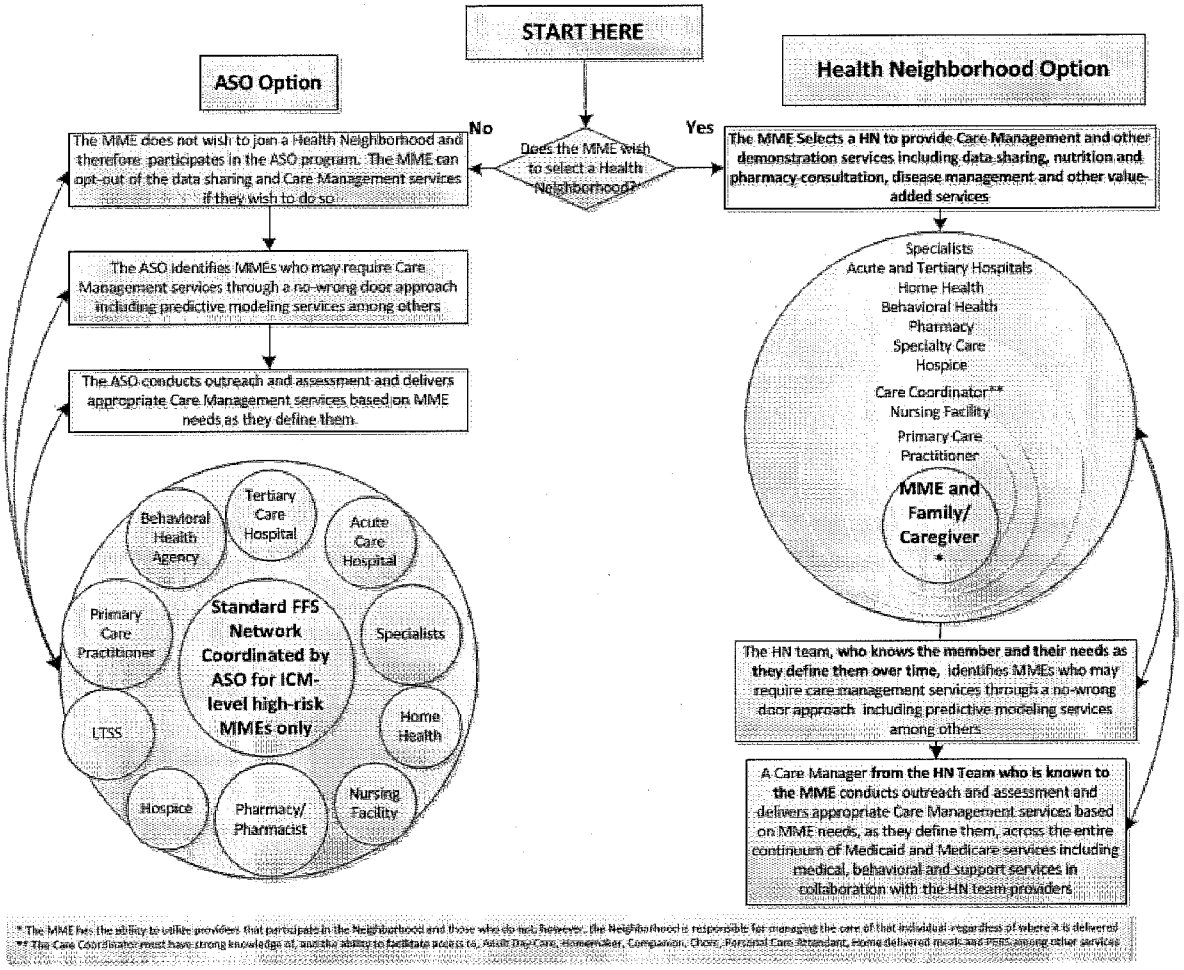
- **Demonstration to Integrate Care for Medicare-Medicaid Enrollees.** Connecticut has submitted an application for implementation funding under the federal Demonstration to Integrate Care for Dually Eligible Individuals. This is a managed fee-for-service model. The Connecticut proposal seeks to integrate 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: 1) data integration and state- of-the-art information technology and analytics; 2) care coordination in support of effective management of chronic disease; 3) expanded access to Person Centered Medical Home (PCMH) primary care; and 4) a payment structure that will align financial incentives (advance payments related to costs of care coordination and supplemental services, as well as performance payments) to promote value. The Demonstration will create new, multi-disciplinary provider arrangements called "Health Neighborhoods" through which providers will be linked through care coordination contracts.

