Connecticut Department of Social Services

Medicaid Quality Improvement and Shared Savings Program (MQISSP)

DRAFT CONCEPT PAPER

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Part 1: Executive Summary

Overview

Connecticut's Proposed Integrated Care Model (ICM)

As part of the State of Connecticut's (Connecticut's/State's) State Innovation Model (SIM) model test grant, the State of Connecticut Department of Social Services (DSS/Department), Connecticut's single State Medicaid agency, is developing an Integrated Care Model (ICM) initiative that will focus upon enhancing the capacity of Federally Qualified Health Centers (FQHCs) and "Advanced Networks" (defined under Programmatic Considerations below) to provide care to Medicaid beneficiaries that is integrated, both on a clinical basis and in connection with community services.

The goals of this initiative, the Medicaid Quality Improvement and Shared Savings Program (MQISSP), are to improve health outcomes and care experience for Medicaid beneficiaries who are assigned to MQISSP using the methodology described below (hereafter "MQISSP members"), and to contain the growth of health care costs. Specifically, MQISSP will build on DSS' existing Person-Centered Medical Home (PCMH) model by incorporating new Enhanced Care Coordination Activities and Care Coordination Add-On Payment Activities related to the integration of primary care and behavioral health care, building provider competencies to support Medicaid beneficiaries with complex medical conditions and disability needs, and promoting linkages to 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, lack of personal safety, limited office hours at medical practices, chronic conditions, and low literacy. Enabling connections to organizations that can support MQISSP members in resolving these access barriers will further the Department's interests in preventative health. Further, partnering with providers on this transformation 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 mental health, limited educational attainment, poverty, homelessness, and exposure to neighborhood violence.

Under MQISSP, DSS will conduct a request for proposals (RFP) process to select qualified FQHCs and Advanced Networks (collectively referred to as "MQISSP Participating Entities"). MQISSP Participating Entities will provide Enhanced Care Coordination Activities to improve the quality, efficiency, and effectiveness of care delivered to MQISSP members. FQHCs will also

provide Care Coordination Add-On Payment Activities in addition to the Enhanced Care Coordination Activities.

If MQISSP generates savings for the Medicaid program, MQISSP Participating Entities that meet identified benchmarks on quality performance standards and measures of under-service will be eligible to participate in shared savings. In addition, MQISSP Participating Entities that are FQHCs will receive monthly payments for Care Coordination Add-On Payment Activities that the FQHC provides to MQISSP members. There will be no downside risk (i.e., MQISSP Participating Entities will not return any share of increased expenditures incurred by Medicaid). Beneficiaries will be prospectively assigned to MQISSP Participating Entities on the basis of DSS' existing PCMH retrospective attribution methodology, which will be adapted as necessary for MQISSP.

Related Programs and Initiatives

Connecticut Medicaid has already implemented a range of integrated care strategies, and is in the process of developing other initiatives that are consistent with the goals of MQISSP. These include DSS' PCMH program, behavioral health homes (BHH), home- and community-based services (HCBS) waivers and State Plan Amendments (SPAs), and Money Follows the Person (MFP) Rebalancing Demonstration:

1. PCMH Program — DSS implemented its PCMH initiative on January 1, 2012 within the Medicaid State Plan under section 1905(a) of the Social Security Act within the physician, other licensed practitioner, and outpatient hospital benefit categories (as detailed in approved SPAs 12-005 and 12-008). 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. Through this effort, the Department is investing significant resources to help primary care physician, nurse practitioner, and outpatient hospital clinic practices obtain patient-centered medical home Level 2 or Level 3 recognition from the National Committee for Quality Assurance (NCQA). FQHCs that participate in the Department's PCMH program can choose between NCQA recognition or certification from The Joint Commission. Practices on the "Glide Path" toward recognition receive technical assistance from Connecticut's Medicaid medical Administrative Services Organization (ASO). Physician, nurse practitioner, and outpatient hospital clinic practices that have received recognition (but not FQHCs) are eligible for financial incentives including enhanced fee-for-service payments and also retrospective payments for meeting benchmarks on identified quality measures.

   MQISSP builds upon, but will not supplant or change, Connecticut's Medicaid PCMH initiative. Specifically, in the course of developing the model design for MQISSP, DSS has made direct reference to existing PCMH attribution methodology and quality measures and has also carefully inventoried how proposed MQISSP Enhanced Care Coordination Activities will enhance existing PCMH standards. In addition, PCMH program participation will be one of the minimum provider qualifications for MQISSP Participating Entities. Additional information related to the linkages between the existing PCMH program and proposed MQISSP design elements can be found throughout this paper.

2. ASO Intensive Care Management

By contrast to almost all other Medicaid programs in 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 health 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 (currently, Community Health Network of Connecticut), Behavioral Health (currently, ValueOptions), Dental (currently, BeneCare), and non-emergency medical transportation (NEMT) (currently, Logisticare).

Employing a single, fully integrated set of claims data, which spans all coverage groups and covered services, Connecticut Medicaid takes full advantage of data analytic tools to risk stratify beneficiaries and to connect those who are at high risk or who have complex health profiles with ASO intensive care management support. ICM is provided by each ASO (with the exception of the NEMT ASO) as Medicaid administrative services that are part of each ASO contract. ICM is structured as a person-centered, goal directed intervention that is individualized to each beneficiary's needs. Connecticut Medicaid's ICM interventions:

- Integrate behavioral health and medical interventions and supports through co-location of clinical staff of the medical and behavioral health ASOs;
- Promote the use of community care teams and peer supports for behavioral health;
- Include special initiatives such as texting programs, and initiatives related to such focus areas as pain management and high risk pregnancy;
- For dental care, promote community engagement around dental homes, and partnerships with pediatricians offices regarding dental care for pregnant women, parents/caregivers and children;
- Augment Connecticut Medicaid's PCMH program (described above);
- Are directly embedded in the discharge processes of a number of Connecticut hospitals;
- Sustain the reduction of emergency department usage, inpatient hospital admissions and readmission rates;
- Reduce utilization in confined settings (psychiatric and inpatient detoxification days) among individuals with behavioral health conditions; and
- Reduce use of the emergency department for dental care, and significantly increase utilization of preventative dental services by children.

