

**STATE OF CONNECTICUT  
DEPARTMENT OF SOCIAL SERVICES**

**PROPOSAL TO THE  
CENTER FOR MEDICARE AND MEDICAID INNOVATION**

***STATE DEMONSTRATION TO INTEGRATE CARE FOR  
DUAL ELIGIBLE INDIVIDUALS***



**DATE, 2012**

**DRAFT**

## Table of Contents

A.	Executive Summary .....	3
B.	Background.....	5
i.	Overall vision and barriers to address	5
ii.	Description of the eligible population	
C.	Care Model Overview.....	10
i.	Proposed delivery system model	10
ii.	Proposed benefit design	18
iii.	Description of new supplemental benefits	
iv.	Evidence-based practice	10
v.	Context of other Medicaid initiatives and health care reform	19
D.	Stakeholder Engagement and Beneficiary Protections.....	20
i.	Stakeholder engagement during the design phase	20
ii.	Beneficiary protections	22
iii.	Ongoing stakeholder input	23
E.	Financing and Payment .....	23
i.	State-level payment reforms	23
ii.	Payments to providers	23
F.	Expected Outcomes.....	27
i.	Key metrics related to the Demonstration’s quality and cost outcomes	27
ii.	Potential improvement targets	27
iii.	Expected impact on Medicare and Medicaid costs	28
G.	Infrastructure and Implementation .....	30
i.	State infrastructure/capacity to implement and oversee the Demonstration	30
ii.	Need for waivers	34
iii.	Plans to expand to other populations and/or service areas	34

iv.	Overall implementation strategy and anticipated timeline	34
H.	Feasibility and Sustainability .....	34
i.	Potential barriers, challenges and/or future State actions that could affect implementation	35
ii.	State statutory and/or regulatory changes needed to move forward with implementation	36
iii.	State funding commitments or contracting processes necessary before full implementation	36
iv.	Scalability of the proposed model and its replicability in other settings or states	36
v.	Letters of support	36
I.	CMS Implementation Support – Budget Request .....	36
J.	Additional Documentation (as applicable).....	37
K.	Interaction with Other HHS/CMS Initiatives .....	37
	Appendix A. Workplan and Timeline .....	
	Appendix B. Cluster Maps .....	
	Appendix C. Stakeholder Participation.....	
	Appendix D. Stakeholder Engagement .....	
	Appendix E. Key Focus Group Themes .....	
	Appendix F. Performance Measures .....	

## A. Executive Summary

Connecticut intends to implement the Demonstration to Integrate Care for Medicare-Medicare Enrollees for MMEs age 18-64, and age 65 and older. The Demonstration will integrate Medicare and Medicaid long-term care, medical and behavioral services and supports, promote practice transformation, and create pathways for information sharing through key strategies including:

- data integration and state of the art information technology and analytics;
- Intensive Care Management (ICM) and care coordination in support of effective management of co-morbid chronic disease;
- expanding access for MMEs to Person Centered Medical Home (PCMH) primary care;
- Electronic care plans and integration with Connecticut's Health Information Exchange to facilitate person-centered team based care, and
- a payment structure that will align financial incentives (advance payments related to costs of care coordination and supplemental services; performance payments) to promote value.

Connecticut MMEs face significant health status challenges related to chronic disease, incidence of Serious Mental Illness (SMI), cognitive impairment and co-morbidity of conditions. In addition, spending for Connecticut's 64,000 MMEs is 155% of the national average (\$53,500 per MME as compared with \$34,500), for a total cost of more than \$3.4 billion. The high incidence of MME's co-occurring medical and behavioral health conditions, and associated costs, present unique challenges, and also opportunities for improvement.

Under the Demonstration, MMEs will either: 1) remain attributed to Connecticut's existing Administrative Services Organization (ASO) (Model 1) or 2) be enrolled in a "health neighborhood" (HN) (Model 2). Model 1 will feature plan-based care coordination. By contrast, Model 2 will require a neighborhood of clinicians and providers to work together to provide localized, person-centered, team-based interdisciplinary care coordination. Both models will include primary care practices that have already achieved, or are in process of achieving, qualification as Person-Centered Medical Homes (PCMH). MMEs will be aligned with the ASO model if they are not enrolled in a Medicare Advantage (MA) Plan, or aligned with the Comprehensive Primary Care Initiative (CPCI) or an Accountable Care Organization (ACO) as of December 1, 2012. MMEs will also be attributed to PCMH practices quarterly, based on claims history. A subset of the MMEs that participate in the Demonstration will be passively enrolled in HNs based on receiving primary care from a participating HN provider. These MMEs will be notified that they have been assigned to an HN and will have the option to decline to participate.

The Demonstration will focus upon opportunities to optimize use of and build upon existing services and supports for both MMEs and providers. The Department will continue to support primary care practices that wish to pursue NCQA Level 2 or 3 recognition and qualification under Medicaid as a PCMH, while extending this program to MMEs who are participating in the Demonstration. Further, Medicaid waiver long-term care services and supports (LTSS) will for the first time be purposefully connected to the medical and behavioral health care received by MMEs. Additionally, the Demonstration will engage stakeholders in the Connecticut Health Information Exchange (HIE) to map opportunities for information exchange. Finally, the Department will promote dialogue and collaboration among partners across the

spectrum of services. This will feature new partnerships among state agencies (Departments of Social Services, Developmental Services and Mental Health and Addiction Services), medical, behavioral health, long-term care services and supports, and adjunct social services (e.g. housing assistance) providers.

The Demonstration will be a key element of a laboratory environment in Connecticut in which the success of various, co-occurring value-based and/or integrated care initiatives (ACO and CPCI) will be modeled and tested for capacity to achieve the desired results of improved care for participants, enhanced consumer satisfaction and controls on the rate of growth (and where possible, reduction) of costs of care. Principles of person-centeredness will inform every stage of implementation of the Demonstration, and the Department will use diverse means (stakeholder comment, participant focus groups, performance measures, cost and analysis of integrated Medicare and Medicaid data) to evaluate its success. The Department affirms that Connecticut will comply with CMS' Standards and Conditions for the Demonstration.

**Table A-1 Features of the Demonstration Proposal**

<b>Target Population</b>	Full MMEs, age 18 – 64 and age 65 and older
<b>Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide</b>	63,630
<b>Total Number of Beneficiaries Eligible for Demonstration</b>	57,568
<b>Geographic Service Area</b>	<ul style="list-style-type: none"> <li>• Administrative Services Organization (ASO) model will operate statewide</li> <li>• Health Neighborhood (HN) model will be introduced in 3-5 geographic areas</li> </ul>
<b>Summary of Covered Benefits</b>	<ul style="list-style-type: none"> <li>• Medicaid State Plan (including 1915(i))</li> <li>• Medicaid waiver services</li> <li>• Medicare Parts A, B and D</li> <li>• Adjunct services and supports (e.g. Intensive Care Management, nutrition counseling, medication therapy management)</li> </ul>
<b>Financing Model</b> <ul style="list-style-type: none"> <li>• Is this proposal using a financial alignment model from the July 8 SMD?</li> <li>• Payment mechanism</li> </ul>	<ul style="list-style-type: none"> <li>• Yes. Additionally, Connecticut proposes to make performance payments to HNs that achieve benchmarks on identified performance measures.</li> <li>• Managed FFS Model</li> </ul>
<b>Summary of Stakeholder Engagement/ Input</b>	<ul style="list-style-type: none"> <li>• 3 meetings of Medical Assistance Program Oversight Council (MAPOC) (membership includes legislators, state agencies, stakeholders)</li> </ul>

	<ul style="list-style-type: none"> <li>• 12 meetings of MAPOC Complex Care Committee (CCC)(key means of gaining input from legislators, advocates, providers and consumers on overall model)</li> <li>• multiple meetings of work groups affiliated with CCC: Model Design, Performance Evaluation, Enrollment (please see Section D i. and Appendix D for more detail)</li> <li>• consumer input through 1) 8 focus groups (71 participants) with individuals age 65+; and 2) 5 focus groups (45 participants) with individuals with disabilities who are under the age of 65.</li> <li>• ten-day informal comment period for CCC (April 5, 2012 – April 15, 2012)</li> <li>• thirty-day formal comment period (April 17, 2012 – May 16, 2012)</li> <li>• ongoing provider and member education sessions</li> </ul>
<b>Proposed Implementation Date</b>	December 1, 2012

## B. Background

### i. Overall vision and barriers to address

Connecticut’s overall vision for the Demonstration is to create and enable value-based systems through which MMEs will receive integrated, holistic, person-centered services and supports that address the entirety of their needs. Implementation of this Demonstration will result in:

- enhanced population outcomes;
- improved consumer care experience; and
- controls on the rate of growth of (and if possible, reductions in) costs of care.

Key rationales for the Demonstration include the following:

- the 57,568 Connecticut MMEs represent less than one-tenth (10%) of Medicaid beneficiaries in Connecticut yet they account for thirty-eight percent (38%) of all Medicaid expenditures
- per capita Connecticut Medicaid spending for the 32,583 MMEs age 65 and over and the 24,986 MMEs with disabilities under age 65 is fifty-five percent (55%) higher than the national average
- MMEs have complex, co-occurring health conditions:

- roughly 88% of individuals age 65 and older has at least one chronic disease, and 42% having three or more chronic diseases, accounting for 55% of total expenditures
- 58% of younger individuals with disabilities has at least one chronic disease, accounting for 63% of the total expenditures
- 38% has a serious mental illness (SMI)
- comparatively high spending alone on MMEs has not resulted in better health outcomes, better access or improved care experience:
  - illustratively, in SFY'10 almost 29% of MMEs were re-hospitalized within 30 days following a discharge, and almost 10% were re-hospitalized within 7 days following a discharge
  - MMEs have reported in Demonstration-related focus groups that they have trouble finding doctors and specialists that will accept Medicare and Medicaid, and often do not feel that the doctor takes a holistic approach to their needs

Connecticut MMEs face significant barriers related to the current financing and delivery system.

Broadly, these include:

- **Constraints of the current Fee-for-Service (FFS) delivery system:** The current FFS delivery system perpetuates a focus on providing reimbursable services rather than providing value.
- **Lack of integration between Medicare and Medicaid funded services:** Lack of integration between these two programs defeats opportunities to link services and supports:
  - as MMEs transition from care setting to care setting (home to hospital, hospital to nursing facility, nursing facility to home);
  - among providers of medical, behavioral, long-term services and supports, and community-based social services (e.g. housing);
  - lack of Medicare data prevents use of such data to support care coordination and performance measurement.
- **Lack of provider connections across the care continuum:** Providers have historically neither had the opportunity nor the means (e.g. care coordination agreements, real-time utilization data, electronic communication tools) to coordinate across disciplines. Further, providers have not typically worked in multi-disciplinary teams. Coordination and communication is essential to achieve the best possible health outcomes.
- **Situational, provider-driven care planning:** Providers are typically oriented to addressing specific issues and concerns on an episodic basis, and have limited experience with care

coordination that spans the range of presenting needs. Further, providers have had little experience with the applied practice of person-centeredness (e.g. primacy of the patient/consumer in decision-making, need for individually-tailored communication strategies). This limits opportunities to include MMEs in care planning and to honor their values and preferences.

- **Access barriers:** Diverse access barriers inhibit MMEs' ability to get the services and supports that they need. These include, but are not limited to:
  - barriers related to ethnicity, disability, language of origin other than English, culture, values concerning health care that depart from the "norm"

*Example: MMEs with physical disabilities and SPMI who participated in focus groups in support of the Demonstration reported that providers treat people differently on the basis of these disabilities. Individuals with intellectual disabilities reported that some providers accommodate their needs and others do not.*

- barriers presented by out-of-pocket costs for health care that are unsupportable on a fixed income budget

*Example: MMEs who participated in focus groups in support of the Demonstration reported that the Part D co-payments that they are required to make in some cases prevent them from filling needed medications.*

- barriers related to coverage rules:

*Example: To qualify for Medicare coverage in a skilled nursing facility (SNF), an individual must have been hospitalized for at least three consecutive days and be admitted to the SNF for the condition for which he or she was hospitalized. This in some cases represents a perverse incentive to hospitalize an individual who could otherwise be directly and effectively served by a SNF.*

- barriers related to accessing a provider on a timely basis

*Example: Focus group participants also reported difficulty in connecting with their doctors on an immediate basis, potentially resulting in unnecessary trips to the emergency department.*

Connecticut has some experience with care enhancement initiatives to address access and coordination issues associated with primary care, they have operated in relative isolation with other providers, and have been unable to overcome the fragmentation that is inherent in the way in which services are currently organized and delivered. Today, no system of providers in any part of the state can measure

the value they provide to MMEs. And no system of providers can tell whether they are providing better overall value over time.

Connecticut proposes to overcome these barriers by comparing two key models, which are described in Section C.

- **Model 1** primarily addresses the need for more coordination in providing services and supports, through such means as data integration, Intensive Care Management (ICM) and electronic tools to enable communication and use of data.
- **Model 2** incorporates all of the building blocks of Model 1 and enhances them by creating dynamic, innovative, person-centered local systems of care and support that are rewarded for providing better value over time.

ii. Detailed description of population

	Overall	Individuals receiving LTSS in institutional settings	Individuals receiving LTSS in HCBS settings
Overall total	57,568	17,035	15,661
Individuals age 65+	32,583	14,525	8,709
Individuals under age 65	24,985	2,510	6,952
Individuals with serious mental illness	22,158	7,746	3,329
Individuals with developmental disabilities	9,235	1,774	5,877

There were a total of 63,630 full benefit MMEs residing in Connecticut during state fiscal year (SFY) 2010. Of those, 9.5% were enrolled in a Medicare Advantage plan, and the remaining 90.5% received their services on a fee-for-service basis. All Medicaid services were provided on a fee-for-service basis for these MMEs. Given that the Demonstration will exclude those MMEs who are enrolled in a Medicare Advantage plan, the figures below include only those MMEs who would be eligible for the demonstration.

Connecticut is made up of both urban and rural counties. The majority (74% to 78%) of MMEs reside in the urban counties of New Haven, Hartford and Fairfield, consistent with the general population centers in Connecticut. Fairfield, Hartford and New Haven have a higher proportion of elderly MMEs while the rest of the counties experience a more even mix of MMEs as between the elderly and blind individuals and those with disabilities.

The population mix by county has been fairly stable over the past three fiscal years with an overall annual average population growth of 1% for blind individuals and those with disabilities and -1% for the elderly.

The average age of MMEs is 67 years old. 57% are blind or have a disability, and 43% are elderly. The majority of the elderly are over the age of 85 while the majority of blind individuals and those with disabilities are between the ages of 45-54. Very few MMEs are under the age of 21.

Roughly 88% of the elderly MME population has at least one chronic disease, with 42% having three or more chronic diseases, accounting for 55% of the total expenditures. The distribution of MMEs by number of chronic diseases is more evenly spread for blind individuals and those with disabilities where 58% of the population has at least one chronic disease, accounting for 63% of the total expenditures.

38% of the MMEs have a serious mental illness. A greater proportion (51%) of blind individuals and those with disabilities has a serious mental illness as compared to 29% of the elderly MMEs. In addition, 31% of blind individuals and those with disabilities have an intellectual disability, compared to 5% of the elderly. In contrast, 53% of the elderly MMEs have a neurological disability, including some form of Alzheimer's disease and/or dementia.

