

Connecticut Department of Social Services

**Medicaid Quality Improvement and Shared Savings Program
(MQISSP)**

CONCEPT PAPER

Submitted to the Centers for Medicare and Medicaid Services (CMS)

_____, 2015

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" (described below, e.g. Accountable Care Organizations, large integrated physician practices) 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, 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 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, lack of personal safety, limited office hours at medical practices, chronic conditions, and low literacy. 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 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 behavioral 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 federally qualified health centers (FQHCs) and Advanced Networks (collectively referred to as "MQISSP Participating Entities") that will provide enhanced care coordination activities to improve the quality, efficiency, and effectiveness of care delivered to Medicaid beneficiaries. DSS will make fixed care coordination payments to MQISSP-participating FQHCs. These payments are intended to support the care coordination activities that such FQHCs will be expected to provide in addition to the care coordination activities that are already required for their participation in the DSS PCMH program. DSS will not make such payments to "advanced

networks". If MQISSP generates savings for the Medicaid program, MQISSP Participating Entities that meet specified quality performance standards, including measures of under-service, will share in a portion of the savings. 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 attributed to MQISSP Participating Entities on the basis of DSS' existing PCMH 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), the Demonstration to Integrate Care for Medicare-Medicaid Enrollees (the "duals demonstration"), home and community-based services (HCBS) waivers and SPAs, and Money Follows the Person (MFP) Rebalancing Demonstration:

1. **PCMH Program** DSS implemented its Person-Centered Medical Home (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 care coordination activities will enhance existing PCMH standards. In addition, PCMH 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 (ICM) 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 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 (ICM) support. ICM is provided by each 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;
- 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 (MQISSP Participating Entities) and to pair short-term ASO ICM interventions with longer-term, community integrated support for beneficiaries provided by and/or coordinated by MQISSP Participating Entities.

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3. Behavioral Health Homes (BHH) DSS has partnered with its sister state agencies, the Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF) to submit a State Plan Amendment 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 is slated for implementation beginning 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. Duals Demonstration DSS is in negotiations with CMS to implement a demonstration to integrate care for individuals dually eligible for both Medicare and Medicaid ("duals demonstration") using the managed fee-for-service financial alignment model. The model under negotiation is a scaled-down version of the original proposal, which would focus exclusively on enhancing ASO-based Intensive Care Management interventions to best meet the needs of duals. The goals of the duals demonstration are to integrate Medicare and Medicaid services, improve care coordination for dual eligibles, and improve beneficiary outcomes.

MQISSP will not serve individuals who are enrolled in the duals demonstration.

5. HCBS Waivers, section 1915(i) and 1915(k) SPAs and MFP DSS currently operates a range of 1915(c) waivers that 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 (ASD) and individuals with acquired brain injury (ABI). 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, including a vigorous Money Follows the Person 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 waiver, section 1915(i) or section 1915(k) SPA or MFP.

Programmatic Considerations

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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 attribute to MQISSP Participating Entities individuals from all Medicaid coverage groups except:

1. BHH participants.
2. Full and partial Medicaid/Medicare dual-eligibles.
3. HCBS waiver and section 1915(i) and section 1915(k) participants.
4. MFP participants.
5. Nursing facility residents.
6. Beneficiaries who are enrolled in Connecticut Medicaid solely to receive limited benefit package (current limited benefit packages are for family planning and tuberculosis).

DSS plans to use a RFP process to determine and select qualified MQISSP Participating Entities (FQHCs and Advanced Networks) to provide enhanced care coordination activities to beneficiaries. DSS is in the process of developing the provider qualifications for selecting MQISSP Participating Entities through the RFP process. DSS anticipates developing minimum provider qualifications for all Participating Entities, and also provider qualifications specific to each type of MQISSP Participating Entity (FQHCs and Advanced Networks).

Recognizing the benefit of including practices that have already self-initiated practice transformation, DSS intends to require that any Advanced Network entity seeking to be a MQISSP Participating Entity include at least one DSS PCMH participating practice and that any FQHC seeking to be a MQISSP Participating Entity must be a PCMH participant. In addition, all potential Participating Entities must already have at least 2,500 MQISSP-attributable beneficiaries.

The RFP will also include provider qualifications specific to each type of Participating Entity (FQHCs and Advanced Networks). In particular, DSS intends to require that FQHCs be located in the State of Connecticut and have current Health Resources and Services Administration recognition as FQHCs.