In addition to building upon current PCMH practice, MQISSP will enable DSS to start enhancing ICM by engaging with community entities and to pair short-term ASO ICM interventions with longer-term, community integrated support and care coordination for MQISSP members provided by and/or coordinated by MQISSP Participating Entities.

3.	Behavioral Health Homes (BHH)	DSS has partnered with its sister state agencies, the Department of Mental Health and Addiction Services and the Department of Children and Families to submit a SPA under section 1945 of the Social Security Act, seeking authority to implement BHH for Medicaid high cost, high need beneficiaries who have serious and persistent mental illness. BHH was implemented on October 1, 2015, as described in proposed SPA 15-014. MQISSP will not serve individuals who are enrolled in and accept participation in a BHH. Beneficiaries who meet the eligibility criteria for BHH services will be auto-enrolled with their Local Mental Health Authority provider of record but may choose another designated BHH provider or opt out of BHH services. BHH will aim, through a care team model based on Local Mental Health Authorities and their affiliates, to integrate beneficiaries' behavioral health, medical and community services and supports through a person-centered care plan, leading to better patient experience and improved health outcomes.
4.	HCBS section 1915(c) waivers, section 1915(i) and section 1915(k) SPAs and MFP	Connecticut Medicaid has a range of 1915(c) waivers, which are implemented either directly by DSS or by a sister state agency (the Departments of Developmental Services Mental Health and Addiction Services) and which serve 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 and individuals with an acquired brain injury. DSS also administers an HCBS SPA pursuant to section 1915(i) of the Social Security Act and a Community First Choice SPA pursuant to section 1915(k) of the Social Security Act. DSS also administers a comprehensive plan to rebalance long-term services and supports (LTSS), including a vigorous Money Follows the Person (MFP) program. Each participant of Connecticut's HCBS waivers and SPAs under sections 1915(i) and 1915(k) of the Social Security Act and its MFP program has a care manager who provides care coordination activities. MQISSP will not serve beneficiaries participating in a HCBS 1915(c) waiver, section 1915(i) or section 1915(k) SPA, or MFP.

Programmatic Considerations

DSS believes that all full-benefit Medicaid beneficiaries who are not otherwise receiving care coordination services would benefit from participating in MQISSP. Thus, DSS proposes to assign all Connecticut Medicaid beneficiaries to MQISSP except the following:

1. BHH participants.
2. Full and partial Medicaid/Medicare dual eligible beneficiaries.
3. HCBS waiver and section 1915(c) waiver, section 1915(i), and section 1915(k) participants.
4. MFP participants.
5. Residents of nursing facilities, intermediate care facilities for individuals with intellectual disabilities, and other long-term care institutions that are required to coordinate care for their residents.
6. Beneficiaries who are enrolled in Connecticut Medicaid solely to receive limited benefit package (current limited benefit packages include family planning and tuberculosis).

Additional information regarding the prospective assignment methodology is in the Payment Methodology section of this paper.

DSS plans to use an RFP process to select qualified MQISSP Participating Entities to provide care coordination activities to MQISSP members. Respondents must meet minimum qualifications to be selected as an MQISSP Participating Entity. DSS has developed minimum provider qualifications for all MQISSP Participating Entities, and also provider qualifications specific to each type of MQISSP Participating Entity (i.e., provider qualifications for Advanced Networks and provider qualifications for FQHCs).

Recognizing the benefit of including practices that have already self-initiated practice transformation, DSS intends to require that any FQHC that DSS selects to participate in MQISSP and any primary care practice that is affiliated with an Advanced Network that DSS selects to participate in MQISSP: 1) be recognized as a PCMH, holding either Patient-Centered Medical Home certification/recognition from NCQA (for any FQHC or primary care practice) or Primary Care Medical Home certification from The Joint Commission (for FQHCs only); and 2) be enrolled in the DSS Medicaid PCMH initiative. In addition, all potential MQISSP Participating Entities must already have at least 2,500 PCMH-attributed beneficiaries who are eligible to participate in MQISSP. Both Advanced Networks and FQHCs seeking to be a MQISSP Participating Entity must also demonstrate adequate governance and oversight for MQISSP.

The RFP will also include provider qualifications specific to each type of MQISSP Participating Entity. In particular, DSS intends to require that FQHCs have current Health Resources and Services Administration grant funding under section 330 of the Public Health Service Act, operate in Connecticut, meet all federal and state requirements applicable to FQHCs, be a current participant in the DSS PCMH program (except a Glide Path practice), and hold current Patient-Centered Medical Home certification/recognition as defined by NCQA or Primary Care Medical Home certification from The Joint Commission, as applicable.

DSS intends for Advanced Networks to be large, integrated physician networks that build upon the DSS PCMH program. As such, DSS plans for the RFP to describe several acceptable options for Advanced Network composition:

- A single DSS PCMH participating practice;
- One or more DSS PCMH participating practices plus specialists;
- One or more DSS PCMH participating practices plus specialists and hospital(s); or
- A Medicare Accountable Care Organization, as that term is defined for the Medicare Shared Savings Program that includes a DSS PCMH participating practice.

MQISSP Participating Entities must provide Enhanced Care Coordination Activities to MQISSP members. DSS has developed these activities based on national best practices in care coordination. The proposed Enhanced Care Coordination Activities leverage national best practices in care coordination and exceed the FQHC, HRSA, and Patient-Centered Medical Home recognition/certification requirements as defined by NCQA or Primary Care Medical Home certification from The Joint Commission. A proposed list of Enhanced Care Coordination Activities can be found in the Care Coordination section of this paper. In addition, FQHCs will be required to provide Care Coordination Add-On Payment Activities. A proposed list of Care Coordination Add-On Payment Activities can also be found in the Care Coordination section of this paper.