When examining the enrollment by long-term care status, 72% of the elderly and 38% of blind individuals and individuals with disabilities are at nursing home level of care, either receiving home- and community-based waiver services or long term residents of nursing facilities. Of those elderly MMEs who are nursing home level of care, 63% are living in an institution. Blind MMEs and those with disabilities are more likely to reside in the community, with 26% of those who are nursing home level of care, residing in an institution.

Total combined Medicare and Medicaid expenditures for the full benefit MMEs (excluding those enrolled in a Medicare Advantage plan) were \$3.1 billion in SFY 2010. As shown in Chart Q0, Medicaid pays the majority (69%) of the annual costs for MMEs. The total annual Medicare and Medicaid cost is slightly higher for the elderly versus blind individuals and those with disabilities (\$56,100 vs. \$50,200). The difference is largely driven by the Medicare expenditures. Medicaid pays a larger portion of the costs for blind individuals and those with disabilities (73%) compared to the elderly (66%). This difference is primarily driven by the predominance of beneficiaries with intellectual disabilities.

The average per-member-per-month (PMPM) Medicaid expenditures have been fairly stable over the past three fiscal years, with an overall annual average expenditure growth of -1.3% for blind individuals and those with disabilities and .3% for the elderly. Medicare expenditures have increased an average of 4.4% per year.

When examining the PMPM costs in SFY 2010 by eligibility group, blind individuals and those with disabilities' Medicaid and Medicare claims were \$3,067 PMPM and \$1,114 PMPM, respectively, and elderly individuals' Medicaid and Medicare claims were \$3,097 PMPM and \$1,580 PMPM, respectively.

The majority of the Medicare and Medicaid claims are for long term services and supports. Of the \$3.1 billion in combined claims for MMEs, roughly \$2.2 billion, or 72%, are related to long term services and supports (LTSS).

In the elderly population, the top service category is nursing home, which accounts for 46% of the total cost, while waiver services are the top service category for blind individuals and those with disabilities, which accounts for 38% of the total cost.

PMPM costs vary by disease category with those with intellectual disabilities having the highest PMPM costs and those with neurological disabilities having the second highest costs.

### C. Care Model Overview

#### i. Proposed delivery system model

##### Overview

Connecticut intends to integrate non-medical, medical, and behavioral Medicare, Medicaid and supplemental services for MMEs by building upon the strengths of its existing, statewide Administrative Services (ASO) structure (Model 1) as well as launching a new initiative, the Health Neighborhood (HN) (Model 2). MMEs who receive their primary care (including behavioral health care) from an HN participating primary care provider will be passively enrolled with that HN and participate in Model 2. All other MMEs (with the exception of those who are enrolled in a Medicare Advantage (MA) Plan, or are aligned with the Comprehensive Primary Care Initiative (CPCI) or an Accountable Care Organization (ACO) as of December 1, 2012), will remain attributed to Model 1. Both models will be informed by the applied practice of person-centeredness. Please see below for an overview and comparison of the features of Models 1 and 2.

	<b>ASO Services and Supports (Models 1 and 2)</b>
<b>Member Services</b>	Information and assistance including benefit information, referrals to specialists and adjunct supports, resolution of complaints and grievances. PCMH providers and HNs may have a greater role in supporting referrals to specialists and adjunct supports.
<b>Primary Care Support</b>	Quarterly attribution and distribution of MME rosters to all participating primary care and PCMH providers
<b>PCMH</b>	Medical ASO will support expansion of PCMH provider network and associated attribution and performance measurement,

<b>Quality Management</b>	ASOs will include MMEs in all quality management and quality improvement initiatives focused on such areas as chronic pain management, connection to aftercare, COPD and congestive heart failure, dementia, and diabetes.	
<b>Performance Incentives</b>	ASOs will receive performance payments aligned with overall performance goals of the Demonstration and HN specific performance measures.	
<b>Data</b>	<ul style="list-style-type: none"> <li>• Integrated Medicare and Medicaid predictive modeling data will be used to identify high-risk MMEs who could benefit from ICM services</li> <li>• Real-time transmission of inpatient hospital and emergency department data will be used to support timely outreach and care coordination</li> <li>• PCMH providers and HNs provided access to data analytic tools to support population health management and quality improvement</li> </ul>	
	<b>Model 1</b>	<b>Model 2</b>
<b>ICM</b>	ICM will be delivered by the ASOs using an electronic care plan instrument and communication tools specifically adapted for this purpose	ICM will be delivered through local, accountable multidisciplinary teams that include the MME and his or her preferred representative, a Lead Care Manager who has been selected by the MME, and the full range of providers, using an electronic care plan instrument and communication tools specifically adapted for this purpose
<b>Care Coordination</b>	Care coordination will include connections with local sources of care management (e.g. waiver care managers) and the fee-for-service network providers that are providing the care plan services and supports	Care coordination will include all HN providers that are supporting the MME (e.g. primary care, specialists, waiver staff, LTSS) and will feature a team-based approach that aims to address the totality of the MME's needs
<b>Supplemental Benefits</b>	None	<ul style="list-style-type: none"> <li>- chronic illness self-management education</li> <li>- fall prevention</li> <li>- nutrition counseling</li> <li>- medication therapy management</li> <li>- case management (e.g., housing assistance, linkage to vocations services)</li> <li>- additional supports (e.g. financial assistance with out-of-pocket prescription drug co-payments)</li> </ul>
<b>Performance</b>	Integrated data will be used to	Integrated data will be used to support HN performance measurement,

<b>Measurement</b>	support statewide performance measurement and reporting	reporting, and performance payments
--------------------	---	-------------------------------------

**Structural Context**

Two recently implemented structural features of the Connecticut Medicaid program will support the aims of the Demonstration: transition of medical services to an Administrative Services Organization (ASO) and implementation of the PCMH initiative.

Recognizing opportunities to achieve better health outcomes and streamline administrative costs, Connecticut has in recent years shifted management of its Medicaid behavioral health, dental and non-emergency medical transportation (NEMT) services to Administrative Services Organizations (ASOs). On January 1, 2012, Medicaid medical services were transitioned from a managed care infrastructure that included three capitated health plans and a small Primary Care Case Management (PCCM) pilot to a medical ASO. This extended state of art managed care services to the entire Medicaid and CHIP population. The medical and behavioral health (BH) ASOs provide a broad range of services, including: member support, ICM, predictive modeling based on Medicaid data, statewide and provider specific performance measurement and profiling, utilization management, and member grievances and appeals. The medical and BH ASOs will comprise Model 1. However, as shown above, the ASOs will also provide critical infrastructure to support Model 2.

The ASOs are provided with annual performance payments contingent on meeting access and quality standards. Historically, the Department has achieved its best results when ASO and provider performance goals are in alignment. For this reason, performance targets and payments for both ASOs will be aligned with the overall performance goals of the Demonstration and with the performance goals of the HNs.

The Department also implemented its PCMH initiative on January 1, 2012. The Department is investing significant resources, both financial and technical, to help primary care practices obtain NCQA PCMH recognition. Key features of practice transformation that support the goals of the Demonstration include embedding limited care coordination functions within primary care practices, capacity for non face-to-face and after hours support for patients, and use of interoperable electronic health records. All PCMH practices will receive performance payments in return for meeting care experience and quality targets. The Demonstration will extend the PCMH program and associated participation and performance payments to MMEs. The enhanced capabilities afforded by PCMH recognition will support the work of the ASOs, as direct service providers, and the HNs, as members of their networks.

**Intensive Care Management (ICM)/Care Coordination**

A key feature of both models will be assessment, coordination and monitoring of the care needs of MMEs. For purposes of the Demonstration, Intensive Care Management (ICM) will be directed at individuals in highest need of support; care coordination will serve those at moderate and low risk. Both ICM and care coordination will be provided through precepts of person-centeredness, which will be defined for purposes of the Demonstration as an approach that:

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

MMEs who are identified through predictive modeling or other means as in high need of support will receive ICM. For purposes of the Demonstration, ICM will be defined as including the following elements:

- a comprehensive face-to-face assessment of an MME's needs, addressing a broad range of domains;
- development of a plan of care that incorporates:
  1. the range of services and supports that is indicated by the assessment and to which the MME consents;
  2. short and long-range goals; and
  3. identification of family/caregivers, representatives and providers who will play a role in providing the services and supports.

MMEs who are not determined to be at high risk will, as needed, receive care coordination. For purposes of the Demonstration, care coordination reflects activities conducted by telephone or in person that are designed to support the needs of:

- moderate risk individuals with such tasks as transition planning assistance between settings, (e.g. acute care to a nursing home or home), transfer to a new PCP or other key provider, support in resolving a health crisis (e.g. broken hip); and
- low-risk individuals with such tasks as referrals to a specialist, and information on service options.

Individuals who are enrolled in an HN will have the opportunity to select a lead care manager of choice from among the network of participating HN providers. Individuals who do not participate in an HN and who are identified as in need of ICM will receive that service from an ASO nurse care manager.

An important element of operationalizing the ICM and care coordination features of Models 1 and 2 will be to link to, but not supplant, care management that is otherwise available to MMEs through existing systems. Examples of this include:

- care coordination and nursing oversight by Community Living Arrangement (CLA) staff of the Department of Developmental Services (DDS);

- recovery plans overseen by Value Options or Local Mental Health Agencies (LMHAs);
- home and community-based waiver care plans managed by waiver care managers (e.g. Connecticut Home Care Program for Elders, elder waiver; Personal Care Assistant, waiver for individuals with physical disabilities); and
- transition coordinators affiliated with the Money Follows the Person program.

### **Model 2: Health Neighborhood (HN)**

While the Department believes that Model 1 will bring value to MMEs, it is also convinced that enhancements to this model will best marry the interest in achieving improved health outcomes and care experience for MMEs with local accountability for means and costs of care. This is the key premise of Model 2, which will build upon the features of Model 1 by connecting MMEs with a neighborhood of their providers.

Model 2 reflects key aspects of what MME members of Demonstration focus groups reported as being of value and concern to them:

- that communication between doctors and other providers (e.g. social services, providers of durable medical equipment) is important and does not regularly enough occur;
- that there are many sources of formal and informal support (e.g. family, Resident Services Coordinators, visiting nurses) that help to connect them with services and supports;
- that continuity of care is key, although this is frequently described as being a problem;
- that it is important to know how to get help and how to make a complaint, if necessary; and
- that it would be helpful if doctors and other providers took a more holistic approach.

Model 2 will offer significant additional value to MMEs, including:

- a more personalized ICM and care coordination under the auspices of a Lead Care Manager who is chosen by the MME;
- provider networks that are connected through tools including care coordination agreements, electronic care planning and communication tools and a team-based care coordination approach; and
- supplemental benefits.

HN supplemental benefits will include the following:

- Fall prevention intervention will be provided to those MMEs identified by the HN through the comprehensive assessment as likely to benefit from such activities for reasons including, but not limited to, environmental/access concerns, poly-pharmacy, cognitive impairment, and physical health conditions affecting gait and balance.

- Nutrition counseling will be provided to those MMEs identified by the HN through the comprehensive assessment as likely to benefit from such activities for reasons including, but not limited to, chronic conditions, obesity/overweight/underweight, and social isolation. Nutrition counseling will be a contracted service of the HN, and could take such forms as education and counseling provided by the Cooperative Extension services of the University of Connecticut, individual sessions with a registered dietician, and/or incident to referral for home-delivered or congregate meals funded by the Older Americans Act.
- Medication therapy management (MTM) will be provided by pharmacists to those MMEs identified by the HN through the comprehensive assessment, self-referral and data mining activities that indicate poly-pharmacy or non-compliance with a prescribed medication regimen as well as co-morbid physical and behavioral health conditions. Medication therapy management will be a contracted service of the HN and will focus upon enhancing MMEs' understanding of medication compliance, increasing adherence, and preventing complications, conflicts and interactions. A potential means of providing this service is to purchase service from a collaborative operated by the University of Connecticut School of Pharmacy and the Connecticut Pharmacy Providers Association.

Further, the Department will encourage HNs to use a portion of their share of net savings to underwrite the costs of certain pharmacy cost sharing obligations that MMEs have identified through focus groups as barriers to accessing and affording needed pharmacy services. The Department believes that ensuring medication compliance through increased access and decreased financial barriers could result in significant improvements in quality and cost-effectiveness.

What will this mean in practice?

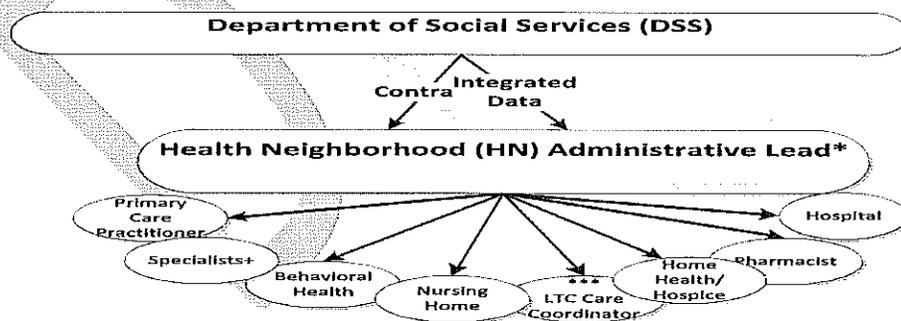
An older adult with COPD who lives alone and who has experienced multiple unexplained falls and associated hospitalizations within the past six months will be able to work with her Access Agency care manager and a team of providers (e.g. primary care physician, cardiologist, pharmacist, home health nurse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

A younger individual with diabetes and bipolar disorder will be able to enlist his Local Mental Health Agency (LMHA) care manager and a multi-disciplinary team to work on strategies for understanding his conditions and effectively managing them.

Providers that have historically had few opportunities and tools to do so will have means and opportunity to be in direct contact and to collaborate. Examples of this could include:

- connections between home care staff and pharmacist to address medication adherence on behalf of an MME who lives at home alone;
- connections between primary care physician offices, hospital discharge planners, Access Agency staff and providers of home and community-based long-term services and supports (LTSS) (home health, adult day care) in support of an MME who has been repeatedly hospitalized for breathing difficulties and is about to be discharged to her home; and
- connections between behavioral health providers and social services staff to help gain access to a rental subsidy that stabilizes an MME's housing and prevents the transiency that inhibits effective management of a chronic condition.

The Department, in partnership with its sister agencies DDS and DMHAS, plans to develop standards for and procure 3-5 HNs. Each HN will identify one or more Lead Agencies (e.g. medical, behavioral health providers), that will serve functions including administrative oversight, performance monitoring, coordination of provider members, identification of the means through which ICM and care coordination will be provided, and distribution of shared savings. As depicted in the graphic below, HNs will be comprised of primary care and physician specialty practices, behavioral health providers, LTSS providers, hospitals, nursing facilities, home health providers, and pharmacists.



\* Health Neighborhood Administrative lead TBD; may vary from neighborhood to neighborhood  
 + Specialists will vary based on the needs of the MME.  
 \*\*\* LTC Care Coordinator must have a high degree of knowledge of, and access to, the full range of LTC Support services including, but not limited to: chore, homemaker, Personal Care Attendant, Personal Emergency Response System (PERS) and all additional waiver services.

