Integrated Care Demonstration Operations Plan Outline – Model 2: Health Neighborhoods (HNs)

(Note: Additional sections of the proposed Operations Plan will be shared at a later date)

Component	Question	Proposal
Health Neighborhood Administrative Structure	What are the requisites for Administrative Lead Agency (ALA)?	• Must be a community based, non-institution provider of health care services or a community based agency with extensive knowledge or expertise in care/care management for MME population • Demonstrated experience and capacity to develop and implement the requested services. Must have: o Content expertise (e.g. experience with MME populations, medical/BH care coordination, capacity to address barriers that inhibit access to care, cultural competency, disability competency, competency in person-centeredness/ dignity of risk) o Generative/connective capability (e.g. experience in connecting providers across disciplines/networking, experience in connecting MMEs with other providers, care coordination) o Program management expertise including quality management and improvement systems and health care financing • Sufficient data systems and capacity to collect, manage, and analyze programmatic data and to provide reports, including those to or from the ASOs, DSS, enrollment broker, and/or providers (such as claims data and client enrollment data). • Must meet the state's contracting standards such as being a Medicaid provider in good financial and legal standing. Must have adequate staffing/credentials and licenses in good standing.
Health Neighborhood Administrative Structure	Should we <u>exclude</u> any entities from serving as the Administrative Lead Agency (ALA)?	The following are categorically excluded: • ICF/MRs • Nursing homes • MCOs • Stand alone hospitals. • Medicaid ASOs Hospital-owned physician groups are **not** excluded
Health	Will we require HNs to have	An HN must indicate its governance structure (such as an advisory board or governance board),

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Neighborhood Administrative Structure	a governing or advisory body? Should we indicate requirements for composition (e.g. providers, consumers) of board, and/or requirements for participatory decision making?	including plans for consumer engagement, in the RFP response. Criteria for evaluation include inclusiveness of HN members and consumers, and their opportunity for input/feedback. Composition of any board is not specified. HNs are given flexibility and must indicate plans in the RFP response.
Health Neighborhood Administrative Structure	Should we require co-Lead Agencies (medical and BH)?	HN leadership must incorporate both physical and behavioral health expertise - **Administrative Lead Agency (ALA)** and **Behavioral Health Partner Agency (BHPA).** Roles are not mutually exclusive and are described below.
Health Neighborhood **Roles of Lead Agency**	What are the roles of the **Administrative Lead Agency (ALA)**?	*Overall HN structure:* • Establish an integrated service network within its geographic area. (See below regarding provider composition) • Communicate with and educate non-HN providers about the work of the HN. • Work with the Behavioral Health Partner Agency (BHPA) in ensuring that the needs of those with behavioral health conditions are met. *Care coordination:* • Execute care coordination contracts between provider members (template contract[s] to be provided by the Department, and potentially adapted by HNs). Identify, determine structure of, and oversee the system of Lead Care Managers (LCMs). Enforce the terms of the contracts with providers and LCMs. • In partnership with the BHPA, develop care coordination standards and procedures and identify and disseminate best practices in care coordination and health promotion (including areas such as chronic disease self-education, preventive care) throughout the HN • In partnership with the BHPA, develop a quality improvement program for care coordination • Details on care coordination practices will be in the ICM section of the operations plan *Data, reporting, and quality:* • Receive, analyze, and act upon claims and enrollment data; share data with and between

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		providers. Collect and report data (from and to providers, LCMs, ASOs, and/or the Department) as specified by contract.
		• In partnership with the BHPA, design and implement quality monitoring and improvement activities within the HN.
		