All MQISSP Participating Entities that meet identified benchmarks on quality performance standards and measures of under-service will be eligible to participate in shared savings. DSS will also make Care Coordination Add-On Payments to MQISSP Participating Entities that are FQHCs to support the Care Coordination Add-On Payment Activities. These payment methodologies are described in more detail in the Payment Methodology section of this paper.

Facilitating Circumstances, Gaps, and Barriers

MQISSP represents an opportunity for DSS to build on its existing efforts to support its primary care network. Connecticut chose to continue payments to primary care providers that were made available through section 1202 of the Affordable Care Act. Although that provision of the federal law and associated enhanced federal funding expired on December 31, 2014, DSS continued these payments using state-share funds with standard federal matching percentages for a narrower set of codes that are focused on community-based primary care. The extension of these payments after expiration of the enhanced federal funding is a significant investment in supporting and expanding access at primary care practices, which are the focus of the Advanced Networks' participation as MQISSP Participating Entities. A substantial number of practices that receive enhanced payments for primary care services also participate in the DSS PCMH initiative.

DSS is also in the process of finalizing and implementing supplemental payments to FQHCs which, as of the current draft proposal, will be a combination of risk-adjusted payments and payments based on quality. This funding was previously appropriated through the Department of Public Health and was recently transferred to DSS to be used for Medicaid supplemental payments. DSS plans to submit a SPA to implement these payments on or before December 31, 2015.

MQISSP also represents an opportunity to build on the successful PCMH program (described above under related programs and initiatives), which currently serves over one-third of Connecticut's Medicaid beneficiaries.

The PCMH program makes available additional payments for qualifying physician, nurse practitioner, and outpatient hospital clinic practices under Connecticut's Medicaid State Plan (Attachment 4.19-B). The program includes an add-on for specified procedure codes for physician and nurse practitioner practices or an add-on payment to the per visit medical rate for outpatient hospital clinic visits that include one or more specified procedure codes; a supplemental performance incentive payment based on the PCMH's performance on specified quality measures compared with other PCMH practices; and a supplemental performance improvement payment based on each PCMH's degree of improvement compared with the previous year. In addition, although they do not receive PCMH financial payments, FQHCs are eligible to participate in the PCMH program through a choice of NCQA recognition or certification from The Joint Commission. FQHCs receive technical assistance and recognition from the Department's PCMH program.

As noted above, MQISSP will build on the PCMH program by requiring that MQISSP Participating Entities that are Advanced Networks include at least one current PCMH participant and that an FQHC MQISSP Participating Entity must be a PCMH participant. MQISSP Participating Entity providers will provide care coordination activities that go above and beyond current PCMH care coordination standards.

DSS will also seek to align MQISSP with other health system transformation efforts currently underway in the state, such as the CMMI-funded Practice Transformation Network grant obtained by the Community Health Center Association of Connecticut (CHCACT), which is an association of FQHCs. The grant will be used to help clinicians expand their quality improvement capacity, learn from one another, and achieve common goals of improved care, better health, and reduced cost. CHCACT's program will focus on improving health outcomes for three conditions common to health center patients: asthma, diabetes and hypertension. While a strong foundation for MQISSP exists in Connecticut, the State must address certain gaps in existing infrastructure in order to fully implement MQISSP. For example, DSS will need to hire or dedicate existing staff to MQISSP oversight and monitoring. Anticipated staff positions include, at a minimum, an MQISSP program manager and administrative support.

DSS also recognizes potential barriers to full implementation of MQISSP, including:

- A lower than expected take-up rate among providers seeking to become MQISSP Participating Entities. DSS plans to issue an RFP that is attractive to the provider community and preliminary indications of provider interest are high, but the exact take-up rate is unknown at this time.
- Long-term availability of State funding for its portion of the shared savings payments and fixed care coordination payments to FQHCs. While current budget projections look favorable for MQISSP and DSS has been informed that implementing MQISSP is a priority of the State's administration, changes in the State budget could impact future years of MQISSP.
- Any technical difficulties that may be associated with DSS' effort to replace its current Medicaid eligibility system. The new Medicaid eligibility system is targeted to go live in calendar year 2017. The MQISSP assignment methodology will need to carry forward into the new eligibility system and any programming or staffing issues with the new system could have a broad impact on MQISSP.

Part 2: Program Description

I. Program Design

Eligible Participants/Beneficiary Population

MQISSP will be implemented statewide. Eligible Medicaid beneficiaries (see "Programmatic Considerations" above) will be prospectively assigned to MQISSP using the PCMH retrospective attribution methodology, adapted for MQISSP. Beneficiaries will not be "enrolled" in MQISSP. MQISSP members will retain the ability to choose to see any qualified Medicaid provider. MQISSP members will also have the ability to opt-out of prospective assignment to MQISSP. DSS is working to develop a process and tools to notify beneficiaries eligible for prospective assignment to MQISSP Participating Entities about the MQISSP program, their prospective assignment status, and actions to take to opt out of the program.

As mentioned above, beneficiaries participating in certain other programs serving beneficiaries with special needs (such as the section 1915(c) HCBS waivers, section 1915(i) and 1915(k) SPAs, and MFP) will not be eligible for assignment to MQISSP. These programs already provide care coordination for their participants, and MQISSP care coordination would be duplicative of these services.

Eligible Provider Entities/Provider Characteristics

DSS will use an RFP procurement process to select MQISSP Participating Entities that meet the provider qualifications specified in the RFP. However, DSS will not limit the number of MQISSP Participating Entities that meet the provider qualifications.