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

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

DSS is in the process of developing the enhanced care coordination activities that MQISSP Participating Entities must provide to beneficiaries. DSS is developing these activities based on national best practices in care coordination. The enhanced care coordination activities will go beyond the care coordination activities required for Patient Centered Medical Homes recognized by NCQA and ambulatory care entities with a Primary Care Medical Home certification from The Joint Commission, as well as the care coordination expectations that are embedded in the federal Health Resources and Services Administration (HRSA) standards for FQHCs.

DSS will reimburse MQISSP Participating Entities for providing enhanced care coordination activities. FQHCs will receive two types of payments. The first type of payment will be a fixed

add-on payment paid prospectively on a monthly basis for defined enhanced care coordination activities that the FQHC provides to beneficiaries. The second type of payment will be a shared savings payment. Advanced Networks will not receive fixed payments, but will be eligible to qualify for shared savings payments. Shared savings paid to any MQISSP Participating Entity will be based on quality performance, including measures of under service, and actual savings generated. There will be no downside risk on providers. 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 and 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 Advanced Network Participating Entities must include at least one current PCMH participant and that an FQHC Participating Entity must be a PCMH participant. MQISSP Participating Entity providers will perform new enhanced care coordination activities that go above and beyond current PCMH care coordination standards. The MQISSP enhanced care coordination activities that are under consideration are described in further detail in the Quality Strategy section of this paper.

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:

- 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. Accordingly, a potential barrier would occur if there is a lower than expected take-up rate among providers seeking to become MQISSP Participating Entities.
- While current budget projections look favorable for MQISSP, changes in the State budget could impact future years of MQISSP. Accordingly, a potential barrier would occur depending on the long-term availability of State funding for its portion of the shared savings payments and fixed care coordination payments to FQHCs.

- The new Medicaid eligibility system is targeted to go live in 2017. The MQISSP attribution 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. Accordingly, a potential barrier would be any technical difficulties that may be associated with DSS' effort to replace its current Medicaid eligibility system.

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 attributed to MQISSP using the PCMH attribution methodology, adapted for MQISSP. Beneficiaries will not be "enrolled" in MQISSP or assigned to a provider. Beneficiaries will have the ability to opt-out of attribution to MQISSP. DSS is working to develop a process and tools to notify beneficiaries about MQISSP and their attribution status.

As mentioned above, beneficiaries participating in certain other programs serving beneficiaries with special needs, such as the duals demonstration, the HCBS waivers and section 1915(i) and 1915(k) SPAs, and MFP, will not be eligible for attribution 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

As mentioned above, DSS will use a 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.

As noted above, DSS is in the process of developing provider qualifications for Participating Entities (FQHCs and Advanced Networks) in order to contract with entities that are qualified to provide the specified enhanced care coordination activities. MQISSP Participating Entities will be responsible for ensuring that their providers provide the required enhanced 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 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 clinical data.

The Advanced Network Lead Entity will enter into a contract with DSS, will receive shared savings payments from DSS and will be responsible to make any appropriate distribution of the payment among the Advanced Network providers, subject to 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 a clinical director. There will be no Lead Entity requirement for FQHCs.

Advanced Networks will also be required to have a board of directors that includes participation by at least one beneficiary receiving services from the Advanced Network and at least one provider within the Advanced Network. FQHCs already have a board of directors that includes beneficiary participation.

The Advanced Networks will also be required to develop contractual or informal partnerships with the larger community, including:

- Community-based organizations,
- Behavioral health organizations,
- Social services agencies,
- Public health entities, and
- Specialists and hospitals (in cases where the Advanced Network does not already include these entities).

Both FQHCs and Advanced Networks will be required to report specified clinical data to DSS. DSS will otherwise monitor quality through claims data and the Consumer Assessment of Healthcare Providers and Systems (CAHPS).

Covered Services

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

The principal impact of MQISSP will be on improving Connecticut's Medicaid primary care delivery system, as providers implement the new enhanced care coordination activities and work to improve the quality and care experience for beneficiaries. Other care delivery systems such as specialty care, hospital care, and behavioral health will also see improvements as Participating Entities build greater connections with these systems.