### **Geographic Service Area**

As previously stated, Model 1 will operate statewide. Model 2 will be introduced in 3-5 geographic areas, and may be expanded in the future.

### **Provider Networks**

A broad array of providers has participated in the planning phase of the MME Integrated Care Demonstration. For the first time, medical, behavioral and non-medical providers will under the Demonstration have not only motivation but financial incentives to partner in support of improved health outcomes and consumer satisfaction among MMEs.

During conversion to the Medical ASO, which necessitated centralizing administrative oversight and melding reimbursement rates, the Department was attentive to the need to engage with providers to retain its existing F-F-S network and to promote participation by new providers. Elements of these activities included streamlining the provider contracting process, making significantly more frequent on-site visits with providers, and issuing provider bulletins designed to clarify roles and responsibilities. The ASO also compiles access related complaints for use in identifying network gaps and targeting provider outreach activities. Under the Demonstration, the ASO will expand this function to include complaints from all participating MMEs. Launch of the PCMH initiative has also involved extensive outreach to providers to solicit applications for participation, and technical assistance by the ASO for practices along the "glide path" toward NCQA recognition.

The Department recognizes that it will also be necessary to provide technical support to providers as they come together to form Health Neighborhoods. This support will include development of clear procurement standards concerning provider participation; use of Medicare and Medicaid data to identify naturally occurring clusters of providers that serve MMEs in common; template contracts and care coordination agreements; technical guidance on anti-trust implications; and electronic communication tools.

A fulcrum point of both the Enhanced ASO and HN models is a provider network that has the range and depth of capacities necessary to respond to the totality of an MME's needs. Provider networks will be supported ongoing through the above activities, as well as through a "learning collaborative" approach that will enhance the capacity of providers to overcome historical "silos" of expertise and emphasis and recognize the applied value of a multi-disciplinary approach.

DDS and DMHAS, as well as other partners, will provide expert support in development of curriculum for and facilitating learning collaborative sessions. Examples of this include:

- benefitting from DDS', DMHAS' and Money Follows the Person Program's extensive experience with the applied practice of person-centeredness;
- on behalf of individuals with intellectual disabilities:

- exploring practice protocols for delivery of behavioral health services that do not immediately default to use of medication as compared to other strategies;
- identifying means of increasing access to and effective utilization of dental services;
- on behalf of individuals with SMI, training for providers in communicating with, understanding the capabilities and legal rights of, and effectively serving the needs of individuals with SMI.

**ii. Proposed benefit design**

The MME Initiative will encompass a benefit array that includes services covered by Medicare Parts A, B, and D, the Connecticut Medicaid State Plan and 1915(i) services, and the 1915(c) home and community-based waivers for which Connecticut has been approved. The ASOs will support the alignment of benefits under both models by using integrated data to review population and diagnosis-related trends; transmitting utilization and cost data to inform the practice of the fee-for-service providers and HNs who are supporting MMEs; and use of “learning collaboratives” to educate and connect clinicians and providers regarding the disconnects between Medicare and Medicaid. In addition to these activities, the HN model will support local alignment of benefits through team-based interdisciplinary care coordination. The Department intends to contract with a vendor to perform data integration services for the purposes of supporting alignment of benefits. Specifically, this will permit examination of Medicare and Medicaid claims data to determine which MMEs are at high risk and could most benefit from Demonstration interventions.

**iii. Description of new supplemental benefits**

Section C i details the supplemental benefits that will be provided under the Demonstration. These services will augment State plan services and the extensive array of Medicaid waiver services that are already in place for the seven 1915(c) waivers for which Connecticut has been approved in support of these populations: elders, individuals with physical disabilities, individuals with intellectual or developmental disabilities, medically fragile/technology dependent children, and individuals with acquired brain injuries (ABI). These waiver services expand upon and complement the Medicaid-covered home health services (e.g. nursing visits, home health, skilled therapies).

Connecticut’s waiver services vary by population and include in-home supports, community-based services, self-directed personal-care assistance, and residential and family supports. Specific services available to individuals with SMI under the mental health waiver include: assertive community treatment (ACT), community support program (CSP), peer support, recovery assistant, short-term crisis stabilization, supported employment, transitional case management, non-medical transportation, specialized medical equipment, and home accessibility adaptations. Services that support the needs of individuals with intellectual disabilities include: licensed residential services (community living arrangements, community training homes, assisted living), residential and family supports (supported living, personal support, adult companion, respite, personal emergency response systems, home and vehicle modifications), vocational and day services (supported employment, group day activities,

individualized day activities), specialized and support services (behavior and nutritional consultation, specialized equipment and supplies, interpreters, transportation, family consultation and support).

In addition to continuing to provide waiver services for the above populations, the Department has submitted a 1915(i) State Plan Amendment to extend the full complement of elder waiver services to a group of financially eligible individuals age 65 and older who do not meet nursing home level of care requirements.

#### **iv. Evidence-based practice**

The foundation of Connecticut's approach to enhancing its FFS system for MMEs is delivery of evidence-based coordinated care. Three key elements of this approach include:

- use of evidence-based data analytic methods to identify high-risk MMEs who can benefit from care coordination activities;
- use of chronic illness self-management training strategies that are supported by clinical evidence for MMEs with chronic conditions; and
- use of evidence-based measures to assess provider performance (please see Appendix F for examples).

The Department also recognizes, however, that person-centeredness in care coordination will require flexibility and individual tailoring of the approaches that are used. This may mean adapting evidence-based practice in a manner that furthers outcomes. Providers must be prepared to support consumers with complex needs in situations in which the consumer's preferred course of action diverges from established guidelines. This will involve applied aspects of person-centeredness (e.g. sharing clinical information in a manner that can be heard and understood by the consumer). Ultimately, consumers will be informed regarding their options for care delivery and will work with providers to drive all decision-making regarding their care.

#### **v. Context of other Medicaid initiatives and health care reform**

We anticipate that the Demonstration will be one of several initiatives that include MMEs with the goal of improving care experience, quality and cost. The other two initiatives include Medicare's ACO program and CPCI. The Department recognizes that a sub-set of the MME demonstration population could be attributed through the means described in the Shared Savings Program ACO Rule to Accountable Care Organizations (ACOs). While several Connecticut groups are in the process of ACO formation, none are likely to qualify as ACOs as of the start of the Demonstration. Accordingly, the Department's preference is that MMEs who have been attributed to the Demonstration remain attributed to the Demonstration throughout its three year term, even if such individuals receive their primary care from practices that become ACOs. If Connecticut is selected to be a participating market under CPCI, the Department expects that MMEs who have received their primary care services from one of the 75+ practices will be attributed to those practices. The Department will seek assistance from CMS to confirm whether MMEs have been attributed to CPCI practices so that overlap of beneficiary

participation does not occur. Further, the Department will identify and exclude any MMEs who are or become enrolled with MA plans at any time during the Demonstration.

The Demonstration will also enable the Department to include participating MMEs in its PCMH initiative. The Department will use an attribution model to align MMEs with participating PCMH practices in order to make advanced payments and performance payments on their behalf. Finally, as noted previously, the Demonstration will also enable highest and best use of 1915(c) HCBS and 1915(i) state plan amendment extension services for MMEs who meet functional participation criteria.

## **D. Stakeholder Engagement and Beneficiary Protections**

### **i. Stakeholder engagement during the design phase**

Over the last eight months, Connecticut has undertaken a robust stakeholder engagement process that has included legislators, consumers, advocates, family members and providers and has yielded substantive and actionable input on the design of the Demonstration. Stakeholder input has and will continue to be essential to the success of the Demonstration.

#### **a. Stakeholder meetings and active web site**

Key means of having engaged stakeholders include the following:

- The Department has made three formal presentations to and consulted ongoing with the Connecticut's Medical Assistance Program Oversight Council (MAPOC). The MAPOC was originally enacted to advise the Department on its Medicaid Managed Care program, but 2010 legislation expanded its oversight authority to encompass the entire Connecticut Medicaid program. MAPOC is composed of legislators, representatives of state agencies, and appointed individuals who reflect a broad range of consumer and provider interests. Minutes of meetings and materials presented to MAPOC are memorialized on its web site: [www.cga.ct.gov/ph/medicaid](http://www.cga.ct.gov/ph/medicaid). Please see Appendix C for a list of the MAPOC membership.
- The Department has worked regularly and directly with the MAPOC subcommittee of cognizance: the Complex Care Committee (CCC). MAPOC leadership charged CCC with oversight of the Department's planning process for the Demonstration. The CCC meets monthly, and provided advice, expert support and comment on each of the design features of the Demonstration. See Appendix D for a schedule of CCC meetings and topics covered.
- The Department also worked regularly and directly with three key work groups of the CCC (see Appendix D for a schedule of work group meetings):
  - The Model Design Work Group was charged with developing the overall Demonstration design including the responsibilities of contracted entities, infrastructure, reimbursement, enrollment, and relationship to other initiatives. Key points of concern for this work group included the methods of enrolling MMEs in HNs and sharing savings

with HNs. The Department sought to respond to these concerns by engaging Mercer to make two technical presentations (a webinar and an in-person meeting) on these topics.

- The Performance Measurement Work Group was charged with identifying performance measurement goals and objectives; developing a set of criteria to assess measures; reviewing a compendium of measures prepared by the University of Connecticut Health Center's (UCHC) Center on Aging; reviewing key issues and options for the selection of performance measures; and reviewing the results of surveys that were conducted with members of the CCC, Model Design Group and other stakeholders to prioritize measures. This Work Group was supported by an adjunct group of experts in performance measurement, which included two practicing clinicians. The Department presented a technical assistance webinar on performance measurement for stakeholders.

b. Additional Consumer input

Consumers and consumer advocates who are members of the CCC and its work groups provided valuable feedback on every aspect of the planning phase for the Demonstration. Additionally, the Department conducted 13 focus groups to gain additional learning on key topics from MMEs and their family members. These included:

- 8 focus groups with 71 participants age 65+; and
- 5 focus groups with 45 participants addressing the needs of younger individuals with disabilities (three groups including individuals with intellectual disabilities and their family members, one group including individuals with SMI, and one group including individuals with physical disabilities).

Participants varied by geographic location (Eastern, North Central, South Central, Southwest, and Western regions), location of care (community dwelling and nursing home residents), race, culture, language, and level of health risk. Approximately 10% of participants were family members of MMEs, 15% were nursing home residents, 60% were community dwelling individuals, and 15% were Spanish speakers. Community-based organizations and the Money Follows the Person Steering Committee assisted in identifying participants. Key themes of responses to focus group questions are noted throughout this application and also summarized in Appendix E.

c. Public Comment

Prior to the formal comment period in Connecticut, the Department shared the document with over 125 stakeholders to solicit comment. The Department held a meeting with the CCC on April 12th and the MAPOC on April 13<sup>th</sup> to discuss comments and incorporate stakeholder input prior to the issuance of the formal thirty-day comment period.

Connecticut has complied with all CMS requirements related to posting notice of the draft Demonstration proposal and inviting public comment for a thirty-day period. Connecticut published a

notice in the Connecticut Law Journal on April \_\_\_\_ announcing the proposal's public posting and inviting comment.

## ii. Beneficiary protections

The Demonstration will retain and expand upon the existing array of Medicare and Medicaid beneficiary protections. Further, the Initiative will establish customer service standards for the Medical and BH ASOs, HNs and clinicians/providers that will be providing education to and supporting the needs of participants. These will be developed in partnership with the Consumer Access Committee of the MAPOC and tested through consumer focus groups in partnership with DDS, DMHAS and other partners. Once vetted, the standards will be published in the form of a statement of beneficiary rights and responsibilities and also will be incorporated within operational requirements for both the Medical and BH ASOs and HNs. Requirements will reflect the Demonstration's express commitment to person-centeredness and will outline the means by which it must be applied in practice.

Beneficiary protections will include 1) strict adherence to existing statutory and State Plan requirements concerning beneficiaries' right of choice of provider; 2) right to participate in and to identify "next friend(s)" to join in participating in care planning; 3) right to receive care that is consistent with values and preferences; 4) statutory protections concerning rights of grievance, appeal and (Medicaid) fair hearing; 5) Health Insurance Portability Act of 1996 (HIPAA) rights concerning "protected health information" (PHI); 6) informed consent regarding release of PHI; 7) right of access to health records; 8) informed consent regarding participation in Intensive Care Management (ICM); 9) informed consent regarding participation in an HN, including disclosure of additional benefits of participation and financial incentives related to quality and cost; and 10) rights of accommodation, including, but not limited to, rights afforded by the Americans with Disabilities Act of 1990.

Enhancements to these protections will include liaising with CMS to assess the viability of establishing a unified grievance and appeals system to streamline and universalize the process through which MMEs address such issues as eligibility determinations and re-determinations, limitations on or denials of approval for services and supports, and termination of eligibility. This will model Affordable Care Act mandated changes in the Medicare program, which now require consistent methods and time frames for response to grievances, and have made uniform the levels of appeal across Parts A, B, C, and D [redetermination, reconsideration, Administrative Law Judge hearing, Medicare Appeals Council, federal court]. At a minimum, this could encompass: identifying a statewide Ombudsman entity through which grievances could be submitted; and using a standard appeals form that would initiate the process of appeal, irrespective of funding source, which could be internally tracked by the ASO or HN through either the DSS fair hearing process or Medicare appeals process, as applicable. The Department will require the ASOs to 1) inventory complaints, grievances and appeals; 2) detail responses/decisions; and 3) identify and address trends through staff training and member services protocols.

Further, the Department will establish clear standards for such customer services aspects as 1) outreach and education materials to guide MMEs who are considering whether to remain in an HN; 2) roles of the ASO and HN, respectively, in responding to MMEs' care and services-related inquiries and requests for

information and referral to clinicians or other providers; 3) means of providing language interpretation services; and 4) means of accommodating individuals with disabilities (e.g. TTY/TDD, accessible formats). DDS and DMHAS will partner with the Department to ensure that consumer materials are clear and accessible for individuals with intellectual disabilities and individuals with SMI.

Finally, the Department will implement safeguards to ensure that MMEs receive necessary care in support of good health outcomes and a high quality of care experience. These safeguards will include 1) provider standards; 2) provider education through learning collaboratives; 3) population-specific studies of outcomes; and 4) audits. DDS plans to work with the Department to identify additional means of ensuring that individuals with intellectual disabilities do not face discrimination or differential treatment.

### iii. Ongoing stakeholder input

The Department plans to utilize multiple means of obtaining continued feedback on the implementation and ongoing operation of the Demonstration. Formal feedback will be solicited through 1) monthly meetings of the MAPOC; 2) town hall meetings with MMEs and advocates to introduce the concept of the HNs; and 3) educational meetings with the broad range of provider associations that have participated in the planning period. Additionally the Department will continue provide progress reports and solicit input from the CCC and its Model Design, Consumer Protection, and Performance Measurement workgroups.

## E. Financing and Payment

### Section C Financing and Payment

#### State-level payment reforms and Payments to providers

Connecticut has designed an innovative and creative reimbursement structure to support accountability for care experience, quality and cost. The Models 1 and 2 have different financing and payment methods to recognize the differing program requirements.