- **Health Homes for Individuals with SPMI.** The Department is also working with the Department of Mental Health and Addiction Services (DMHAS) to implement integrated behavioral and medical hubs called health homes for individuals who are diagnosed with an identified Serious and Persistent Mental Illness (SPMI), have high expenditures, and are served by Local Mental Health Authorities (LMHAs). As conceptualized, this model is anticipated to make per member per month (PMPM) payments to LMHAs that will permit them to incorporate nurse care managers within their existing models of behavioral health support.

- **Behavioral Health Screening for Children.** Further, the Department recently implemented a proposal to provide an annual behavioral health screen for children ages 1 through 17 years, as part of an EPSDT evaluation. Almost every day we hear of tragedies in the news that could and should have been prevented with early intervention and especially with systemic follow up. Too many children have behavioral health concerns that are left unaddressed; too many go on to have major behavioral illnesses after having fallen through the cracks. In light of this, DSS' Division of Health Services (DHS) now requires practitioners to indicate on claims for screenings whether the result was positive or negative. This indicator will enable DHS to track whether children who have screened positive for a behavioral health condition receive appropriate referrals and aftercare.

How Are We Doing?

- DHS is in final stages of negotiating a Memorandum of Understanding (MOU) with the Centers for Medicare and Medicaid Services (CMS) to implement the Demonstration to Integrate Care for Medicare-Medicaid Enrollees . DHS expects to launch the Demonstration in early 2015. Below please see a diagram that illustrates the two options that beneficiaries (known as Medicare/Medicaid Enrollees or MMEs) will be able to choose from in the Demonstration:



- DHS and DMHAS are working collaboratively with CMS on the Medicaid State Plan Amendment that will authorize implementation of the health home project. Health homes are anticipated to go live in early 2015.

Meet a Medicaid Beneficiary:

Mr. H. was referred to Intensive Care Management (ICM) at CHN after he was discharged from the hospital discharge after treatment for an intestinal blockage and for management of a serious and persistent mental illness. Upon treating the blockage and stabilizing his psychiatric illness, Mr. H. was discharged to his nursing home where ICM contacted Mr. H. and helped him find a primary care provider (PCP) as well as a gastroenterologist. The gastroenterologist suggested gastric bypass surgery and referred him for nutritional counseling sessions to prepare for the bypass surgery. ICM helped arrange the counselling and coordinated transportation with Logisticare. Mr. H is so successful with his nutritional counseling that he may not require surgery. ICM also helped him find a behavioral health provider. Mr. H. is able to keep all of his doctor's visits and is engaged with CHNCT's Community Support Services team for assistance with a SSI application and for housing as he aspires to secure independent housing.

Connecticut Medicaid

Rebalancing of Long-Term Services & Supports

Department of Social Services

What is Rebalancing?

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. Achieving a rebalanced LTSS system requires that states examine current policies, services, access, and other systemic elements that may present challenges to rebalancing goals. In January, 2013, the Governor, the Office of Policy and Management and the Department of Social Services released the State's Strategic Plan to Rebalance LTSS. This plan details diverse elements of a broad agenda that is designed to support older adults, people with disabilities and caregivers in choice of their preferred means, mode and place in which to receive LTSS. Key aspects of the plan include 1) continued support for Money Follows the Person; 2) Balancing Incentive Program (BIP) activities; 3) nursing home diversification; and 4) launch of a new web-based hub called "My Place". The strategic plan also identifies 'hot spots' for development of services, including medical services, by projecting demand attributed to the aging population at a town level. Consistent with the Supreme Court's decision in *Olmstead,* the rebalancing plan supports provision of services in the most integrated setting that is appropriate for each individual.

Why Are We Focusing Here?