DSS is in the process of developing provider qualifications for MQISSP Participating Entities in order to contract with entities that are qualified to provide the specified Enhanced Care Coordination Activities and Care Coordination Add-On Payment Activities (in the case of FQHCs). MQISSP Participating Entities will be responsible for ensuring that their providers provide the required care coordination activities and work to improve quality and beneficiary experience of care.

In addition to the criteria described in "Programmatic Considerations" above, Advanced Networks will be required to designate a Lead Entity for administrative and oversight purposes, which must be a participating provider in the Advanced Network. At a minimum, the Advanced Network Lead Entity will be responsible for ensuring that the required Enhanced Care Coordination Activities are implemented as intended, including, but not limited to:

- Monitoring of day-to-day practice;
- Establishment of connections with community providers; and
- Submission to DSS of any required reporting.

The Advanced Network Lead Entity will enter into a contract with DSS, will receive any earned shared savings payments from DSS and will be responsible to make any appropriate distribution of the payment among the Advanced Network providers, subject to a methodology that will be reviewed and approved by DSS. The Advanced Network must identify a senior leader to represent the Advanced Network and champion the MQISSP goals and requirements within the Advanced Network and a clinical director for the Advanced Network. There will be no Lead Entity requirement for FQHCs because each FQHC is already a single legal entity with an established administrative structure.

Advanced Networks will also be required to have a board of directors that includes at least one MQISSP member assigned to the Advanced Network and at least one provider participating in the Advanced Network. FQHCs already have a board of directors that includes beneficiary participation.

MQISSP Participating Entities will also be required to develop contractual or informal partnerships with the larger community, including:

- Community-based organizations, including organizations that assist the community with housing, clothing, utility bill assistance, nutrition, food assistance, employment assistance, education, child care, transportation, language and literacy training, elder support services, etc.;
- Behavioral health organizations, including those providing substance use services;
- Organizations that serve children;
- Peer support services and networks;
- Social services agencies;
- The criminal justice system;

- Local public health entities;
- Specialists and hospitals (in cases where the Advanced Network does not already include these entities); and
- Other State and local programs, both medical and non-medical.

The purpose of these partnerships will be to develop and implement initiatives to identify and actively refer members with behavioral health conditions that require specialized behavioral health treatment to appropriate sources of care, and address social determinants of health and facilitate rapid access to care and needed resources.

Covered Services

MQISSP will not limit the amount, duration, or scope of Medicaid services available to MQISSP members. MQISSP members will continue to be eligible for all services covered by the Connecticut Medicaid program and will retain free choice of any qualified Medicaid provider.

The principal focus of MQISSP is to improve Connecticut's Medicaid primary care delivery system, as providers implement the new care coordination activities and work to improve the quality and care experience for MQISSP members. It is anticipated that other care delivery systems such as specialty care, hospital care, and behavioral health will also see improvements as MQISSP Participating Entities build greater connections with these systems.

Stakeholder Input

DSS has and will continue to seek review and comment on all aspects of MQISSP from the Care Management Committee (Committee) of the Council on Medical Assistance Program Oversight (MAPOC). MAPOC was established by Connecticut statute as a collaborative body consisting of state legislators, Medicaid consumers, advocates, health care providers, insurers, and State agencies to advise DSS on the development of Connecticut's Medicaid program and for legislative and public input to monitor the implementation of the program. MAPOC leadership identified MAPOC's Care Management Committee (the Committee) as MAPOC's lead entity for providing review and comment to DSS on the development of MQISSP.

The Committee includes longstanding membership as well as members of the SIM Steering Committee[1] and the SIM Consumer Advisory Board[2]. The Committee reviews and provides comments to DSS on all aspects of MQISSP, including, but not limited to: standards to include in the RFP for MQISSP Participating Entities; the assignment methodology; the quality measures; how to ensure beneficiary protections; how to assess whether desired outcomes have been achieved; care coordination activities; methods to engage with MQISSP members; and the shared savings methodology. Meetings of the Committee are open to the public and agendas and meeting materials are available on the Committee website: http://www.cga.ct.gov/med/comm1.asp?sYear=2015

[1] The SIM Steering Committee is a diverse, multi-stakeholder committee comprised of providers, consumers, advocates, health plans, and State agencies charged with providing oversight and guidance related to the implementation of the Connecticut Healthcare Innovation Plan.
[2] The purpose of the SIM Consumer Advisory Board is to ensure significant consumer participation in the SIM planning and implementation process.

To promote integrated planning between MQISSP and SIM, as noted above, representatives of the SIM governance structure are included on MAPOC's Care Management Committee. In addition, MAPOC representatives are included in the SIM governance structure, including the SIM Steering Committee, the SIM Consumer Advisory Board, the SIM Equity and Access Council[3] and the SIM Quality Council.[4]

DSS has engaged additional stakeholders in developing the MQISSP quality measure set, including advocacy organizations and sister state agencies. A list of stakeholders engaged in that effort can be found in the Quality Strategy section of this paper.

In addition, regardless of the federal authority required to implement MQISSP, DSS plans to provide a public notice and comment period of at least 30 days.

Oversight and Monitoring

MQISSP Participating Entities will be subject to reporting requirements, which are currently under development. The reporting requirements will be incorporated into the contract with MQISSP Participating Entities.

MQISSP will include a series of internal monitoring and reporting measures on quality and cost that will be collected and analyzed regularly (e.g., monthly or quarterly). DSS expects that quality measure data will principally rely on beneficiary claims, which DSS will analyze directly. DSS will develop and implement methods to monitor delivery of Enhanced Care Coordination Activities and Care Coordination Add-On Payment Activities. MQISSP Participating Entities will be responsible for reporting data to DSS on a regular (e.g., monthly or quarterly) basis to be determined and as specified in the contract. DSS will review the reports and follow up with MQISSP Participating Entities as needed regarding their performance.