##### a. Description of State level payment reforms and provider payment

The Department proposes to reform the traditional fee-for-service reimbursement approach by utilizing multiple payment streams, expanding upon the successful model developed by Connecticut in establishing its PCMH program. Each stream of payment is designed to reward providers for specific behaviors and the ability to address specific program requirements associated with the Demonstration while collectively offering a reimbursement design that rewards quality and cost-effective care delivery. Table 1 below outlines the timing of each payment stream and the type of reimbursement:

**Table 1: Payment Streams: Timing and Type of Reimbursement**

Component	Timing of Payment	Type of Reimbursement
1. Start-up Payment*	<i>Prospective</i> to assist with initial Health Neighborhood Infrastructure Development	<b>Model 2:</b> Lump-sum payment to Health Neighborhood Lead Administrator
2. Targeted Quarterly Payments	<i>Concurrent</i> to support advanced primary care activities provided by PCMH providers and for demonstration services provided by Health Neighborhoods	<b>Models 1 and 2:</b> APM I – Quarterly APM payments to PCMH  <b>Model 2:</b> APM II – Risk Adjusted Quarterly APM payment to designated Health Neighborhood Lead Administrator
3. Fee-For-Service (FFS) Payments	<i>Concurrent</i> for services provided	<b>Models 1 and 2:</b> FFS Payments per existing Medicare and Medicaid payment methods to Rendering Provider
4. PCMH and HN Performance Payments	<i>Retrospective</i> for certain quality and outcome targets as described by PCMH Performance Payment and HN Performance Payment Programs (HN)	<b>Models 1 and 2:</b> PCMH Performance payments: PMPM performance incentive and improvement payments.  <b>Model 2:</b> HN Performance Incentive lump-sum payment: Health Neighborhood payment based on measured care experience and quality, contingent on its achievement of savings

\* Only Health Neighborhoods meeting pre-established criteria will be eligible for Start-Up payments

Consistent with a managed fee-for-service environment, the main reimbursement mechanism will be fee-for-service payments based on the established Medicare and Medicaid payment methods for both Model 1 and Model 2. To address program requirements for PCMH and Health Neighborhood providers, the Demonstration will also make per member payments – APM I and APM II – for those members attributed to them. DSS will pay the APM I directly to the PCMH providers and APM II directly to the Health Neighborhood Lead Administrator, which will then be responsible for distributing the APM II to the “lead” Care Manager selected by the MME in the Neighborhood, less a percentage of the total fee for administration. Table 2 below provides the source of funding for, and a more detailed description of, each payment stream:

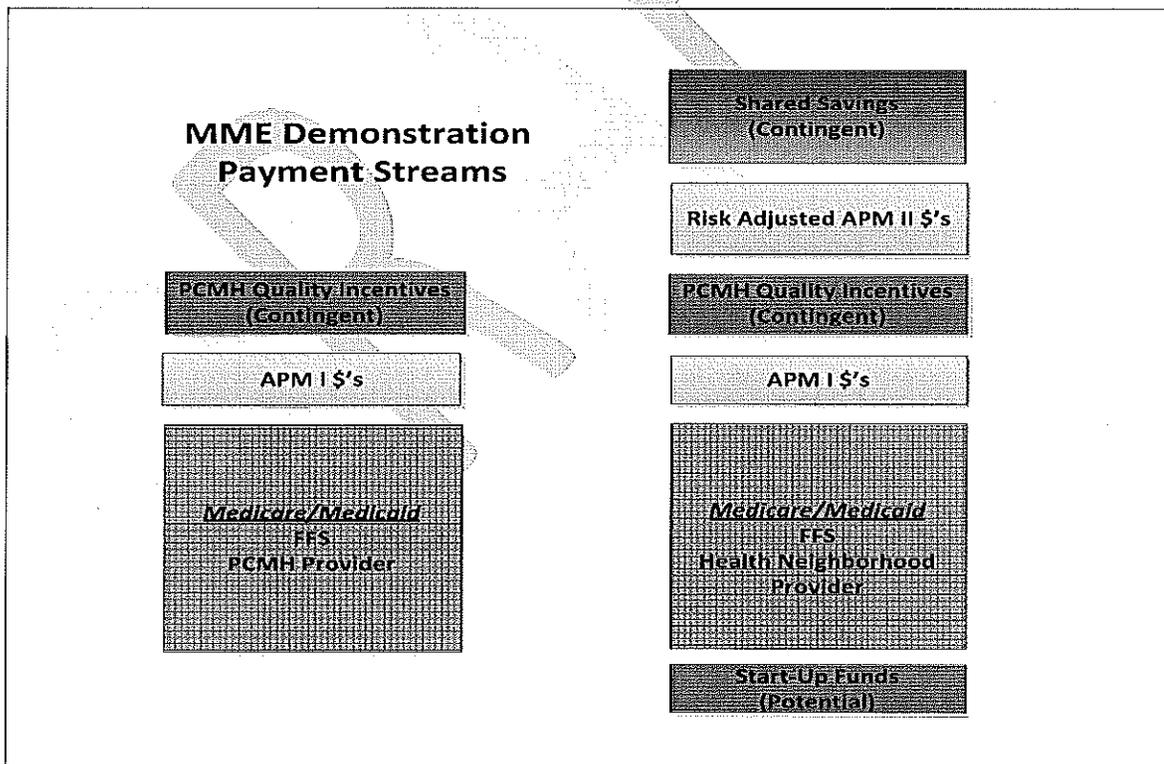
**Table 2: Payment Streams: Source and Description**

Payment Stream and Source of Funding	Description
<p><b>1. Start-Up Payment</b>   <u>Funding – State/Federal Administrative Matching Funds</u></p>	<p>The Demonstration will make available Start-up Supplemental Payments as a prospective payment to approved Health Neighborhoods only. The Demonstration intends the start-up supplemental payment to offset a portion of the costs associated with developing and implementing a Health Neighborhood.</p>
<p><b>2a. APM I</b>   <u>Funding – State/Federal Projected Savings</u></p> <p><b>2b. Risk Adjusted APM II</b>   <u>Funding – State/Federal Projected Savings</u></p>	<p>Connecticut is currently administering a PCMH program. PCMH qualified practices receive a combination of enhanced FFS and PMPM performance incentives. Connecticut anticipates converting this program from enhanced FFS to advanced bundled payments (APM1). This will be launched concurrent with the Integrated Care Demonstration. The Department will introduce APM I and will extend the PCMH program to the MMEs that participate in the Demonstration. This will be done for all qualified PCMH practices and all members aligned with these practices, whether or not they are participating with a HN.</p> <p>Connecticut will introduce risk-adjusted APM II under the Demonstration. This payment will bundle reimbursement for intensive care management, nutritionist consultation, pharmacist consultation, case management and chronic disease self-management education. APM II will be paid to HNs for MMEs aligned with the HNs. Extension to all MEs is under consideration.</p>
<p><b>3. FFS Payments</b></p>	<p>The Demonstration will utilize the existing Medicare and Medicaid payment methods</p>
<p><b>4a. PCMH Performance Payment Program</b>   <u>Funding – State/Federal Projected Savings</u></p> <p><b>4b. HN Performance Payment Program</b>   <u>Funding – State/Federal Actual Savings</u></p>	<p>The Demonstration will extend the state’s PCMH Performance Program to Demonstration participants. The program will reward providers for providing the highest quality care in the most efficient and effective settings. The payments will be based on PCMH-specific performance against benchmarks (performance incentive payment) and improvement (performance improvement payment) over time.</p> <p>The State will establish a Performance Payment Pool for each HN that will be jointly funded by a withhold from the targeted per member per quarter APM II and from savings determined based on the HN’s actuarially determined savings target. Distributions from the Performance Payment Pool will be made based on HN-specific performance against benchmarks (performance incentive payment) and improvement (performance improvement payment)</p>

Payment Stream and Source of Funding	Description
	<p>over time.</p> <p>Shared savings will be calculated by comparing risk adjusted PMPM amounts to actuarially sound PMPM benchmark targets for a comparable population. Included in the calculation of the actuarially sound PMPM targets will be Medical Cost Trend, Program Changes, Administration Expenses, as well as any offsets as a result of advanced payment.</p>

Table 3 below is a summary showing the Department's proposed payment approach in the Demonstration:

Table 3: Demonstration Reimbursement Structure Summary



Model 1 – ASO and PCMH

Model 2 – Health Neighborhood and PCMH

## F. Expected Outcomes

### i. Key metrics related to the Demonstration's quality and cost outcomes

Through the Demonstration, the Department and its stakeholders seek to: improve the health of individual MMEs and the health of MMEs as a population; improve MMEs' care experience; and control increases in (and where feasible, reduce) the costs of care. The Department seeks to improve quality of care and care experience both on a system-wide and individual provider level.

Specially, the Department intends to:

- use measures that are associated with identified domains to assess the impact of the Health Neighborhood (HN) and ASO model on MMEs as individuals and as a population;
- identify key strategies (provider array, care coordination, communication tools, etc.) that help to achieve person-centered, integrated care within ASO and the HNs ; and,
- identify the factors that support success and determine means by which the Health Neighborhood model can be expanded within Connecticut or other states.

The Department's plan for quality improvement will allow it to 1) analyze near-term trends; 2) make policy, program and operational adjustments within the Demonstration period; and 3) understand the impact of the Demonstration over time. The strategy supports the Department's overall goal of achieving measurable value for its purchasing dollar for this population. This work will augment CMS's formal evaluation.

To meet these aims, the Department will contract with a Performance Measurement vendor to 1) validate and confirm the realizability of the identified measures; 2) offer operational guidance on use of the identified performance measures; and 3) make recommendations on an overall strategy to evaluate Demonstration performance.

The Department's will also contract with an evaluator to 1) conduct studies and surveys, including, but not limited to a goal-oriented patient care study<sup>1</sup>; 2) conducting annual focus groups with MMEs; 3) analyze data from the Connecticut Health Information Exchange; and 4) use integrated person-specific Medicare and Medicaid claims data to make comparisons on population- and diagnosis-specific bases as well as to identify interrelationships, potential for duplication and occurrence of cost shifting as between Medicare and Medicaid.

### ii. Potential improvement targets

In support of development of the Demonstration, the Department engaged in an extensive stakeholder process, described in Section D. i., to identify key performance measures to assess ASO and Health Neighborhood performance. Stakeholders used criteria including relationship to the goals of the Demonstration, emphasis on quality, and ease of implementation to select measures from among a list of 122 evidence-based, measures. During the implementation phase of the Demonstration, the Department will obtain additional input from stakeholders and clinicians, in support of selecting 10 to 12 key quality performance measures from this larger list. Those performance measures that are not

selected as key will likely be used as required reporting measures. The initial list of selected performance measures is included as Appendix F.

### iii. Expected impact on Medicare and Medicaid costs

Under Model 1, the State will use the ASO to better manage care for a large population of MMEs at the statewide level. The primary tools for improving management will be data analytics and intensive care management (ICM). Since hospital and physician services are paid for directly by Medicare and are exempt from prior authorization, the ASO will be limited in its ability to reduce costs, so it is planned only as a transitional approach.

Through Model 2, the State believes that there will be greater incentives to reduce waste (e.g., reduced incentive to order unnecessary tests or procedures) and duplication (e.g., reduced incentive to order duplicative tests) and efficiencies (e.g., phone/e-mail communication with patient or caregiver in lieu of office visits).

The identified savings generated from four key areas of intervention include: 1) reduced hospital inpatient readmission rates; 2) reduced inpatient hospital admission rates for potentially preventable hospitalizations; 3) reduced unnecessary emergency department (ED) use; and 4) re-balancing to more community based care.

- 1) Hospital readmissions are frequent and costly events, particularly to Medicare. Recent Dartmouth Atlas statistics show that "roughly one in six Medicare patients wind up back in the hospital within a month after being discharged for a medical condition." The issue is even more pronounced for MMEs. In Connecticut, almost 29% of MMEs (aged and disabled) in the state fiscal year 2010, were re-hospitalized within 30 days following a discharge, and almost 10% were re-hospitalized within 7 days following a discharge. Most prevalent diagnoses for the readmissions were for shortness of breath, DM uncomplicated Type II, chest pain and abdominal pain. Research suggests that hospital readmission rates can be reduced through improved transitional care planning, timely follow-up care and persistent treatment of chronic illnesses. *We estimate that a 3.7% reduction in hospital re-admissions is achievable in SFY13 increasing to 8.25% in SFY10 and would represent \$100M in total SFY13-15 savings.*
- 2) Increased care management and the delivery of timely, effective ambulatory care are also expected to result in reduced frequency of potentially preventable hospitalizations. A CMS Policy Insight Report on Dual Eligibles and Potentially Avoidable Hospital Conditions, (June 2011) showed that 26% of hospital admissions for MMEs were for potentially preventable conditions. Connecticut results were consistent with the national results of the CMS study, with over 27% of duals having an acute care episode being the result of potentially preventable conditions. Common conditions included asthma, congestive heart failure, bacterial pneumonia, urinary tract infection, and dehydration. *We estimate that a 3.7% reduction in hospital re-admissions is achievable in SFY13 increasing to 8.25% in SFY10 and would represent \$100M in total SFY13-15 savings.*

- 3) Research has also shown that PCMH models and increased care management results in lower use of emergency care as high frequency emergency department (ED) patients are targeted for interventions and patients without a medical home seek low acuity non-emergency care in the physician's office rather than the ED. For example, in Connecticut, the average number of outpatient ED encounters for MMEs with chronic conditions is 3.7 per year for individuals with disabilities and 2.3 for the elderly population. *We estimate that hospital savings of 15% in SFY13 increasing to 24% in SFY15 could be achieved through managing the number of emergency visits, resulting in cumulative savings from SFY14-SFY15 of \$6.5M.*
- 4) MMEs in Connecticut are more likely to be Institutionalized compared to most other states. There is historical evidence of this in a Direct Care Alliance Policy Briefing (April 2010) that reported Connecticut's percentage of long term care Medicaid recipients in HCBS in 2006 to be 25%, which was more than 20% below the average of all states. Connecticut believes there is a significant opportunity for savings through re-balancing of the percentage of nursing home certifiable (NHC) MMEs that are institutionalized. Connecticut currently has 52% of its NHC MME population in the institutional setting, based on SFY 2010 data. This is estimated to reduce by 4% over the next three years. *This 4% shift in setting for this subset of MMEs would represent \$180M in total savings between SFY13-SFY15.*

In total, estimated annual savings related to the activities described above, as well as savings related to other activities that are less impactful from a savings standpoint, are: Year 1, 2.1%; Year 2, 5.4%; Year 3, 6.8%.

Connecticut has also developed quality measures that may produce additional sources of savings. These are in the areas of person-centered care, care transitions, medication management, prevention, behavioral health, palliative and end of life care, clinical care, access to care, functional status measures, and quality of life. Among these measures, medication management is one area that is expected to generate medical savings through reduction in poly-pharmacy use, offset by an improvement in medical adherence which could decrease hospitalizations and acute care expenditures under Medicare.