DSS is in the process of finalizing the required enhanced care coordination activities that MQISSP Participating Entity providers will provide to beneficiaries. The goal of care coordination under MQISSP is to improve the quality and beneficiary experience of care. DSS is evaluating care coordination activities in a variety of domains including behavioral health and physical health integration, cultural competence, and competencies in care for individuals with disabilities, and will select the care coordination activities that best align with this goal.

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 Committee¹ and the SIM Consumer Advisory Board². The Committee reviews and provides comment to DSS on all aspects of MQISSP, including, but not limited to: standards to include in the RFP for MQISSP Participating Entities; the attribution methodology; the quality measures; how to ensure beneficiary protections; how to assess whether desired outcomes have been achieved; 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>

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 Council³ 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 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 intends for reporting by Participating Entities to be limited to any clinical data, at least initially, to support demonstration of care coordination activities, as determined by DSS.

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

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.

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 council 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.

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achieve, the goals of the program, including improving health outcomes and the care experience for Medicaid beneficiaries.

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 renew 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, through updates to the federal authority.

Timeline

DSS proposes to implement the “first wave” of MQISSP effective July 1, 2016. This proposed implementation date is pending CMS approval of an extension request. 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.	August 31, 2015
2.	Continue program development including the standards for MQISSP Participating Entities, the enhanced care coordination activities, beneficiary attribution methodology, the quality measures, and the shared savings methodology.	December 15, 2015
3.	Public notice for federal authority request.	November–December 2015
4.	Submit MQISSP federal authority request to CMS.	December 2015
5.	Publish RFP to procure first wave of MQISSP Participating Entities.	January 5, 2016
6.	Finalize methodology for fixed care coordination payments to FQHCs.	May 1, 2016
7.	Finalize the quality measures for shared savings.	May 1, 2016
8.	Finalize the shared savings methodology.	May 1, 2016
9.	Execute contracts with MQISSP Participating Entities.	June 1, 2016
10.	Complete pre-implementation review of MQISSP Participating Entities.	June 17, 2016
11.	Implement first wave of MQISSP.	July 1, 2016
12.	Conduct regular monitoring and oversight.	Ongoing
13.	Calculate and distribute shared savings.	July 1, 2018

II. Quality Strategy

The goal of the MQISSP quality strategy is to improve quality and care experience for beneficiaries. 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:

- Child Health and Development Institute of Connecticut
- Connecticut Health Policy Project
- Connecticut Hospital Association
- National Alliance on Mental Illness
- New Haven Legal Assistance Association
- Connecticut Department of Mental Health

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.

Stakeholders will work 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. Participating Entities will receive a shared savings payment only if they meet minimum benchmark standards on the quality measures, including measures of under-service. 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 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.

Some examples of measures under consideration for inclusion in the final measure set are:

Adult Measures

- The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer in a two year period.
- Adults age 18–75 with a diagnosis of Type I or Type II diabetes who received at least one HbA1c screening during the measurement year.

Pediatric Measures

- Percentage of children three months to eighteen years of age with a diagnosis of Upper Respiratory Infection who were not dispensed an antibiotic medication.
- Percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.

DSS will also work to finalize the process to assess quality at the point of care. Data for the majority of quality measures, including Healthcare Effectiveness Data and Information Set (HEDIS) measures, will be collected from beneficiary claims and CAHPS. DSS staff will be responsible for collection and analysis of this data. DSS plans to share quality data with Participating Entities on a regular basis, and will work to determine the frequency, process, and tools for this activity.

The proposed MQISSP quality strategy aligns with other DSS quality strategies. 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 Participating Entities in enhanced care coordination activities that improve communication and strengthen the relationship between providers and patients.

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, and Patient Centered Medical Homes recognized by the NCQA and ambulatory care entities with a 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 PCMH recognition. In order to participate in the DSS PCMH program, FQHCs are required to receive either NCQA Level 1, 2, or 3 PCMH recognition or PCMH certification from The Joint Commission.

The enhanced care coordination activities under MQISSP will be 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.

DSS will develop and implement methods to monitor provider delivery of enhanced care coordination activities. 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 Participating Entities as needed regarding their performance. Participating Entities that do not provide sufficient evidence of performing the required enhanced care coordination activities will be ineligible to receive applicable MQISSP payments.

