A Brief Primer on the Medicaid Quality Improvement and Shared Savings Program (MQISSP)

The Department of Social Services is launching a planning process to develop a new, upside-only shared savings initiative entitled the Medicaid Quality Improvement and Shared Savings Program (MQISSP). The Department's goal with MQISSP, which is a component of the State Innovation Model (SIM) Model Test Grant initiative, is to improve health and satisfaction outcomes for Medicaid beneficiaries currently being served by Federally Qualified Health Centers (FQHCs) and "advanced networks" (e.g. Accountable Care Organizations, ACOs), which will be competitively selected by the Department via a Request for Proposals. Both FQHCs and certain ACOs are currently providing a significant amount of primary care to Medicaid beneficiaries.

MQISSP represents an opportunity for Connecticut Medicaid to build on, but not supplant, its existing and successful Person-Centered Medical Home initiative, through which over one-third of beneficiaries are being served. While PCMH will remain the foundation of care delivery transformation, MQISSP will build on PCMH by incorporating new requirements related to integration of primary care and behavioral health care, as well as linkages to the types of community supports that can assist beneficiaries in utilizing their Medicaid benefits. Typical barriers that inhibit the use of Medicaid benefits include housing instability, food insecurity and lack of personal safety. Enabling connections to organizations that can support beneficiaries in resolving these access barriers will further the Department's interests in preventative health. Further, partnering with providers on this will begin to re-shape the paradigm for care coordination in a direction that will support population health goals for individuals who face the challenges of substance abuse and behavioral health, limited educational attainment, poverty, homelessness, and exposure to neighborhood violence.

In developing MQISSP, the Department will seek review and comment on all aspects of model design from the Care Management Committee of the Medical Assistance Program Oversight Council (MAPOC). The Department has memorialized a protocol that governs coordination of this work with activities of the SIM Quality Measures and Equity& Access Councils. This protocol emphasizes that Department is the single state Medicaid agency for Connecticut, and that consistent with federal law, DSS' primary obligation is to promote and safeguard the interests of Medicaid beneficiaries.

Item	Description
Overall statement of purpose	The Connecticut Medicaid Quality Improvement and Shared Savings Program (MQISSP) aims to improve health outcomes and care experience of single-eligible Medicaid beneficiaries through arrangements with competitively selected, participating providers (FQHCs and "advanced networks") that will receive care coordination payments (FQHCs only) and a portion of any savings that are achieved (FQHCs and advanced networks), on the condition that they meet benchmarks on identified quality measures.
Timing and participation	The "first wave" of MQISSP was originally intended to be implemented effective January 1, 2016, but Connecticut is considering an extension of this date to allow for engagement with stakeholders as well as to permit time to gain approval of Medicaid authority by CMS for the care

	coordination and shared savings payments that are proposed to be made under MQISSP. The first wave is slated to include 200,000 to 215,000 Medicaid beneficiaries. DSS must issue a Request for Proposals (RFP) in 2015 to select participating entities. A "second wave" of MQISSP must be implemented effective January 1, 2017.
Target population and method of affiliating beneficiaries with the initiative	DSS will be attributing single-eligible Medicaid beneficiaries to MQISSP participating entities using our current PCMH attribution method (to be refined, if necessary). MQISSP will not include any full or partial dually-eligible (Medicare and Medicaid eligible) individuals. DSS will seek feedback from the Care Management Committee about both the target population and the attribution method.
Overview of financial model	Under MQISSP, DSS will select a number of FQHCs and advanced networks by RFP. DSS will then enter into upside-only shared savings contracts with the providers (FQHCs and advanced networks) that are selected. There will be no downside risk on providers. Additionally, DSS will be making add-on care coordination payments ONLY to the FQHCs that are selected (not to the advanced networks).
Process steps	To implement MQISSP, the Department must take actions including, but not limited to the following, on each matter seeking review and comment by the Care Management Committee: • frame provider qualifications and program parameters; • select relevant quality measures on which shared savings will be based, as well as other means of evaluating quality that will include, but not be limited to, measures of under-service; • develop and implement the means of making care coordination payments to the FQHCs as well as a shared savings methodology; • investigate, review, decide upon and pursue relevant Medicaid authority to make care coordination payments to the FQHCs that are selected to participate, and shared savings payments to all entities that are selected to participate; and • develop, issue and select participating entities through an RFP.
For more information	Please see the full SIM application at this link: http://www.healthreform.ct.gov/ohri/lib/ohri/sim/test_grant_documents/application/ct_sim_test_program_narrative_final.pdf