The current lack of integration between Medicare and Medicaid fosters cost-shifting and underinvestment. The lack of alignment between Medicare and Medicaid coverage rules creates incentives for providers to shift costs by transferring patients from one service or setting to another. For example, in Connecticut, elderly MMEs receiving home and community based services are more costly to Medicare (\$2,086 PMPM) than their counterparts residing in an institution (\$1,709 PMPM). This may create an incentive to promote institutionalization of elderly MMEs in order to reduce Medicare costs. In addition to not serving members in the best way possible, this shifting increases both state and federal spending over time. The effects are an underinvestment in these important cost-effective services, missed savings potential and missed opportunities to better coordinate care and improve health outcomes for members.

## G. Infrastructure and Implementation

### i. State infrastructure/capacity to implement and oversee the Demonstration

In partnership with its sister agencies DDS and DMHAS, Department will have primary accountability for implementation and oversight of the Demonstration. Key areas of internal support include the Division of Medical Care Administration (MCA), the Division of Financial Management & Analysis (DFMA), the Office of Legal Counsel, Regulations and Administrative Hearings (OLCRAH), and the Office of Organizational Skill & Development (OSD). Further, contractors that are currently in place will support the Initiative with administrative and consulting functions including claims processing (HP); data integration (JEN); actuarial analysis and consultation on implementation (Mercer), and consultation on implementation (Optumas). Additionally, the Department will utilize and build upon the existing capacities of its Medical (CHN-CT) and (in partnership with DMHAS) Behavioral Health (Value Options) ASOs, develop its nascent partnership with the Connecticut Health Information Exchange (HIE), and work with academic partners and other partners including the University of Connecticut to refine proposed methods of performance measurement. Finally, the Department intends to contract for additional services in support of the Initiative, including 1) enrollment-related services in support of participants of Health Neighborhoods (HNs); and 2) development and implementation of a project evaluation protocol that will complement reporting of data on quality measures with additional means of evaluating success (e.g. targeted surveys, focus groups).

The Department has received Medicare data from CMS and through contractor JEN has completed initial integration of the same with Medicaid data in support of producing a data profile of Connecticut MMEs. The Department intends to continue to contract with Jen for the more extensive data integration activities that will be required to support the Initiative.

Entity		Current Role	Anticipated/Enhanced Role
DSS			
	MCA  Director, Associate Directors, Medical Director, Director of Medical Care Management, Planning Specialist, Health Program Associate	MCA has directed the overall application development, coordinated state agency involvement, and convened and facilitated the process by which a broad array of stakeholders has contributed to development of model design and shared savings method.	MCA will: <ul style="list-style-type: none"> <li>• provide overall administrative oversight</li> <li>• draft RFP standards and qualifications for HNs</li> <li>• establish contract scope and deliverables for ASOs and HNs</li> <li>• procure HNs and administer HN contracts</li> <li>• oversee evaluation of the Initiative</li> <li>• oversee implementation of value-based purchasing strategy including provider reimbursement and</li> </ul>

			performance measurement.
	DFMA Director Financial & Contract Support Services Unit	DFMA has assisted in the preparatory process by modeling fiscal impact and providing oversight of budget development and actuarial work.	DFMA will provide oversight of actuarial work in support of shared savings calculations.
	OLCRAH Director Staff Attorneys	OLCRAH is instrumental in supporting MCA with SPAs and waivers, and is accountable for oversight of MME grievance and appeal processes.	OLCRAH will support MCA in 1) drafting and submission of any required waivers of Medicaid rules; 2) drafting of MME rights and responsibilities materials; 3) in conjunction with the entity designated as Ombudsman, development of uniform grievance and appeals form; and 4) ongoing administration of MME grievance and appeal processes.
	OSD Director Production and media staff	OSD supports MCA in development of consumer materials.	OSD will support MCA in drafting and focus group testing of consumer education materials regarding 1) rights and responsibilities; 2) participation in an HN; and 3) grievances and appeals.
Administrative Contractors/ Consultants			
	HP	HP is responsible for processing of Medicaid claims.	Same.
	Mercer	Mercer is contracted to perform a range of actuarial services functions for the Department. Mercer has undertaken all of the data analytic work to support the application. Additional key areas of focus have included review of shared savings methods used by other integrated care initiatives and technical support to the Complex Care Committee in reviewing the Department's proposed method.	Mercer will be responsible for <ul style="list-style-type: none"> <li>actuarial work to support establishment of risk-adjusted ASO and HN budget targets and associated savings calculations based on actual expenditures;</li> <li>development of APMs for both PCMH and HN participants; and</li> <li>calculation of performance incentives.</li> </ul>

	<p>Mercer Optumas Health Policy Matters UCONN JEN Associates</p>	<p>Mercer, Optumas, Health Policy Matters, UCONN and JEN Associates are contracted to support application development and associated projects including focus groups, stakeholder input, performance measurement, data integration, data analysis, and overall model design.</p>	<p>Consultants will provide support to the Department on various aspects of implementation, including:</p> <ul style="list-style-type: none"> <li>• development of protocols in support of administrative structure/roles and responsibilities of Department/ASO/HNs/providers</li> <li>• technical specifications for performance measurement</li> <li>• data integration</li> </ul>
	<p>CT HIE</p>	<p>The CT HIE expects to become operational in May, 2012. Staff has been advising the Department on best practices for linkage of ASOs and HNs to the HIE.</p>	<p>The Department intends to partner with the CT HIE to connect the ASOs and the HNs to the HIE's communication tools and data capabilities.</p>
ASOs			
	<p>CHN-CT/ Value Options</p>	<p>The ASOs currently serve administrative, data analytic, predictive modeling, care management, member service, provider support and technical assistance functions. The medical ASO also collects data to support PCMH performance measurement and payments</p>	<p>The ASOs will continue to provide all listed functions. Further, the ASOs will be asked:</p> <ul style="list-style-type: none"> <li>• to expand their capacity to provide ICM by contracting for sufficient additional nurse care managers to support the incidence of MMEs identified through predictive modeling as at high risk;</li> <li>• to modify an existing electronic care planning tool to reflect a person-centered approach</li> <li>• to utilize the identified electronic care coordination tool and associated provider/member alert function to further communication and to support mutuality in development of care plans;</li> <li>• to collect data to support evaluation of statewide ASO model participants on HN</li> </ul>

			<p>performance measures; and</p> <ul style="list-style-type: none"> <li>to collect data from HNs and evaluate HN performance on identified Demonstration measures.</li> </ul>
Contractors			
	<p>Data integration</p> <p>JEN</p>	<p>The Department has received Medicare data from CMS and has through an initial data integration process produced a data profile of MMEs' service utilization and diagnostic/demographic features.</p>	<p>The Department intends to continue to contract with JEN to perform data integration services in support of the ASOs and the HNs.</p>
	<p>Enrollment counseling/payment of APM II</p> <p>ACS</p>	<p>N/A</p>	<p>The Department intends to contract with a neutral vendor (ACS) to provide counseling to MMEs who are assigned through a passive enrollment process to an HN. This counseling process will outline MMEs' option to decline to participate in an HN. Further, ACS will make APM II payments to HNs.</p>
	<p>Project evaluation protocol</p>	<p>Initial preparatory steps in support of project evaluation have included development of selection criteria for and refinement of a set of measures of quality that will be associated with performance incentives. This has been conducted by UConn, a group of expert stakeholders, and a work group of the Complex Care Committee.</p>	<p>The Department intends to contract with a vendor to outline a protocol for project evaluation that will complement reporting of data on quality measures with additional means of evaluating success, such as:</p> <ul style="list-style-type: none"> <li>cost measures; and</li> <li>means of evaluating consumer satisfaction (e.g. CAHPS survey, focus groups).</li> </ul>

ii. **Need for waivers**

Connecticut will continue to administer the service array for which it has been approved under State Plan authority as well as authority related to the 1915(c) waivers. It will seek a 1915(i) state plan amendment to provide LTSS for individuals over age 65 years who do not meet institutional level of care criteria. The Department will continue to work with CMS to identify any additional authority necessary to implement its proposal to administer APM II payments to HNs and to share savings with HNs.

iii. **Plans to expand to other populations and/or service areas**

The Demonstration will serve MMEs age 18 to 65, and age 65 and older. The populations served will include individuals with Serious and Persistent Mental Illness (SPMI) and individuals with Developmental Disabilities. Participation of MMEs in the ASO model will be statewide. Participation of MMEs in HNs will be limited service areas of the HNs.

HNs will be launched on a pilot basis and tested against performance and savings measures. The Department then plans to use the knowledge gained in this pilot period to expand the initiative to serve additional MMEs and also potentially to expand the model to serve single-eligible individuals (MEs).

iv. **Overall implementation strategy and anticipated timeline**

The Department will in partnership with DDS and DMHAS employ an implementation strategy that systematically addresses overall Demonstration requirements, ASO requirements and Health Neighborhood requirements. Overall direction in developing and implementing the Demonstration will be provided by a Steering Committee comprised of the Department's Medical Care Administration Executive Team; representatives of the behavioral health, medical operations, dental, pharmacy, Money Follows the Person and HCBS waiver programs; DDS and DMHAS; and consumers.

The Department plans to build upon the current infrastructure and capabilities of its current Medical and BH ASOs to serve MMEs. Further, the Department plans to procure three to five (3-5) HNs, to be overseen by HN Lead Agencies, which will serve the needs of MMEs that elect to participate within established geographic service regions. Additionally, the Department plans to procure data integration and analytics support, as well as a means through which to provide electronic communication tools to members of HNs (the Connecticut Health Information Exchange, HIE). Finally, the Department plans to engage a performance measurement contractor through which to assess the success of the Initiative.

Implementation steps associated with enhancing the current ASO model include 1) establishing an applied definition of ICM; 2) defining standards for beneficiary protections and customer service; and 3) evaluating and establishing role definition for data analytics and electronic communication tools as between the ASOs, HNs and the HIE. Correspondingly, implementation steps associated with procuring the HNs include 1) continued community outreach and engagement to facilitate partnerships among providers; 2) education concerning the model; 3) drafting and issuance of an RFP that defines such features as scope, role of and standards for Lead Agencies, participation standards, reporting, performance metrics, and shared savings mechanism; 3) issuance of the RFP and procurement process; 4) selection of HNs and contracting; and 5) technical support for HN implementation. Further, the

Department plans to draft and disseminate consumer education and rights and responsibilities materials, as well as to draft and issue notices to MMEs and providers regarding the Initiative. Principles of person-centeredness will inform every stage of implementation of the Demonstration, and the Department will use diverse means (stakeholder comment, participant focus groups, provider learning collaboratives) to inform the operations plan.

## H. Feasibility and Sustainability

### i. Potential barriers, challenges and/or future State actions that could affect implementation

The Department has identified, and is proactively managing, potential barriers and challenges that could affect timely implementation. Specific potential barriers and challenges include the following: 1) resource constraints; 2) consumer participation in Health Neighborhoods (HN); 3) provider participation in HNs; and 4) lack of linkages among medical, behavioral and non-medical LTSS providers.

**Resource Constraints.** The State of Connecticut is through this Demonstration application requesting \$\_\_\_\_\_ to support implementation. While the State will be dedicating significant financial and in-kind support to this effort, CMS funding will represent an essential support for effective implementation of new model design and value-based purchasing strategies.

**Consumer Participation in HNs.** In order to meaningfully measure results and to achieve system change, the Department estimates that each Health Neighborhood must serve at least 5,000 MMEs. The Department is proposing to attribute MMEs who have received their primary care (including behavioral health care) from a HN provider to that HN. Consistent with individual choice, however, an MME will have the option to elect not to participate in the HN. If there is a significant incidence of opt-out, HN could fall short of the necessary participation levels. The Department intends to address these concerns through use of enrollment counseling and related consumer education materials.

**Provider Participation in HN's.** Related to the above concern, each HN must have robust participation by the full array of medical, behavioral and non-medical providers. Providers may struggle to understand where they fit in across a landscape that will include ACOs and CPCI practices. The Department intends to address these concerns and to promote participation by: 1) publishing provider standards as an element of its RFP to procure HNs; 2) provider transmittals; and 3) meetings with provider associations.

**Lack of Linkages Among Providers.** In order to form an HN, providers must develop care coordination and shared savings agreements with providers across the spectrum of medical, behavioral and non-medical providers. Historically, there have been few opportunities to enter into multi-disciplinary care coordination arrangements. Further, shared savings is a new concept in Connecticut. The Department intends to address this issue by: 1) publishing standards for provider agreements regarding care

coordination and shared savings in its RFP to procure HNs; and 2) hosting learning collaboratives designed to help develop relationships across the continuum.

**ii. State statutory and/or regulatory changes needed to move forward with implementation**

The Department does not anticipate that any statutory or regulatory changes will be needed to implement the Demonstration. In 2011 the Department was authorized by the Connecticut legislature to implement the Demonstration. Section 110 of P.A. 11-44 provided, in relevant part:

(b) The commissioner may implement policies and procedures necessary to . . . (2) pursue optional initiatives authorized pursuant to the Patient Protection and Affordable Care Act, P. L. 111-148, and the Health Care and Education Reconciliation Act of 2010, relating to: . . . (F) the establishment of a dual eligible demonstration program.

**iii. State funding commitments or contracting processes necessary before full implementation**

The Department has outlined its plans for procurement of Health Neighborhoods and contracting in support of operationalizing the Demonstration in the Work Plan that is featured in Appendix A.

**iv. Scalability of the proposed model and its replicability in other settings or states**

The Department anticipates that its overall model design, featuring ASO and HN configuration, will be scalable in the future to serve additional MMEs and also Medicaid Eligible individuals. Key structural elements that will support expansion include use of one predictive modeling tool for all participants that incorporates Medicare and Medicaid claims data, a universal care plan document, electronic health record and communication tools, and flexibility to expand the network of provider participants.

The Department anticipates that both its overall value-based purchasing strategy and ASO and HN model design will be replicable and of interest to other states as an alternative to a managed system of care. Connecticut's value-based strategies include 1) administrative integration; 2) the use of local care delivery arrangements to integrate all Demonstration services and supports and to improve the MME's care experience; and 4) use of HN performance payments to promote quality of and improved experience of care.

**v. Letters of support**

Please find letters of support attached in Appendix B.

**I. CMS Implementation Support – Budget Request**

Please find budget request attached in Appendix

## J. Additional Documentation (as applicable)

Connecticut will provide additional documentation at CMS's request.

## K. Interaction with Other HHS/CMS Initiatives

By improving care coordination and appropriate follow up care during care transitions, the **Partnership for Patients** seeks to reduce hospital readmissions. In Connecticut, almost 29% of the duals population (aged and disabled) in the state fiscal year 2010, were re-hospitalized within 30 days following a discharge, and almost 10% were re-hospitalized within 7 days following a discharge. The ASO/HN model of care will direct primary care providers to: (1) improve communication with inpatient providers in order to be informed when their patients are admitted to an inpatient setting; (2) communicate with the inpatient provider about the patient's care and discharge; and (3) follow up in a timely manner post-discharge; and (4) develop and implement a patient-centered care plan. Through these practice reforms, Connecticut expects to improve patient care and reduce hospital readmissions.

Building on recent efforts by the Department of Public Health's Office of Multicultural Health to comprehensively evaluate health disparities in the state, Connecticut plans to reduce disparities in line with HHS' **Action Plan to Reduce Racial and Ethnic Health Disparities**. Connecticut has leveraged a grant from the National Academy of State Health Policy to engage policy makers in Equity Learning Collaboratives, with a focus of maximizing Medicaid participation by minority populations and improving the transition to PCMHs. In 2011, the Connecticut Health Foundation joined this effort with a \$100,000 grant to integrate racial and ethnic health disparities identification and reduction into the PCMH planning and implementation process.