At the end of the first year, DSS will evaluate MQISSP to demonstrate improvement against past performance to determine whether the program has achieved, or needs revisions to achieve, the goals of the program, including improving health outcomes and the care experience for MQISSP members.

[3] The SIM Equity and Access Council will recommend analytic methods to ensure safety, access to providers and appropriate services, and to limit the risk of under-provision of requisite care. DSS will work directly with a workgroup of the council to develop strategies to address and safeguard against under-service that address the special needs of Medicaid members. This workgroup will share its recommendations with MAPOC's Care Management Committee, and the recommendations of the Care Management Committee will be shared with council. DSS retains the authority to implement the strategies and safeguards against under-service that it determines to be in the best interest of the Medicaid program.

[4] The SIM Quality Council will recommend a core set of quality measures for use in the assessment of primary care, specialty and hospital provider performance. DSS will work directly with a workgroup of the Care Management Committee to develop a supplemental set of quality measures to address the special needs of Medicaid members. This workgroup will share its recommendations with MAPOC's Care Management Committee, and the recommendations of the Care Management Committee will be shared with the council. DSS retains the authority to implement the measures that it determines to be in the best interest of the Medicaid program.

DSS will:

1. Provide CMS, at least annually, with data and reports evaluating the success of the program against the goals of the program;
2. Provide CMS, at least annually, with updates, as conducted, to the State's metrics;
3. Review and, if necessary, update or revise the payment methodology as part of the evaluation; and
4. Make all necessary modifications to the methodology, including those determined based on the evaluation of program success. If changes to the methodology are different from the approved methodology in the applicable federal authority, then DSS will propose appropriate updates to the federal authority.

Timeline

DSS proposes to implement the "first wave" of MQISSP effective January 1, 2017. This proposed implementation date is pending CMS approval of modification to the original State SIM timeline. A "second wave" of MQISSP will be implemented effective January 1, 2018.

The proposed timeline for the "first wave" of MQISSP is as follows:

Task No.	Task Name	Due Date/Timeframe
1.	Submit MQISSP concept paper to CMS.	December 31, 2015
2.	Continue program development, including the standards for MQISSP Participating Entities, beneficiary assignment methodology, and the shared savings methodology.	July 1, 2016
3.	Public notice for federal authority request.	May–June, 2016
4.	Submit MQISSP federal authority request to CMS.	July 1, 2016
5.	Publish RFP to procure first wave of MQISSP Participating Entities.	June 6, 2016
6.	Finalize methodology for fixed care coordination payments to FQHCs.	October 19, 2016
7.	Finalize the quality measures for shared savings.	October 19, 2016
8.	Finalize the shared savings methodology.	October 19, 2016
9.	Execute contracts with MQISSP Participating Entities.	October 19, 2016
10.	Complete pre-implementation review of MQISSP Participating Entities.	October–December, 2016
11.	Implement first wave of MQISSP.	January 1, 2017
12.	Conduct regular monitoring and oversight.	Ongoing
13.	Calculate and distribute shared savings for Year 1.	January 1, 2019

II. Quality Strategy

The goal of the MQISSP quality strategy is to improve quality and care experience for MQISSP members. While DSS staff has spearheaded the development of the MQISSP quality strategy, the process has included active participation of key stakeholders, both directly and through their participation on the MAPOC Care Management Committee, such as provider associations,

health organizations, legal services providers, other state agencies, as well as various providers and advocates for consumers of health services.

These and other stakeholders have worked together to begin building a quality strategy that is rooted in national best practices and Connecticut-specific data, including historical PCMH quality reporting data.

DSS will continue working with stakeholders over the next few months to finalize the MQISSP quality strategy, including a quality measure set (which includes measures of under-service), that will be used to evaluate MQISSP success and will link quality to payment. The final version of the quality measure set will be included in the contract with MQISSP Participating Entities. Quality measures used to determine shared savings payments, at least in the first Performance Year, will be limited to those claims-based measures that are currently being reported.

MQISSP Participating Entities will only receive a shared savings payment if they meet identified benchmarks on quality performance standards and measures of under-service. Providers will be disqualified from receiving shared savings if they demonstrate repeated or systematic failure to offer medically necessary services, whether or not there is evidence of intentionality. The criteria for identifying systemic under-service are still under development in consultation with stakeholders.

In choosing measures for inclusion in the final measure set, DSS is prioritizing measures that are aligned with the goals of DSS' other quality initiatives and with the recommendations of the SIM Quality Council, and that are recognized by national organizations such as NCQA, Agency for Healthcare Research and Quality, Oregon Health and Science University, and the American Dental Association.

The current version of the draft measure set is attached as Appendix 1 to this concept paper.

Data for the majority of quality measures, including Healthcare Effectiveness Data and Information Set (HEDIS) measures, will be collected from MQISSP member claims and the CAHPS, conducted annually by DSS. DSS will collect and analyze this data. DSS plans to share quality data with MQISSP Participating Entities on a regular basis, and will work to determine the frequency, process, and tools for this activity.

Regular assessment of quality improvement will be an important component of the overall program evaluation for MQISSP. Quality improvement will be monitored through MQISSP quality measure reporting (described above), monitoring for evidence of increased preventative care and linkages to community and medical services, and monitoring potential under-service to ensure that savings are generated appropriately from improved care coordination and ensuring that all MQISSP members receive prompt access to all medically necessary services.

The proposed MQISSP quality strategy aligns with other DSS quality strategies and with quality measure alignment activities undertaken as part of the SIM initiative. Connecticut Medicaid already examines outcomes using a broad range of HEDIS and other measures, and this activity will continue in support of examining the impact of MQISSP. The foundation of the MQISSP quality strategy is the PCMH program quality strategy, which is an ongoing initiative. In addition, Connecticut has established a local initiative of the national "Choosing Wisely" campaign. The initiative's goal is to "promote patient-provider communication to improve health

care practice and prevent unnecessary care and costs"[5]. MQISSP will build on this initiative by requiring further investments on the part of MQISSP Participating Entities in Enhanced Care Coordination Activities that improve communication and strengthen the relationship between providers and patients (described in the following section of this paper).