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 FY 2013, a total of $3.1 billion was spent in Connecticut on LTSS. This represented 12% of the state budget and 36% of the Medicaid budget. In FY 2013, 58% of beneficiaries of Medicaid LTSS received those supports in the community, but 43% of LTSS spending was attributable to these services. While only 7% of the Medicaid population receives LTSS, 51% ($3.1 billion) of the 2013 Medicaid expenditures ($6.1 billion) were made on behalf of these beneficiaries.

Key Strategies:

The Department of Social Services Division of Health Services is employing diverse strategies to achieve improved health outcomes and cost efficiencies in the Medicaid program. Strategies include:

1) use of an administrative services organization (ASO) to promote efficient, cost-effective and consumer/provider responsive Medicaid medical, behavioral health, dental and non-emergency medical transportation (NEMT) services;
2) use of data analytics to improve care;
3) activities in support of improving access to preventative primary care;
4) efforts to support integration of medical, behavioral health, and long-term services and supports (LTSS);
5) **initiatives designed to "re-balance" spending on LTSS;** and
6) efforts to promote the use of health information technology.

Looking for information on LTSS?

Access MyPlace CT at the following link:

http://www.myplacect.org/

MY PLACE CT

What Do We Mean by Person-Centered Care?

We define person-centeredness as an approach that:

- provides the individual with needed information, education and support required to make fully informed decisions about his or her care options and, to actively participate in his or her self-care and care planning;
- supports the individual, and any representative(s) whom he or she has chosen, in working together with his or her non-medical, medical and behavioral health providers and care manager(s) to obtain necessary supports and services; and
- reflects care coordination under the direction of and in partnership with the individual and his/her representative(s); that is consistent with his or her personal preferences, choices and strengths; and that is implemented in the most integrated setting.

Re-balancing is an overarching agenda that has as its main goals enabling choice for consumers, optimizing use of public spending on long-term services and supports, and diversification of provider services.

Connecticut Medicaid Key Strategies

- **Money Follows the Person (MFP).** The MFP initiative has led efforts toward systems change in LTSS. In addition to having transitioned individuals from nursing facilities to the community, MFP is implementing diverse strategies that support reform. Key MFP demonstration services include: care planning specialized in engagement and motivation strategies, alcohol and substance abuse intervention, peer support, informal care giver support, assistive technology, fall prevention, recovery assistance, housing coordination, self-directed transitional budgets including housing set-up, transportation assistance and housing modifications. Further, systems focus areas for MFP include housing development, workforce development, LTSS service and systems gap analysis/recommendations and hospital discharge planning interventions. An additional key aspect of the demonstration is the development of improved LTSS quality management systems. In 2012, the Governor publicly committed to a significant expansion in the target for individuals transitioned, to a total of 5,000 individuals.

- **Balancing Incentive Program (BIP).** MFP has also led efforts to submit an application to CMS under the BIPP. Connecticut received confirmation in Fall, 2012 of a $72.8 m. award. Key aspects of the award include:

    - The development of a pre-screen and a common comprehensive assessment for all persons entering the LTSS system, regardless of entry point.
    - The development of conflict free case management across the system.
    - The development of a 'no-wrong door' system for access to LTSS. Phase one of the State's 'no wrong door' launched in June, 2013. The web based platform was branded "My Place CT" and aims to coordinate seamlessly with both ConneCT and the health insurance exchange over the next two years.
    - The development of new LTSS aimed to address gaps that prevent people from moving to or remaining in the community, streamline the existing LTSS delivery system, and build a sufficient supply of services to address the projected demand.

Connecticut Medicaid Key Strategies (cont.)

- **Nursing Home Diversification.** Another important feature of rebalancing is $40 million in grant and bond funds through FY 2017 that has been dedicated to nursing facilities that are interested in diversifying their scope to include home and community-based services. Supporting selection of facilities through a Request for Proposals process are town-level projections of need for LTSS and associated workforce, and a requirement that applicant nursing facilities work collaboratively with the town in which they are located to tailor services to local need.