The **Million Hearts Campaign** aims to reduce the rates of heart disease and stroke by targeting the "ABCS" strategy - Aspirin for people at risk, Blood pressure control, Cholesterol management and Smoking cessation. As one of eight states to receive funding under the Medicaid Incentives for Prevention of Chronic Disease grant program, Connecticut is in the process of implementing iQuit, a tobacco cessation program that utilizes counseling, peer coaching, and other techniques. The Demonstration will use the ASO/HN model to provide care management and care coordination in order to effectively monitor health indicators, treat high-risk patients, and prevent heart disease. Referral to community and social services will be used to offer additional support and access to tobacco cessation programs such as iQuit.

# Appendices

---

DRAFT

## Appendix A. Workplan and Timeline

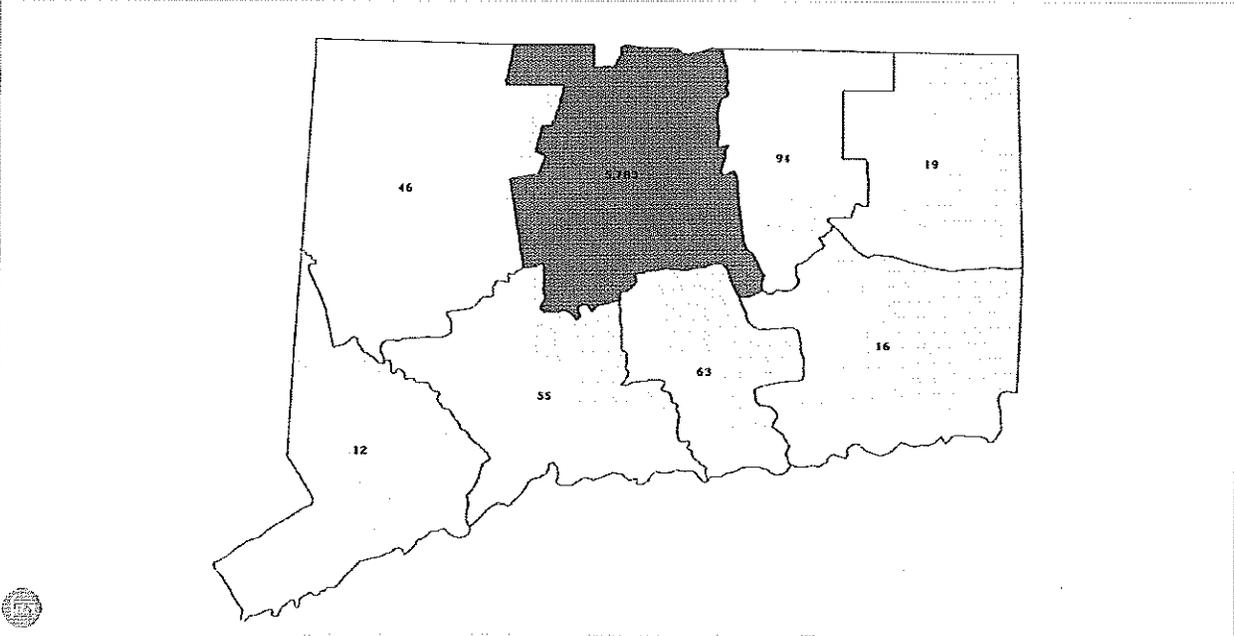
Timeframe	Key Activities/Milestones
April, 2012 – May, 2012	<p>Solicit comments on proposal</p> <ul style="list-style-type: none"> <li>• obtain key stakeholder comment on draft proposal (Medical Assistance Program Oversight Council, Complex Care Committee)</li> <li>• conduct formal public comment period</li> <li>• incorporate comments prior to submission to CMS on May 29, 2012</li> </ul>
May, 2012 – June, 2012	<p>Develop and implement operational standards for ASO model</p> <ul style="list-style-type: none"> <li>• outline member support services</li> <li>• define and develop protocols for person-centered Intensive Care Management (ICM)</li> <li>• establish data collection, analysis and reporting requirements</li> <li>• establish protocols for collection of performance data from HNs</li> </ul>
May, 2012 – June, 2012	<p>Develop and implement operational standards for HN model</p> <ul style="list-style-type: none"> <li>• outline roles and responsibilities regarding enrollment (ASO, HN, enrollment counseling contractor)</li> <li>• define and develop standards for multi-disciplinary ICM and provider communication</li> <li>• identify reporting responsibilities</li> </ul>
June, 2012 – August, 2012	<p>Develop and implement operational standards for exchange of electronic health information</p> <ul style="list-style-type: none"> <li>• outline roles and responsibilities (ASO, HN, Health Information Exchange)</li> <li>• define and establish protocols for required waivers, protection of privacy and opt-out</li> <li>• establish incremental plan to enhance interoperability of EHR</li> </ul>
May, 2012 – July, 2012	<p>Develop and implement reimbursement methodology</p> <ul style="list-style-type: none"> <li>• conduct actuarial analysis of and calculate prospective infrastructure support (if any), advance payment methodology, shared savings methodology</li> <li>• select risk adjustment methodology</li> <li>• identify roles and responsibilities for making payments (Department, ASO, ACS)</li> </ul>
May, 2012 – June, 2012	<p>Conduct HN procurement</p> <ul style="list-style-type: none"> <li>• develop and issue procurement</li> <li>• evaluate procurement responses and select successful HNs</li> </ul>

	<ul style="list-style-type: none"> <li>• contract for HN services based on the procurement requirements</li> <li>• conduct Health Neighborhood readiness review</li> <li>• implement Health Neighborhoods</li> </ul>
May, 2012 – July, 2012	<p>Develop and implement overall performance evaluation plan</p> <ul style="list-style-type: none"> <li>• work with expert and stakeholder groups to refine initial selections of metrics</li> <li>• work with contractor to define measures, expected outcomes and targets for each metric</li> <li>• implement various elements of performance evaluation strategy, including reporting, surveys, consumer focus groups</li> </ul>
July, 2012 – August, 2012	<p>Develop and seek comment on member rights and responsibilities</p> <ul style="list-style-type: none"> <li>• ASO participation</li> <li>• HN participation</li> <li>• Opt-out of HN participation, information sharing, ICM</li> <li>• Grievances and appeals</li> </ul>
July, 2012 – August, 2012	<p>Develop and implement member communication plan</p> <ul style="list-style-type: none"> <li>• draft and seek comment on member outreach materials (e.g. description of Demonstration, overview of HN participation)</li> <li>• establish standards and protocols for contracted enrollment counseling</li> <li>• draft and seek comment on Intensive Care Management (ICM) materials (e.g. care plan, member rights and responsibilities, disease management and self-care materials)</li> <li>• translate materials into primary languages of origin</li> </ul>
May, 2012 – December, 2012	<p>Draft and implement provider engagement plan</p> <ul style="list-style-type: none"> <li>• conduct educational sessions across the provider continuum</li> <li>• present “learning collaborative” sessions</li> </ul>
September, 2012 – December, 2012	<p>Collaborate with CMS to develop and finalize the Demonstration</p> <ul style="list-style-type: none"> <li>• develop comparison group methodology</li> <li>• identify any waivers that are needed</li> <li>• negotiate terms of the proposal with CMS</li> <li>• enter Memorandum of Understanding (MOU) with CMS by early September</li> <li>• enter Final Agreement with CMS by mid-October</li> </ul>
December 1, 2012	<p>Launch Demonstration</p>

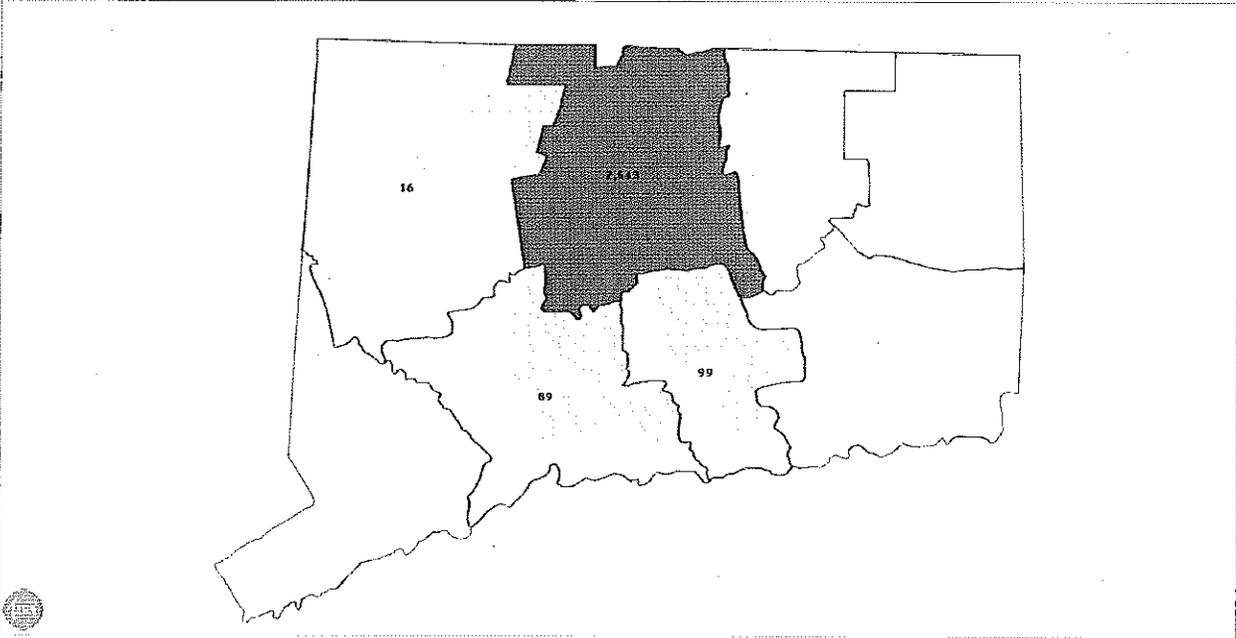
Appendix B. Cluster Maps

Connecticut's Largest 7 Health Neighborhoods (non ACO PCPs)

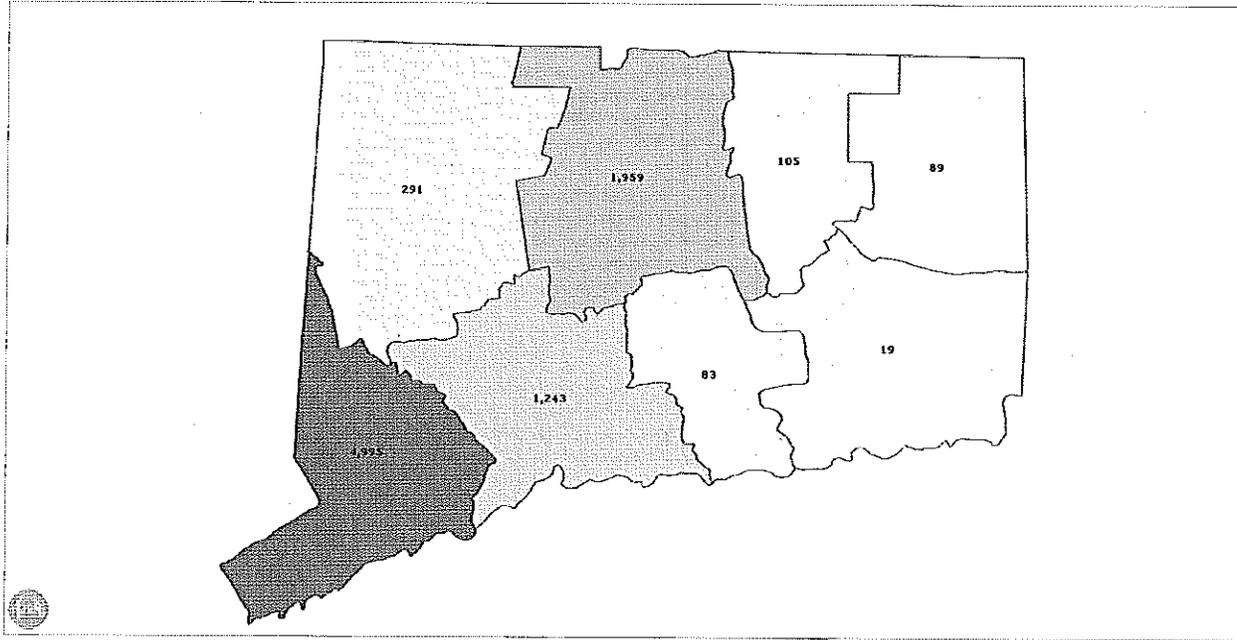
North Central--A (St Francis Hospital, Cluster #16)



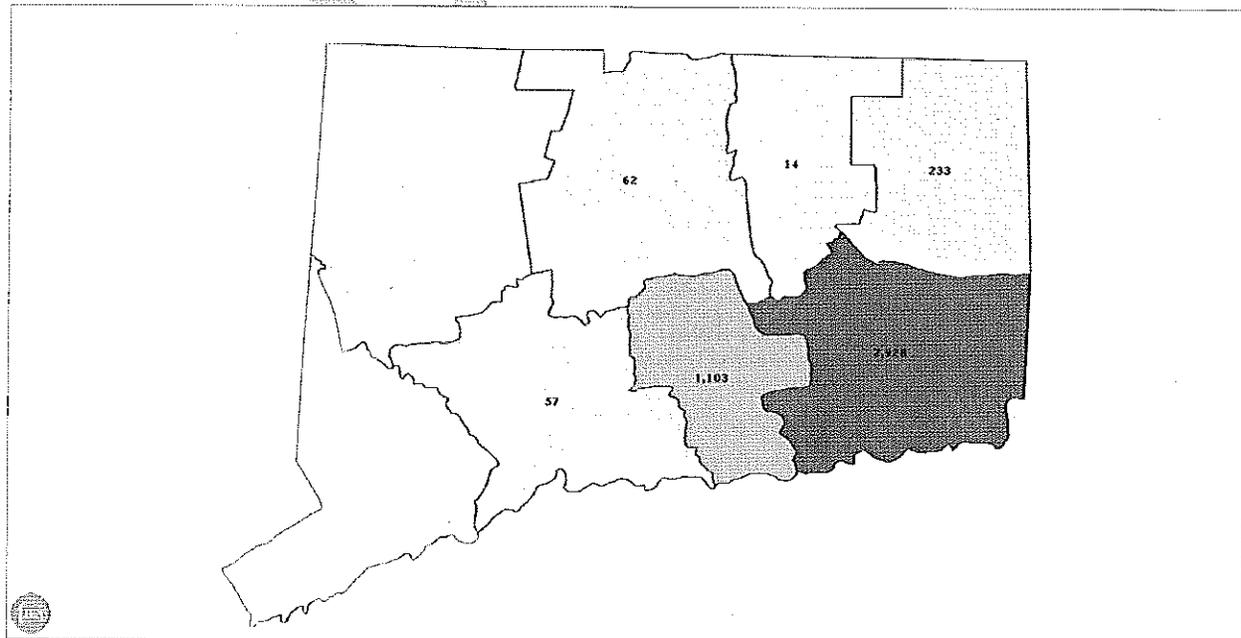
North Central--B (New Britain Hospital, Cluster # 19)