III. Care Coordination

The primary mechanism for care transformation and savings generation under MQISSP will be the required Enhanced Care Coordination Activities performed by MQISSP Participating Entity providers. The required Enhanced Care Coordination Activities will exceed the requirements for FQHCs under HRSA standards, as well as requirements of Patient-Centered Medical Homes recognized by the NCQA and Primary Care Medical Home certification from The Joint Commission. As described above, in order to participate in the DSS PCMH program, physician, nurse practitioner, and outpatient hospital clinic practices are required to receive NCQA Level 2 or Level 3 Patient-Centered Medical Home recognition. In order to participate in the DSS PCMH program, FQHCs are required to receive either NCQA Level 1, 2, or 3 Patient-Centered Medical Home recognition or Primary Care Medical Home certification from The Joint Commission.

The Enhanced Care Coordination Activities under MQISSP are based on national best practices in care coordination, particularly in the areas of: behavioral health and physical health integration, the provision of culturally competent services, availability and education requirements for care coordinator staff, caring for children and youth with special healthcare needs, and competencies in caring for individuals with disabilities.

The proposed Enhanced Care Coordination Activities to be provided by all MQISSP Participating Entities are:

- Behavioral Health/Physical Health Integration:
    - Employ a care coordinator with behavioral health education, training, and/or experience who participates as a member of the interdisciplinary team.
    - Use standardized tools to expand behavioral health screenings beyond depression.
    - Promote universal screening for behavioral health conditions across all populations, not just those traditionally identified as high risk.
    - Obtain and maintain a copy of the psychiatric advance directive in the member's file.
    - Obtain and maintain a copy of the Wellness Recovery Action Plan (WRAP) in the member's file.
- Culturally Competent Services:
    - Require annual cultural competency training for all practice staff. Cultural competency training will include the needs of individuals with disabilities.
    - Expand the individual care plan to assess the impact culture has on health outcomes.
    - Expand CAHPS surveys, conducted by the DSS PCMH program, to include the supplemental Cultural Competency Item Set.
    - Require compliance with culturally and linguistically appropriate services standards as defined by the U.S. Department of Health and Human Services, Office of Minority Health.

[5] http://consumerhealthchoices.org/ccwc/#welcome

- Care Coordinator Staff Requirements: Availability — Providers may select at least one of these options based on the model(s) that fit their practice:
    - Employ a full-time care coordinator dedicated solely to care coordination activities.
    - Assign care coordination activities to multiple staff within a practice.
    - Contract with an external agency to work with the practice to provide care coordination.
- Care Coordinator Staff Requirements: Education:
    - Define minimum care coordinator education and experience requirements and determine if leveraging non-licensed staff such as Community Health Workers is desired.
- Children and Youth with Special Healthcare Needs[6] (CYSHCN): Age 0–17 Years:
    - Require advance care planning discussions for CYSHCN. Advance care planning is not limited to CYSHCN with terminal diagnoses. It can occur with CYSHCN with chronic health conditions, including behavioral health conditions, which significantly impact the quality of life of the child/youth and their families.
    - Develop advance directives for CYSHCN.
    - Include school-related information in the health assessment and health record, such as: the individualized education plan or section 504 plan, special accommodations, assessing patient/family need for advocacy from the provider to ensure the child's health needs are met in the school environment, determining how the child is doing in school and how many days have missed been due to the child's health condition, and documenting the school name and primary contact.
- Competencies in Care of Individuals with Disabilities (inclusive of physical, intellectual, developmental and behavioral health needs):
    - Expand the health assessment to include questions about: Durable Medical Equipment (DME) and DME vendor preferences, home health medical supplies and home health vendor preferences, home and vehicle modifications, prevention of wounds for individuals at risk for wounds, and special physical and communication accommodations needed during medical visits.
    - Adjust appointment times for individuals who require additional time to address physical accommodations, communication needs, and other unique needs for individuals with disabilities. Individuals may be seen by the primary care physician and other members of the interdisciplinary team during these adjusted appointment times.
    - Develop and require mandatory disability competency trainings to address the care of individuals with physical and intellectual disabilities.
    - Acquire accessible equipment to address physical barriers to care (e.g., wheelchair scales, a high/low exam table and/or transfer equipment and lifts to facilitate exams for individuals with physical disabilities).

[6] Maternal Child and Health Bureau (MCBH) Definition of CYSHCN: "Those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. " This definition is broad and inclusive, and it emphasizes the characteristics held in common by children with a wide range of diagnoses. Examples include children with diagnoses such as diabetes and asthma that is not well controlled. http://mchb.hrsa.gov/cshcn05/

  - Address communication barriers to care (e.g., offer important medical information and documents in Braille or large print, implement policies to ensure services animals are permitted into an appointment). Providers may coordinate with the ASO to obtain available materials.
  - Expand the resource list of community providers to include providers who specialize in or demonstrate competencies in the care of individuals with disabilities (e.g., mammography centers that can accommodate women who use wheelchairs, providers who will take the time to help a patient with cerebral palsy who experiences spasticity or tremors during a physical examination).
- Provider Report Cards:
  - Evaluate and utilize the results of provider report cards on a quarterly basis to improve quality of care.