- **Waiver services.** Connecticut is continuing to expand the scope of its Medicaid "waiver" coverage. "Waivers" permit the state to be excused from certain federal Medicaid rules and to cover home and community-based long-term services and supports using Medicaid funds. Existing waivers provide services to older adults, individuals with physical disabilities, individuals with behavioral health conditions, children with complex medical profiles, individuals with intellectual disabilities, children with autism spectrum disorder (ASD) and individuals with acquired brain injury. Recent activity has included expansion of the array of waivers that is available to people with intellectual disabilities, as well as creation of a small waiver to support children with ASD who are aging out of the Birth to Three program.

How Are We Doing?

- **MFP transitions:** In FY 2014, MFP transitioned 552 individuals from nursing facilities to community-based settings. Since its inception in December, 2008, MFP has transitioned over 2,300 individuals from nursing facilities to community-based settings, towards an ultimate goal of 5,000.

- **Nursing home diversification:** In early 2014, the administration awarded $9 million in grant funds to seven entities. Another Request for Proposals will be issued in October, 2014.

- **BIP:** 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;
    - in support of streamlined intake processes (No Wrong Door), DSS drafted and submitted an Advanced Planning Document outlining the funding and information technology architecture required to support standardization of functional eligibility processes and assessments across LTSS programs.

- **System Transformation**

    - 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.
    - 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.

Meet a Beneficiary:

"Great . . . Laugh . . . Alive . . . Blessed"

Ms. C's four words describe her thriving experience at home under MFP after ten years in a nursing facility. She glows as she talks of her connections and re-connections with family and friends. Although a stroke limits her speech, hearing and use of part of her body, she overcomes communication and mobility issues in creative ways. A whiteboard and laptop are her constant companions to express thoughts and feelings, and for visitors to utilize when conversations are not heard adequately or get complicated. This process enables Ms. C to socialize; visiting as well as receiving family, friends and neighbors at her home and "chatting across the table like a normal home activity".

Loving children and their playfulness, she is grateful she lives in a large community where many of her neighbors are families. Most days, she is outside in the quad area watching the children play. A lifelong lover of music, she is delighted to make friends with a young neighbor who routinely comes to play her instrument for her. Feeling the freedom of home, Ms. C practices her spiritual life. Her faith is very important to her, as expressed in her surroundings and her own sacred latch-hooked rugs. She feels blessed and spiritually connected by the weekly visits she has with a Eucharistic minister from her church.

Connecting with nature is very important. Previously an avid camper, Ms. C finds time every day to fill her bird feeders on her patio and observe the birds' behaviors. Weather doesn't stop her; she loves to feel the seasons. In her wheelchair, she and her aide take almost daily walks to the pond and picnic tables to scout out and observe the wildlife, especially the great blue heron, as well as the flowers and country scenery. Dogs are a personal favorite, and she visits with therapy dogs at Hartford Hospital as well as a nearby Yorkie Rescue House.

Although there is always more therapy to do, she now uses one hand and arm to pursue bowling and other occupational therapy activities. A life-long crafter and knitter, she is working hard to adapt to using one hand and now paints colorful sun-catchers, ornaments and other art. An expert Scrabble player, she also participates in indoor and outdoor games to keep her mind and body alert.

What Impact has this had for the 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 move to the community;
- increased the percentage of people who report that that are doing fun things in their communities - from 42% while institutionalized to 60% after move to the community; and
- increased the percentage of people report that they are being treated the way in which they wish to be - from 82% while institutionalized to 93% after move to the community.

Connecticut Medicaid
Promotion of Health Information Technology (HIT)

Department of Social Services

Information Sharing Among Providers and Patients

Historically, medical providers kept unique paper records for each of their patients, and aside from making referrals to colleagues in other specialties, did not share much information in support of diagnosis, transitions across care settings (e.g. home to hospital, hospital to nursing home) or management of chronic health conditions. Indeed, providers themselves could not easily retrieve information from their own records. As technology has developed, there is emerging agreement that it would serve both provider and patients' needs to better support collaboration and information sharing. The aims are that 1) patients will be more capable of engaging with their providers around health care decisions; 2) patients will better understand the cost of care; 3) providers will benefit from data that helps them to assess whether their patients' health status is improving; and 4) patients' clinical information will go along with them as they navigate the health care system. That said, there are many important aspects to be taken into account in developing means of sharing information. These include, but are not limited to, patient choice regarding disclosure of information, privacy, security, and means of retaining and disposing of data. Certain health conditions – notably behavioral health, substance abuse and HIV/AIDS – require specific permissions for information to be shared. All of this must be carefully considered in establishing systems and also creating procedures for use of HIT.