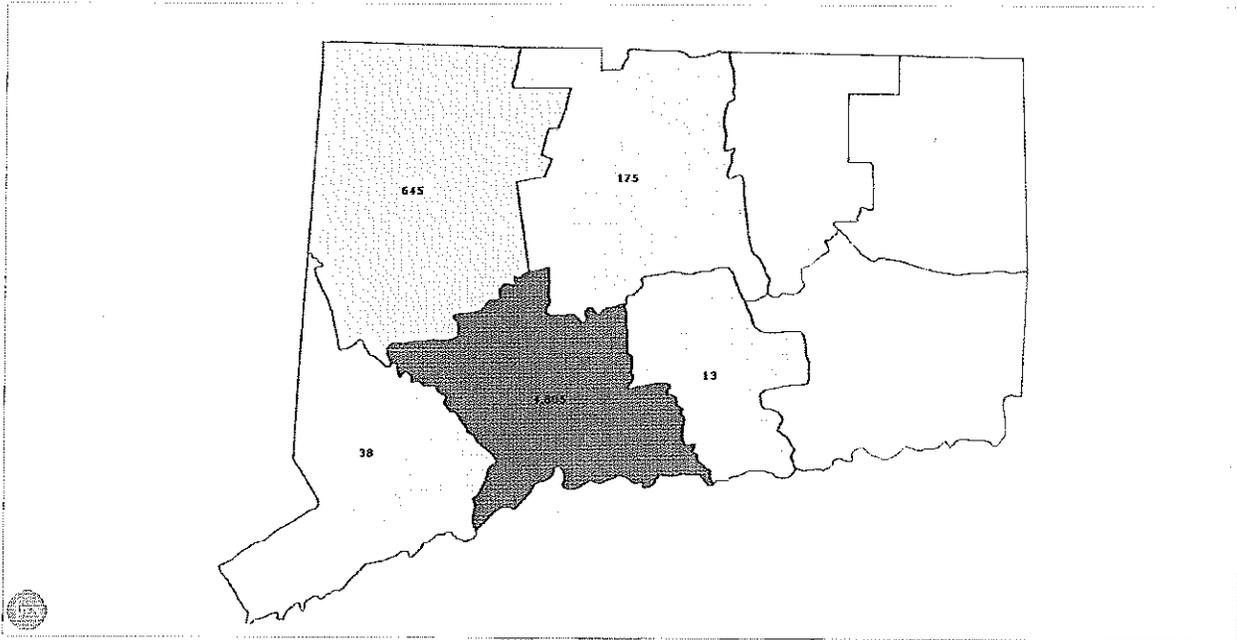
South West (Bridgeport Hospital, Hartford Hospital, St Vincent's Hospital,  
Masonic Home and Hospitals, Cluster # 20)



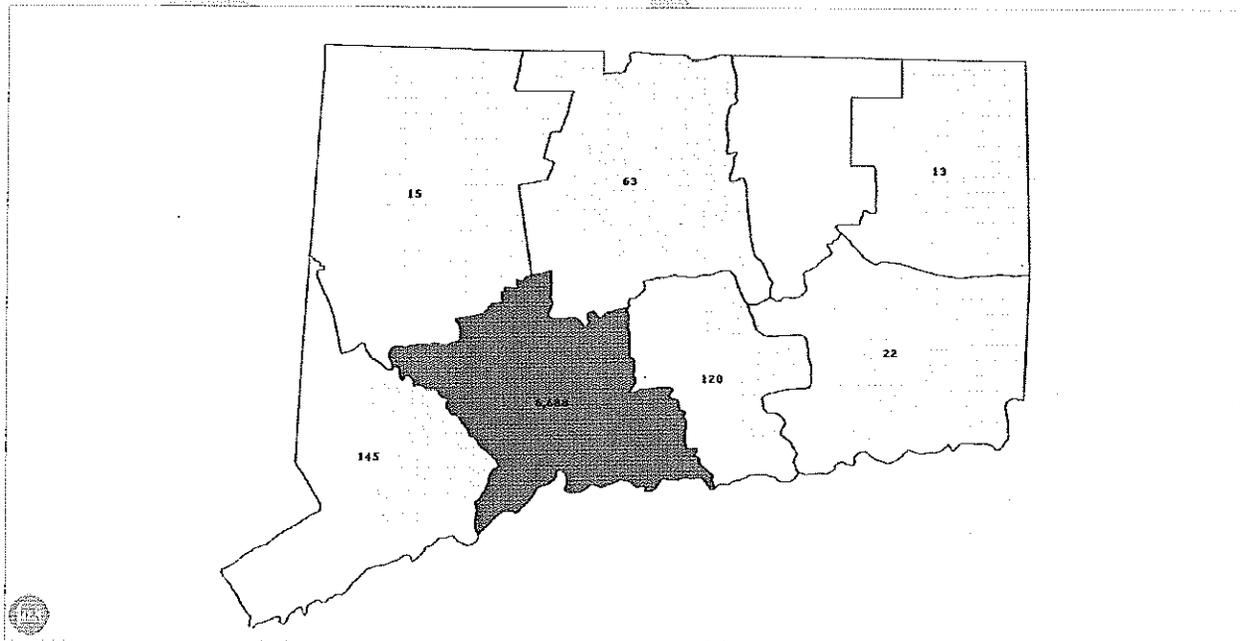
South East Lawrence & Memorial Hospital, Cluster # 14)



South Central (St Mary's Hospital, Cluster # 27)



South Central (St. Raphael's, Yale-New Haven Hospitals, Cluster # 13)



North West (Charlotte Hungerford Hospital, Bristol Hospital, Hartford Hospital, Cluster # 33)

## Appendix C. Stakeholder Participation

<b>MAPOC Members</b>	<b>Organization</b>
Gavin, Molly	CT Community Care
Price, Meryl	Health Policy Matters
McEvoy, Kate	Department of Social Services
Fiocchetta, Bill	Community Health Network
Harrington, Colleen	DMHAS
Polun, Debra	Community Health Care Association of CT
Frayne, Stephen	CHIME
Holcomb, Claude	Consumer Advocate
Gualtieri, Claudio	AARP
Robinson, Julie	UCHC - Center on Aging
Smith, Karen	CHNCT
Rathier, Margaret	UConn
Smith, Marie	UConn
Borton, Mark	Equity Health Partners
Schaefer, Mark	Department of Social Services
Cyr, Mary Ann	CHNCT
Barrett, Matthew	CAHCF
McCarthy, Maureen	Chat Health Care
Tikoo, Minakshi	UConn
Cole, Molly	DSS
Gavin, Molly Rees	DSS
Puckett, Olivia	LOB - Council on Medical Assistance Program
Love, Peter	UConn
Fortinsky, Rick	UConn
Amdur, Sheila	Co-Chair
Meehan, Tom	MD Qualidigm

<b>Complex Care Committee Membership</b>	<b>Organization</b>
Price, Meryl	Health Policy Matters
McEvoy, Kate	Department of Social Services
Abbot, Quincy	The ARC CT
Becker, Alevin	CT Mirror
Allen, Marie	SW CT Agency on Aging
Amdur, Sheila	Co-Chair
Andrews, Ellen	CT Health Policy
Ayers, Neil	OFA
Barrett, Matt	CAHCF
Fiocchetta, Bill	Community Health Network
Bissell, Michele	Apt Foundation
Bloom, Michael	RSL Lobbyist
Bohnet, Carol	Allied Community Resources
Borton, Mark	Equity Health Partners
Bruni, Kathy	Department of Social Services
Bustow, Sheldon	Hospital for Special Care
Chin, Alyse	DMHAS
Cole, Molly	Department of Social Services
Collins, Elizabeth	YNHH & BHP OC
Cournoyer, Brian	CHA
Cyr, Mary Ann	CHNCT
Demers, Kathleen	Day Kimball
Denny, Marilyn	GHILA
DiLeo, Paul	DMHAS
Dinwoodie, Jennifer	R AmeriChoice
Dufore, Marcia	NCRMHB

Complex Care Committee Membership	Organization
Duncan, Nora	ARC of CT
Duval, Deborah	DDS
Eccleston, Susan	DSS
Edelstein, Teri	CCPA
Elwell, Alice	Qualidigm
Atalla, Erica	Wellcare
Erlingheuser, John	AARP
Fay, Janine	VNA CH Care
Fecteau, Jojn	DMHAS
Felton-Reid, Hilary	R & C
Ferrucci, Ken	CSMS
Foley, Anne	OPM
Gallagher, Jennifer	MedOptions
Gallagher, Sarah	CSH
Gamelin, Yvonne	All About You HC
Gates, Heather	CHR
Gavin, Molly	CT Community Care
Gelgauda, Julie	South Central AAA
Goodman, Erica	Wellcare
Gridley, Elizabeth	AAYCT
Gualtieri, Claudio	AARP
Guerino, Neysa	AOA Partnerships
Hall, Karyl Lee	CLRP
Halpin, Susan	Robinson & Cole
Holcomb, Claude	Consumer Advocate

Complex Care Committee Membership	Organization
Hoyt, Deborah	CAHCH
Hutchinson, Jennifer	DMHAS
Jacob, Annie	Department of Social Services
Benson, Jill	Community Health Resources
Kelley, Brenda	AARP
Krause, David	OPM
Krodel, Nancy	AARP
Lambert, Dawn	Department of Social Services
Langton, Mary Ann	CT Council on Development Disabilities
Larcen, Stephen	Natchaug
Leonard, Nancy	New England Home Care
Lipschutz, David	Medicare Advocacy
McGrath, Doreen	DDS
McNichol, Jane	LARCC
Meehan, Thoma	MD Qualidigm
Meliso, Pamela	Medicare Advocacy
Moore, Steven	Value Options
Morelli, Mag	Leading Age CT
Morgan, Siobhan	DDS
Hage, Christina	Murtha Law
Nystrom, Kimberly	New England Home Care
Oldham, Jean	AAY Home Care
Ostrout, Sherry	CT. Community Care Inc.
Paek, Hyung	Optimus HC
Polun, Debra	CHACT
Reese-Gavin, Molly	CT Community Care

Complex Care Committee Membership	Organization
Villano, Peter	State Rep. Co-Chair
Robinson, Julie	UCHC-Center on Aging
Schaefer, Mark	Department of Social Services
Schwalbe, Katherine	SEIU
Shepard, Emily	OFA
Shugrue, Noreen	UCHC
Small, Henrietta	CMHACC
Smith, Carol	DMHAS
Smith, Marie	UCONN
Soucey, Debra	Athena Health Care
Stein, Judy	Medicare Advocacy
Szczygiel, Lori	Value Options
Teed, Hillary	CCPA
Toubman, Sheldon	NH Legal Aid
Trapp, Carol	ACS
Turi, Sue	Board Member, CT-USPRA
Vantassel, Jan	CLRP
Vinikas, Matt	CHC, Inc.
Watson, Deborah	Bridgeport Hosp. Foundation
Weekes, Brad	Kowalski Group
Weiser, Rivka	Department of Social Services
White, J. D.	Wellcare
Williams, Holly	OFA
Wodatch, Tracy	CAHCH
Wojnarowicz, Randy	Wellcare

Complex Care Committee Membership	Organization
Woodsby, Alicia	PCS Housing
Zavoski, Robert	Department of Social Services
Zito, Cathy	Magellan Health
Flocchetta, Bill	Community Health Network
Harrington, Colleen	DMHAS
Polun, Debra	Community Health Care Association of CT
Atalla, Erica	Wellcare
Evans-Starr, Julia	Commission on Aging
Sprague, Kim	CHIME
Denny, Marilyn	GLHA
O'Neil, Mary Ann	CT Community Providers Association
Towers, Mike	ACS
Rockwell, Patricia	Senior Care Centers
Frayne, Stephen	CHIME
Moore, Steven	VO
Ganesan, Uma	Department of Social Services

<b>Model Design Work Group</b>	<b>Organization</b>
Price, Meryl	Health Policy Matters
McEvoy, Kate	Department of Social Services
Amdur, Sheila	Co-Chair
Andrews, Ellen	CT Health Policy
Fiocchetta, Bill	Community Health Network
Chin, Alyse	DMHAS
Cole, Molly	UCONN Health Center/Center on Disabilities
Demers, Kathleen	Day Kimball
Gavin, Molly	CT Community Care
Ferrucci, Ken	CSMS
Morelli, Mag	Leading Age CT
Reese-Gavin, Molly	CT Community Care
Schaefer, Mark	Department of Social Services
Toubman, Sheldon	NH Legal Aid
Teed, Hillary	CCPA
Weiser, Rivka	Department of Social Services
Zavoski, MD	Department of Social Services
Harrington, Colleen	DMHAS
Polun, Debra	Community Health Care Association of CT
Towers, Mike	ACS
Frayne, Stephen	CHIME
Ganesan, Uma	Department of Social Services

## Appendix D. Stakeholder Engagement

Committee Name	Meeting Date	Topics Covered
Complex Care Committee	January 25, 2011	Overview of State Demonstrations to Integrate Care for Dual Eligible Individuals and discussion
Complex Care Committee	February 4, 2011	Overview of Federal Initiatives (medical homes, health homes, community health teams, Integrated Care Organization for Dual Eligibles) and discussion
Complex Care Committee	March 25, 2011	Overview of 1915(c) Waivers in CT and 1915(i) state plan amendment and discussion
Complex Care Committee	April 29, 2011	Overview of Department of Mental Health and Addiction Services and discussion
Complex Care Committee	May 20, 2011	Overview of DDS 1915(c) Waivers and discussion, planning process for ICO Dual Eligible proposal discussion
Complex Care Committee	August 26, 2011	ICO Planning and Development
Complex Care Committee	September 14, 2011	Overview of ICO Initiative; advisory groups; focus group strategy; performance management strategy
Performance Measures Workgroup	December 19, 2011	Model design, overview of measurement
Complex Care Committee	October 21, 2011	Focus group plan, performance measurement work group, Dual Eligibles Overview, key analysis questions, review of model characteristics
Complex Care Committee Model Design Workgroup	December 22, 2011	Health Home ASO Option Medicare and Medicaid Eligibles Model
Performance Measures: Expert Group – conference call	December 23, 2011	Discussion of measures
Model Design Workgroup	January 9, 2012	Model design, population served, shared savings options,
Performance Measures: Expert Group	January 17, 2012	Discussion of compendium
Model Design Workgroup	January 24, 2012	ASO services and supports, shared savings model, demonstration population, enrollment, HNs