Building on the mix of primary care, specialists, behavioral health services and existing care coordination activities available at FQHCs, FQHCs participating in MQISSP will also provide Care Coordination Add-On Payment Activities in addition to the Enhanced Care Coordination Activities required of all MQISSP Participating Entities. The proposed Care Coordination Add-On Payment Activities are:

- Behavioral Health/Physical Health Integration:
  - Employ a care coordinator with behavioral health experience who serves as a member of the interdisciplinary team and has the responsibility for tracking patients, reporting adverse symptoms to clinical team, providing patient education, supporting treatment adherence, taking action when non-adherence occurs or symptoms worsen, delivering psychosocial interventions, and referring to behavioral health services outside of the FQHC as needed.
- Develop WRAPs in collaboration with the patient and family:
  - Expand the development and implementation of the care plan for transition age youth (TAY) with behavioral health challenges (e.g., collaborative activities to achieve success in transition and/or referrals to and coordination with programs specializing in the care of TAY with behavioral health challenges.
- Require the use of an interdisciplinary team that includes behavioral health specialist(s):
  - The team has the responsibility for driving integrated physical and behavioral health integration, to conduct interdisciplinary team case review meetings at least monthly, promote shared appointments and develop a comprehensive care plan outlining coordination of physical and behavioral health care needs.

DSS will develop and implement methods to monitor provider delivery of enhanced care coordination and Care Coordination Add-On Payment Activities. MQISSP Participating Entities will be responsible for reporting data to DSS on a regular (e.g., monthly or quarterly) basis. DSS program staff will review the reports and follow up with MQISSP Participating Entities as needed regarding their performance. MQISSP Participating Entities that do not provide sufficient evidence of performing the required Enhanced Care Coordination Activities will be ineligible to participate in shared savings. MQISSP Participating Entities that are FQHCs that do not provide sufficient evidence of performing the Care Coordination Add-On Payment Activities will not receive the Care Coordination Add-on Payment.

To assist MQISSP Participating Entities in implementing the MQISSP Enhanced Care Coordination Activities, all MQISSP Participating Entities will be eligible to receive SIM grant-funded technical assistance in their practice transformation through the Community and

Clinical Integration Program (CCIP). The SIM Project Management Office (PMO) will manage CCIP. The program will seek to improve access to high quality clinical care for complex patients (related to clinical reasons, social reasons or both) and patients experiencing a gap in their care, as well as to improve overall care experience for the general patient population through improving clinical and community integration. CCIP will provide resources to practices to support transformation across their patient panel, regardless of payer. Participation in the CCIP is anticipated to help MQISSP Participating Entities accelerate advancement of practice and technical resources to improve the delivery of care and achieve the goals of MQISSP. DSS and the SIM PMO will further detail the relationship of CCIP to MQISSP; as well as to existing ASO-based ICM and PCMH efforts; as model design is refined.

IV. Payment Methodology

Overview of Payment Methodology

MQISSP Participating Entities that are FQHCs will be reimbursed for Care Coordination Add-On Payment Activities by a Care Coordination Add-On Payment paid prospectively on a monthly basis that the FQHC provides to MQISSP members. These payments will provide financial support to help FQHCs make the necessary investments to provide Care Coordination Add-On Payment Activities. The Care Coordination Add-On Payments are separate from the FQHC's participation in a shared savings payment. FQHCs will also be eligible to receive a shared savings payment if they meet identified benchmarks on quality performance standards and measures of under-service.

Advanced Networks will be reimbursed for Enhanced Care Coordination Activities solely using the shared savings methodology.

DSS will supply the non-federal share for all Care Coordination Add-On Payments and shared savings payments using state funds appropriated by the legislature.

Overview of Shared Savings Methodology

It is DSS' goal that approximately 200,000 to 215,000 beneficiaries will be assigned to MQISSP Participating Entities in the "first wave" of the program as identified in the timeline included above. Medicaid beneficiaries will be assigned to MQISSP Participating Entities using DSS' existing PCMH retrospective attribution methodology adapted as necessary for MQISSP. The PCMH retrospective attribution methodology attributes a Medicaid beneficiary to a PCMH based upon the beneficiary's active choice of provider (i.e., usual source of care). Beneficiaries will be prospectively assigned to MQISSP Participating Entities using this methodology based on past claims history of where the beneficiary chose to receive care. However, beneficiaries will not be "enrolled."

The shared savings methodology is currently being developed by DSS's contracted actuary, Mercer Health & Benefits LLC. The calculations will be made using generally accepted actuarial practices and principles and will adhere to the following guiding principles:

- Only MQISSP Participating Entities that meet identified benchmarks on quality performance standards and measures of under-service will be eligible to participate in shared savings.
- Quality improvement (not just absolute quality ranking) will factor into the calculation of shared savings.

- Higher quality scores may allow a MQISSP Participating Entity to receive more shared savings.
- MQISSP Participating Entities that demonstrate losses (*i.e.*, higher than expected expenditures for MQISSP members assigned to the MQISSP Participating Entity) will not share in losses.
- MQISSP Participating Entities will be benchmarked for quality and cost against a comparison group devised from in-State, non-MQISSP Participating Entities as well as national benchmarks.

The shared savings payment for any MQISSP Participating Entity will be based on both quality performance and savings achieved. The shared savings payment to a particular MQISSP Participating Entity will not exceed 10 percent of expected Medicaid expenditures during the performance year. See below for additional information on the benefits included in the shared savings calculation.

Shared Savings: Benefits Included in the Shared Savings Calculation

All Medicaid claim costs for covered services will be included in the shared savings calculation, with the exception of: hospice; LTSS, including institutional and community-based services; and NEMT. However, MQISSP members will continue to be eligible for all services covered by the Connecticut Medicaid program, including those not included in the shared savings calculation, and will retain free choice of all qualified Medicaid providers. DSS will not factor the Care Coordination Add-On Payments to an FQHC's shared savings calculation. The Care Coordination Add-On Payments are separate from the FQHC's participation in a shared savings payment.

MQISSP Participating Entities will be benchmarked for cost and quality against a comparison group derived from in-State non-MQISSP Participating Entities and any other national benchmarks used in the shared savings calculation.