Why Are We Focusing Here?

Certified Electronic Health Record (EHR) systems enable medical providers to collect complete records of patients' treatment history while allowing for automation and streamlining of their workflows. EHR's can also facilitate increased patient safety through evidence-based decision support, quality management, and outcomes reporting. In addition, the secure sharing of personal health information improves care coordination while reducing duplication of effort across providers.

Key Strategies:

The Department of Social Services Division of Health Services is employing diverse strategies to achieve improved health outcomes and cost efficiencies in the Medicaid program. Strategies include:

1) use of an administrative services organization (ASO) promotes efficient, cost-effective and consumer/provider responsive Medicaid medical, behavioral health, dental and non-emergency medical transportation (NEMT) services;
2) use of data analytics to improve care;
3) activities in support of improving access to preventative primary care;
4) efforts to support integration of medical, behavioral health, and long-term services and supports (LTSS);
5) initiatives designed to "re-balance" spending on LTSS; and
6) **efforts to promote the use of health information technology**.

Looking for information on the Medicaid EHR Incentive program?

Access the following link:

https://www.ctdssmap.com/CTPortal/Provider/EHRIncentiveProgram/tabid/55/Default.aspx

What is an Electronic Health Record (EHR)?

EHRs are digital (computerized), real-time, patient-centered versions of patients' paper charts. A key feature of an EHR is that it can be created, managed, and consulted by authorized providers and staff across more than one health care organization. A single EHR can bring together information from current and past doctors, emergency facilities, school and workplace clinics, pharmacies, laboratories, and medical imaging facilities.

Connecticut Medicaid Key Strategies

Health information technology is on the vanguard of connecting people and providers with the information that they need to make informed choices about health care.

- **Medicaid Electronic Health Record Incentive Program:** Utilizing 100% federal funding for payments and 90% for administration as authorized by Section 4201 of the *American Recovery and Reinvestment Act of 2009* (ARRA), this program provides incentive payments to Medicaid-enrolled hospitals and "eligible professionals," which include physicians, physician assistants, nurse practitioners, certified nurse-midwives, and dentists, for the adoption and meaningful use of certified electronic health record technology. Enhanced funding is also available through the federal Medicaid EHR program to support various health information technologies (HIT) and health information exchange efforts. The Department is partnering with the State's HIT Coordinator and the University of Connecticut Health Center to promote this program and to implement the related health information exchange initiatives listed below.

- **Medicaid Provider Directory:** The Department is planning development of an electronic directory that will serve as an authoritative source of provider information for electronic exchanges. An accurate provider directory will enhance the utility of secure health information exchange, including DIRECT messaging.

- **Promotion of DIRECT Messaging:** Using 90% HIT federal funding, the Department is offering free DIRECT accounts for one year to eligible professionals to enable exchange of messages between providers and/or systems that are secure and HIPAA compliant. This effort supports overall care coordination and enables timely data exchange. It also supports an array of existing and planned programs (e.g. PCMH, Medicare/Medicaid Eligible demonstration) by ensuring secure exchange of documents (e.g. discharge summaries, assessments, and continuity of care documents).

Connecticut Medicaid Key Strategies (continued)

- **Medicaid Personal Health Record (PHR):** The Department will leverage existing PHR efforts in the state to provide Medicaid beneficiaries with the option to access a Personal Health Record. A PHR enables beneficiaries to view their healthcare information, including records from multiple providers, using a single log in ID and password.

- **Strategic HIT Planning:** Expanding beyond Medicaid, an interagency planning process is underway to create a common vision, identify common goals, identify and support an interoperability framework, and operationalize HIT governance across several state health and human services agencies.

How Are We Doing?

- As of September 30, 2014, DSS has paid over $41.1 million in incentive payments to 2,261 eligible professionals since Connecticut's program was launched in mid-2011. Slightly over $35.7 million has been paid to 26 eligible hospitals over the same time period.