To assist Participating Entities in implementing the MQISSP enhanced care coordination activities, all Participating Entities will be eligible to receive SIM grant-funded technical assistance in their practice transformation through the Community and Clinical Integration Program (CCIP). CCIP is a SIM initiative not specific to Medicaid (not administered by DSS) that will seek to improve overall access to high quality clinical care for complex patients (either due to clinical reasons, social reasons or both), patients experiencing a gap in their care, and improve overall care experience for the general patient population through improving clinical and community integration. Participation in the CCIP will help Participating Entities accelerate advancement of practice and technical resources to improve the delivery of care and achieve the goals of MQISSP.

Overall program evaluation for MQISSP will include regular assessment of quality improvement. Quality improvement will be monitored through MQISSP quality measure reporting (principally based on beneficiary claims data), 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 beneficiaries receive prompt access to all medically necessary services. DSS is building

⁵ <http://consumerhealthchoices.org/ccwc/#welcome>

mechanisms to identify savings sources to ensure savings are generated from avoidance of inefficient or unnecessary services, and not due to limiting access to medically necessary beneficiary services. This will be done through a combination of monitoring quality measures, evaluating health disparities, increased access to preventative care, and evaluation of beneficiary experience via the CAHPS survey.

III. Payment Methodology

Overview of Payment Methodology

Participating Entities that are FQHCs will be reimbursed for enhanced care coordination activities through two types of payments. The first type is a fixed payment paid prospectively on a monthly basis for defined enhanced care coordination activities that the FQHC provides to beneficiaries. These payments will provide some initial financial support to help FQHCs make the necessary investments to provide enhanced care coordination activities beyond those required by HRSA and the DSS PCMH program. The second type of payment to FQHCs will be a shared savings payment based on a portion of savings achieved on an annual basis. Advanced Networks will be reimbursed for enhanced care coordination activities solely using the shared savings methodology.

The shared savings payment for both FQHCs and Advanced Networks will be risk adjusted, paid annually, and will be based both on quality performance and also on savings achieved.

DSS will supply the non-federal share for all ICM 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 attributed to MQISSP Participating Entities in the "first wave" of the program as identified in the timeline included above. For purposes of distributing shared savings, these beneficiaries will be attributed retrospectively using DSS's current PCMH attribution logic adapted for MQISSP. In order to be eligible for a shared savings payment, a MQISSP Participating Entity must already have at least 2,500 attributed beneficiaries.

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 Participating Entities that meet quality standards and under-service measures 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 will allow a Participating Entity to receive more shared savings.
- Participating Entities that demonstrate losses will not be required to share in losses.
- Participating Entities will be benchmarked for quality and cost against a comparison group devised from in-State, non-participating Entities as well as national benchmarks.

As further explained below, DSS does not propose to include a minimum savings rate in the shared savings methodology.

The shared savings payment to a particular MQISSP Participating Entity will not exceed 10 percent of expected Medicaid expenditures for benefits included in the shared savings calculation for beneficiaries attributed to that entity. See below for additional information on the benefits included in the shared savings calculation.

Shared Savings: Benefits Included in the Shared Savings Calculation

Beneficiaries will continue to be eligible for all services covered by the Connecticut Medicaid program and will retain free choice of all qualified Medicaid providers. All Medicaid claim costs for covered services will be included in the shared savings calculation, with the exception of: hospice; long-term services and supports (LTSS), including institutional and community-based services; and NEMT. DSS does not intend to include the fixed care coordination add-on payments to Participating Entities that are FQHCs in the shared savings calculation, as these payments will compensate FQHCs for activities not currently performed by FQHCs.

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

Shared Savings: Trend Rate Calculation

DSS intends to use the comparison group to establish the actual realized trend retrospectively. As such, trend assumptions are unlikely to be necessary. Where trending is needed, Connecticut specific data will be used to develop trends. These trends will be developed using generally accepted actuarial practices and principles and based on the different eligibility categories and service categories.

Shared Savings: Risk Adjustment

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

Because of the retrospective nature of the calculation, and the comparison group approach to actual trends (from which savings will be based), and because there is no downside risk for the Participating Entities, DSS does not plan to include a minimum savings threshold. 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 Participating Entities.

Shared Savings: Calculating Savings or Losses

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-participating entities. DSS will obtain data for both the MQISSP population and the comparison population for the twelve months

leading up to the demonstration year; this period will serve as the “prior” year. Risk adjusted costs and associate health cost trends in the demonstration years will then be determined for both the MQISSP and comparison populations. 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 of Participating Entities.

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 beneficiaries (and their associated illness burden) from Participating Entities to non-participating entities.

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