Performance Measures Workgroup	February 2, 2012	Discussion of guiding principles, domain definitions
Model Design Workgroup	February 7, 2012	Health Neighborhood structure, services, care teams; Introduction to Shared Savings models
Performance Measures: Expert Group – conference call	February 10, 2012	Discussion of compendium
Performance Measures: Expert Group – conference call	February 14, 2012	Discussion of compendium
Performance Measures Workgroup	February 21, 2012	Discussion of guiding principles, domain definitions
Model Design Workgroup	February 23, 2012	ASO/Health Neighborhood contractual relationships, Model Design, Shared Savings, Timeline, Focus Group update, Performance Management update
Complex Care Committee	February 24, 2012	ASO/Health Neighborhood contractual relationships, Model Design, Shared Savings, Timeline, Focus Group update, Performance Management update
MAPOC	March 9, 2012	Focus Group Feedback, Health Neighborhood/ASO Features, Beneficiary Perspective, ASO/HN Features, Delivery System Design and Care Coordination, Contracting and Anti-trust Issues, Quality Incentives, Performance Measurement
Complex Care Committee	March 12, 2012	Person-centered definition; Performance Measurement update; Shared Savings and Incentive Payments; Enrollment options
Expert Workgroup on Performance Measurement	March 23, 2012	Selection of Measures for Recommendation to the CCC
Performance Measurement Workgroup	March 27, 2012	Definition of Person-Centeredness, Selection of Measures for Recommendation to the CCC and Evaluation Design
Model Design Workgroup	April 4, 2012	Shared Savings Options and Enrollment Design
CCC Executive Committee	April 9, 2012	Review of Draft Demonstration Application
MAPOC	April 13, 2012	Final Presentation of Draft Demonstration Application to the MAPOC

Appendix E. Key Focus Group Themes

<b>Focus Group Questions</b>	<b>Key Themes: Focus Groups with Older Adults Age 65+</b>	<b>Key Themes: Focus Groups with Individuals with Disabilities 18-64</b>
<b>I. Current Experience With the Health Care System</b>		
<b>What happens when you go to the doctor?</b>	<ul style="list-style-type: none"> <li>• Most participants consistently see an office-based PCP and have between one and four specialists in different practices and/or locations</li> <li>• Some change doctors due to rotation of newer/younger docs</li> <li>• Many reported issues with distance to their practitioner and transportation issues</li> <li>• Where alternatives to using the ER exist, participants are willing to use them</li> </ul>	<ul style="list-style-type: none"> <li>• Multiple providers are the norm</li> <li>• Widespread access problems; hard to find providers who accept Medicare/Medicaid</li> <li>• Major issue with dental care; some young adults have not seen a dentist in 3-5 years</li> <li>• Individuals with DD and individuals with SPMI may present differently; it is especially hard to find providers who understand the needs of these populations with special needs</li> <li>• Pediatric to adult care: difficult to find competent providers to treat people with disabilities</li> <li>• Most want to visit the same doctor or clinic that is aware of their medical history, which is typically complex</li> </ul>
<b>If you stayed in a hospital/nursing home in the past year, how did your providers help you prepare to go home?</b>	<ul style="list-style-type: none"> <li>• Many described positive transitions BUT some noted insufficient services at home after the transition</li> <li>• Communication problems between the nursing home and home services for those transitioning from a nursing home were noted</li> </ul>	<ul style="list-style-type: none"> <li>• Many described positive transitions from hospitals to home</li> <li>• Providers who serve individuals with DD noted resistance by hospital staff to engage in discharge planning</li> <li>• Major issues with transition planning from hospital to group home for individuals with DD</li> </ul>
<b>What happens when your doctor prescribes a medication?</b>	<ul style="list-style-type: none"> <li>• Most doctors explain the basics (e.g. dosage)</li> <li>• Most rely on pharmacists for any medication questions</li> <li>• Visiting nurses help educate consumers re: medications</li> <li>• A few had interpretation issues due to language barriers</li> </ul>	<ul style="list-style-type: none"> <li>• Similar to older adults, most doctors explain the basics and most participants rely on pharmacists for questions</li> <li>• Parents of individuals with DD mentioned lack of communication between providers and specialists, and concern about contraindications</li> <li>• Nurses educate staff and families for 24-hour group home, BUT those with less than 24-hour support receive insufficient education and help</li> </ul>

**II. Care Coordination Questions**

<p><b><i>Do you think your doctors talk to one another re: your care? (Asked of individuals 65 years of age only)</i></b></p>	<ul style="list-style-type: none"> <li>• Doctors do communicate -- via fax or EHR</li> <li>• Communication between physicians and other healthcare providers is very important</li> <li>• Important for a relative to be involved (but not necessarily to be involved themselves)</li> <li>• Doctors generally do not communicate with homecare providers (except with visiting nurses)</li> </ul>	<ul style="list-style-type: none"> <li>• N/A</li> </ul>
<p><b><i>Have you seen a written plan for your medical care and other services? (Asked of individuals 65 years of age only)</i></b></p>	<ul style="list-style-type: none"> <li>• Confusion as to what a care plan was; participants reported seeing documents re: homecare; medications, schedule; other medical records</li> <li>• Opinions on who should be involved in designing a care plan varied from not wanting anyone other than the consumer involved to wanting at least one relative involved</li> <li>• Caregivers want to be involved in their relatives' care plan</li> </ul>	<ul style="list-style-type: none"> <li>• N/A</li> </ul>
<p><b><i>Who do you rely on most for day-to-day help? (Asked of individuals 65 years of age only)</i></b></p>	<ul style="list-style-type: none"> <li>• Family, care managers, Resident Service Coordinators (RSCs) find help that includes Visiting Nurse, companion, Activities of Daily Living (ADL)/Instrumental ADLs (IADLs) help and housekeeping</li> <li>• Persons on CT Home Care Program for Elders had more help at home, including Long-term Services and Supports (LTSS), transportation, medical issues and emergency services</li> <li>• Participants noted that "Gatekeepers" (family, RSCs, care managers) can be both helpers and obstacles to care and supports</li> </ul>	<ul style="list-style-type: none"> <li>• N/A</li> </ul>
<p><b><i>If you wanted to see a doctor about your mental health, would you know where to go?</i></b></p>	<ul style="list-style-type: none"> <li>• Yes, (with many participants indicating they use services) consumers know where to go for mental health care</li> <li>• Most people go to their primary care doctor, social worker, or resident services coordinator for a referral</li> </ul>	<ul style="list-style-type: none"> <li>• N/A</li> </ul>

<p><i>(Asked of individuals 65 years of age only)</i></p>	<ul style="list-style-type: none"> <li>• Some consumers did not know who to approach for emotional care and some experienced problems accessing mental health care, e.g., physicians not taking Medicare or Medicaid</li> </ul>	
<p><i>Do multiple people coordinate your care &amp; do you understand their roles? (Asked of 18-64 year old individuals with disabilities only)</i></p>	<ul style="list-style-type: none"> <li>• N/A</li> </ul>	<p><u>General Feedback</u></p> <ul style="list-style-type: none"> <li>• Extensive need expressed for care coordination among multiple providers, but desired coordination is frequently poor or nonexistent</li> <li>• People with all doctors in one practice and DD population with 24-hour coordination have far fewer issues.</li> </ul> <p><u>Issues regarding insufficient care coordination</u></p> <ul style="list-style-type: none"> <li>• Poor medication management</li> <li>• Finding providers who accept coverage</li> <li>• Lack of provider understanding exists regarding issues that individuals with DD and SPMI face</li> <li>• Pediatric to adult care transition</li> <li>• Discharge planning to group homes</li> </ul>
<p><i>Who would you like to coordinate your care? (Asked of 18-64 year old individuals with disabilities only)</i></p>	<ul style="list-style-type: none"> <li>• N/A</li> </ul>	<ul style="list-style-type: none"> <li>• Self or family member (especially parents of individuals with DD)</li> <li>• Group home nurse or house manager</li> <li>• Behavioral Health care manager or clinician</li> </ul>
<p><i>Would you mind if doctors could look at records of all your services to give you better care? (Asked of 18-64 year old individuals with disabilities only)</i></p>	<ul style="list-style-type: none"> <li>• N/A</li> </ul>	<ul style="list-style-type: none"> <li>• Answers overwhelmingly positive</li> <li>• Strong need expressed for making relevant information available to all doctors</li> <li>• Small minority would insist on individual consent each time</li> </ul>
<p><i>Would you rather have the</i></p>	<ul style="list-style-type: none"> <li>• N/A</li> </ul>	<p><u>Overall responses:</u></p> <ul style="list-style-type: none"> <li>• Substantial differences of opinion</li> </ul>

<p><i>current system or health neighborhood coordinate your care? (Asked of 18-64 year old individuals with disabilities only)</i></p>		<ul style="list-style-type: none"> <li>• Individuals with SPMI strongly favor health neighborhood, in concept, for better coordination of care</li> <li>• Health neighborhood appealing to many only if current docs participate</li> </ul> <p><u>Significant reservations from individuals with DD were expressed:</u></p> <ul style="list-style-type: none"> <li>• Fear of losing long-term docs (some out-of-state)</li> <li>• Providers would need to develop sensitivity to individuals with DD and would need to be trained</li> </ul>
<p><b>III. Consumer Protection</b></p>		
<p><i>Do you know the complaint process for problems with care and patient rights?</i></p>	<ul style="list-style-type: none"> <li>• Many don't know how to make a complaint or would change doctors rather than complain</li> <li>• Some would talk to their health care provider directly; others mentioned specific people they would ask for help</li> <li>• While some reported they have been told about their patient rights, many others have not</li> </ul>	<p><u>How to make a complaint</u></p> <ul style="list-style-type: none"> <li>• Additional people to ask for help: <b>social workers, psychiatrists, office manager</b></li> <li>• Complete provider satisfaction surveys</li> </ul> <p><u>Patient rights</u></p> <ul style="list-style-type: none"> <li>• Same variety of experiences as for older adults</li> </ul>
<p><i>Are you able to choose your doctors?</i></p>	<ul style="list-style-type: none"> <li>• Participants reported a wide range of experiences re: choice</li> <li>• Specialists were generally identified through PCP referrals without choices, but many trusted PCPs to identify specialists</li> <li>• Others reported lack of choice in LTSS providers, and denial of requests to change</li> <li>• A <i>significant</i> number had been turned away by providers who don't accept Medicare or Medicaid</li> </ul>	<ul style="list-style-type: none"> <li>• Doctors change often, not by patients' choice</li> <li>• Doctors must be selected from limited lists; many don't take Medicare/Medicaid</li> <li>• Difficult to find providers with needed expertise e.g., psychiatry, dentistry or specific disability diagnoses</li> <li>• Doctors who take Medicaid cancel appointments when their DSS reimbursement is late</li> <li>• Case managers help clients find specialists</li> </ul>
<p><i>Do you think some health care providers treat people differently?</i></p>	<ul style="list-style-type: none"> <li>• Many reported no problem with discrimination</li> <li>• Others had perceived discrimination based on: Race/ethnicity; Age; use of Medicaid (or Medicare)</li> <li>• Others reported poor treatment, with no</li> </ul>	<ul style="list-style-type: none"> <li>• Providers treat people differently based on a mental health diagnosis or disability</li> <li>• Individuals with DD stated that some provider accommodate behavioral issues and others refuse to provide</li> </ul>

	<p>clear cause</p> <ul style="list-style-type: none"> <li>• A few participants felt they receive better treatment due to their age</li> </ul>	<p>service</p> <ul style="list-style-type: none"> <li>• Parents of individuals with DD negative attitudes toward themselves as parents</li> </ul>
<p><b>IV. Ideal Health Care and Service Program Question</b></p>		
<p><i>How would you describe an ideal health care and service program for you?</i></p>	<ul style="list-style-type: none"> <li>• Most agreed that they want more doctors to accept Medicaid and Medicare patients</li> <li>• A holistic approach to health care with their primary care and specialists located in one town, or in one location</li> <li>• Access to a navigator or health care advocate</li> <li>• A streamlined, easy process for submitting medical/prescription claims to DSS</li> <li>• Better information about why some people have to pay co-pays is needed to avoid confusion regarding this issue</li> </ul>	<ul style="list-style-type: none"> <li>• Similar responses to 65+ population</li> <li>• More providers should accept Medicare/Medicaid</li> <li>• Better care coordination needed, especially among medical, social services and durable equipment providers</li> <li>• Value ability to choose one's own PCP and specialists</li> <li>• More information – provide list of providers that accept Medicare/Medicaid and their backgrounds</li> <li>• For those who need anesthesia for routine procedures, e.g. dental and OB-GYN, allow at the same time</li> <li>• Simplify or eliminate Medicaid spend-down; causes considerable confusion</li> </ul>

## Appendix F. Performance Measures

Domain	Measure
Person-Centered Care	Evidence of client receiving timely care, appointments, and information
	Evidence of client and family choice and involvement in care plan design to desired extent
	Person centered care planning questionnaire
	More than 10 percent of all unique patients seen by the practitioner are provided patient-specific education resources
	Evidence client and family treated with respect and dignity
	Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days
Care Transitions	Transition Record Transmitted to Health care Professional (from inpatient facility to community provider within 24 hours)
	Evidence of adequate primary care/specialty care integration
	Percentage of enrollees reporting service coordinators help them get what they need
	Evidence of adequate medical care and long-term services and supports integration
	Maintain an up-to-date problem list of current and active diagnoses. More than 80 percent of all unique patients seen have at least one entry or an indication that no problems are known for the patient recorded as structured data
Medication Management	Percentage with evidence of medication reconciliation at the time of discharge
	Evidence of counseling about medications
	Percentage with evidence of annual monitoring of long-term medications
	Percentage with evidence of medication reconciliation at the time of SNF discharge
Prevention	Percentage receiving mental health assessment
	Percentage receiving body mass index (BMI) assessment
	Percentage with blood pressure measurement in preceding 2 years
	Percentage receiving fall risk assessment
	Percentage receiving cognitive status assessment
	Healthy days at home
Behavioral Health	Evidence of outpatient follow-up after hospitalization for mental health and/or substance use disorder
	Follow-Up After Hospitalization for Mental Illness within 7 days of discharge
	Ability to access behavioral services quickly
	Rate of readmission to psychiatric hospitals within 30 days and 180 days
	Social connectedness to and support from others in the community such as family, friends, co-workers, and classmates
Clinical Care Measures	Percentage with diabetes who receive the following: HbA1C test, Dilated eye exam, Lipid profile, Monitoring for neuropathy, Foot exam
	Percentage of diabetics with elevated BMI with counseling for diet / exercise

	For more than 50 percent of all unique patients height, weight, and blood pressure are recorded as structured data for (A) Height , (B) Weight , (C) Blood pressure , (D) Calculate and display body mass index (BMI), and (E) Plot and display growth charts for the population including BMI
	Percentage with blood pressure within normal range
	Diabetes composite: blood pressure <140/90
	Heart failure: Beta blocker therapy for left ventricular systolic dysfunction (LVSD)
	Percentage with osteoarthritis of hip and/or knee with pain assessments
<b>Access to Care</b>	Evidence of transportation availability assessment
	Evidence of financial assessment to determine any barriers to needed health and social care
	Evidence of assessment of home environment for barriers to full mobility
<b>Functional Status Measures</b>	Substantial decline in 3 or more activities of daily living (bathing, dressing, eating, transferring, toileting)
	Percentage with evidence of functional status assessment
	Percentage who develop pressure ulcer
	Percentage stabilized in transferring in and out of bed
<b>Quality of Life</b>	Psychological health
	Physical health
	Environment
	Social relationships
<b>Claims-based measures suggested by performance measurement expert group</b>	Colorectal cancer screening
	Mammography screening
	All-cause hospital readmission within 30 days
	Ambulatory Sensitive Conditions Admissions-COPD
	Ambulatory Sensitive Conditions Admissions-Congestive Heart Failure
	All-cause emergency department (ED) use
Three (3) or more ED visits in six (6) months	