Shared Savings: Trend Rate Calculation

DSS intends to use a comparison group to establish the actual realized trend retrospectively. Trend assumptions will likely be unnecessary. However, where trending is needed, DSS-specific data will be used, as well as generally accepted actuarial practices and principles. Any trending will be based on Connecticut Medicaid's eligibility and service categories.

Shared Savings: Risk Adjustment

DSS intends to incorporate concurrent retrospective risk adjustment scores in the shared savings calculation using statistical risk adjustment software. Raw risk scores will be calculated for all MQISSP Participating Entities as well as the comparison group. Normalized risk scores will then be calculated so that Connecticut can appropriately compare a MQISSP Participating Entity's level of risk relative to other MQISSP Participating Entities and to the comparison group.

DSS does not plan to include a minimum savings rate because of the retrospective nature of the shared savings calculation, the comparison group approach for expected trends (upon which savings will be based), and the upside-only model design (no downside risk for the MQISSP Participating Entities with higher than expected expenditures for MQISSP members assigned to

those MQISSP Participating Entities). High cost claims will be truncated at the ninety-ninth percentile (subject to data review).

Shared Savings: Risk Sharing

DSS will implement an upside-only shared savings model and does not intend to recover any potential "losses" from the MQISSP Participating Entities.

Shared Savings: Calculating Savings or Losses

MQISSP Participating Entities will be compared on a risk adjusted basis to determine the extent to which they generated lower than average health care cost trends. The average cost trend will be derived from a comparison group of in-State non-MQISSP Participating Entities. DSS will obtain data for both MQISSP and the comparison group for the 12 months leading up to the Performance Year; this period will serve as the "prior" year. Risk adjusted costs and associated health cost trends in the prior year will then be determined for both MQISSP members and the comparison group. The savings for each MQISSP Participating Entity will be calculated as the entity's risk adjusted expected cost (using the comparison group average health care trend) less the entity's actual risk adjusted costs. The total savings pool will equal the sum of only the savings achieved by MQISSP Participating Entities.

The savings pool will be a hybrid savings pool. The hybrid savings pool will consist of both an individual savings pool (where savings are pooled separately and accessible individually for each MQISSP Participating Entity) and a challenge pool that will aggregate all savings not realized individually due to failing to meet identified benchmarks on quality performance standards or evidence of under-service.

In the individual savings pool, MQISSP Participating Entities will be measured using both an absolute quality score and a quality improvement score. MQISSP Participating Entities will first be measured against quality thresholds derived from a comparison group of in-State non-MQISSP Participating Entities as well as national benchmark standards. MQISSP Participating Entities will then be measured against their year-over-year quality improvement. Quality thresholds and measures of under-service will be based on points earned through absolute quality ranking and quality improvement. These points will be turned into a quality factor that will inform the payment from the first savings pool.

The challenge pool will be for all MQISSP Participating Entities exceeding benchmark quality standards. Performance among a second set of quality measures will be used to inform a member-weighted distribution from the challenge pool. The challenge pool will be funded by all unclaimed savings from each individual savings pool.

Shared Savings: Rebasing

Rebasing or updating is not deemed necessary at this time, as DSS plans on using a retrospective approach.

Shared Savings: Cost Shifting

DSS plans to address cost shifting primarily by including effectively all covered services in the calculation of costs and savings. The services excluded from the shared savings calculation, including hospice, LTSS, and non-emergent medical transportation, are unlikely to be susceptible to cost shifting. In addition, the risk adjustment approach will track any movement of

MQISSP members (and their associated illness burden) from MQISSP Participating Entities to non-MQISSP Participating Entities.

Appendix 1: Draft MQISSP Quality Measure Set

MQISSP Quality Measure Set Proposed Rankings

MQISSP Measure Number	Quality Measure Title	Ranking	Potential Means to Identify Under-service
Preventative Care Domain			
1	Adolescent well-care visits	1	*
13	Diabetes HbA1c Screening	1	*
27	Well-child visits in the first 15 months of life	1	*
Medication Management Domain			
5	Asthma Medication Ratio	1	*
Clinically Appropriate Care Domain			
6	Avoidance of antibiotic treatment in adults with acute bronchitis	1	
Access to Appropriate Care Domain			
15	Emergency Department (ED) Usage	1	
22	PCMH CAHPS	1	*
25	Prenatal care & Postpartum care	1	*

MQISSP Measure Number	Challenge Measure Title	Ranking	Potential Means to Identify Under-service
7	Behavioral Health Screening 1-17	N/A	*
20	Metabolic Monitoring for Children and Adolescents on Antipsychotics	N/A	*
23	Readmissions within 30 Days [Medicaid Medical Directors Network (MMDN)]	N/A	
24	Post-Hospital Admission Follow-up	N/A	*

MQISSP Measure Number	Reporting Only Measure Title	Ranking	Potential Means to Identify Under-service
2	Annual fluoride treatment ages 0<4	N/A	*
3	Annual monitoring for persistent medications (roll-up)	N/A	*
4	Appropriate treatment for children with upper respiratory infection	N/A	
8	Breast cancer screening	N/A	*
9	Cervical cancer screening	N/A	*
10	Chlamydia screening in women	N/A	*
11	Developmental screening in the first three years of life. Three age breakouts (ages 1, 2, and 3)	N/A	*
12	Diabetes eye exam	N/A	*
14	Diabetes: medical attention for nephropathy	N/A	*
16	Follow-up care for children prescribed ADHD medication	N/A	*
17	Frequency of ongoing prenatal care	N/A	*
18	Human Papillomavirus Vaccine for Female Adolescents (HPV)	N/A	*
19	Medication management for people with asthma	N/A	*
21	Oral evaluation, dental services	N/A	*
26	Use of imaging studies for low back pain	N/A	
28	Well-child visits in the third, fourth, fifth and sixth years of life	N/A	*

Note: All quality measures are assigned an equal ranking.