		Compliance:
		• In partnership with the BHPA, ensure compliance with Department's contract requirements
		
		Fiduciary:
		• Receive and distribute APM II payments and performance payments to provider members
		
		Supplemental services:
		• Provide or contract for, set standards for, and monitor supplemental services (see more information on services below)
		
		Training for HN provider members:
		• In partnership with the BHPA and the Departments, create forums for core curriculum learning collaborative activities for providers on topics including, but not limited to:
		  • applied practice of person-centeredness;
		  • disability culture;
		  • strategies for engaging with individuals with SMI and intellectual disabilities; and
		  • connecting with the range of non-medical services and supports.
		• In partnership with the BHPA, design and administer curriculum of educational activities for providers (such as learning collaborative sessions), to be indicated in the applicant's proposal.
		
		Consumer Engagement:
		• In partnership with the BHPA, develop a comprehensive client education, outreach, and engagement program and materials (regarding the HN and care coordination, health education, etc)

Health Neighborhood **Roles of Lead**	What are the roles of the **Behavioral Health Partner Agency (BHPA)**?	*Overall Structure:* • Provide behavioral health-related leadership within the Health Neighborhood (HN) • Ensure that behavioral health care and the spectrum of needs and barriers among those with behavioral health conditions are properly integrated into and comprehensively addressed

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Agencies		within the HN
		• Ensure that recovery principles and recovery-oriented systems of care are properly integrated within the HN
		
		Care coordination:
		• In partnership with the Administrative Lead Agency (ALA), develop care coordination standards and procedures and identify and disseminate best practices in care coordination and health promotion (including areas such as chronic disease self-education, preventive care) throughout the HN
		• In partnership with the ALA, develop a quality improvement program for care coordination
		• Be a liaison between BH providers and other medical and non-medical community service providers to promote integration and collaboration for purposes of care coordination
		
		Data, reporting, and quality:
		• In partnership with ALA, design and implement quality monitoring and improvement activities within the HN
		
		Compliance:
		• In partnership with the ALA, ensure compliance with Department's contract requirements
		
		Training for HN Provider members:
		• Identify and reach out to providers who serve the needs of those with SPMI regarding HN membership and education about the HN.
		• In partnership with the BHPA and the Departments, create forums for core curriculum learning collaborative activities for providers on topics including, but not limited to:
		  • applied practice of person-centeredness;
		  • disability culture;
		  • strategies for engaging with individuals with SMI and intellectual disabilities; and
		  • connecting with the range of non-medical services and supports.
		• In partnership with the BHPA, design and administer curriculum of educational activities for providers (such as learning collaborative sessions), to be indicated in the applicant's proposal.
		
		Consumer Engagement:
		• In partnership with the ALA, develop a comprehensive client education, outreach, and

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		engagement program and materials (regarding the HN and care coordination, health education, etc)
Health Neighborhood **Roles of Lead**	Will the ALA be responsible for identifying and compiling the list of all Lead Care Managers for consumers?	Yes. The ALA must identify, determine structure of, and oversee the system of Lead Care Managers (LCMs), including compiling and maintaining a database of LCMs and sharing relevant information with the enrollment broker and LCMs.
Health Neighborhood **Roles of Lead**	Will the ALA be responsible for identifying and compiling the list of all providers of supplemental services?	The ALA is responsible for identifying and compiling the list of all providers of supplemental services.
Health Neighborhood **Roles of Lead**	Will Leads be conflicted from offering care coordination, direct FFS and/or supplemental services under the Demonstration?	For purposes of the Demonstration, it is the preference of the Departments that Health Neighborhoods ensure that care management is provided on a conflict-free basis. HNs that choose to permit providers of direct service to also provide care management can satisfy standards by establishing beneficiary protections that safeguard free and informed choice of providers and adherence to standards of medical necessity.
Health Neighborhood **Roles of Lead**	Is the ALA permitted to sub-contract out for any of these functions? If so, under what circumstances?	The ALA can sub-contract out for its functions.
Health Neighborhood Assistance with Formation	How will the Departments support formation of HNs?	Examples of potential activities include: • Facilitation of relationships by contractor (e.g. Qualidigm) • Distribution of template care coordination agreements, MOUs, transitional care agreements • Distribution of anti-trust guidelines • Use of central website hub/portal for communications with Departments and providers • Drill down and distribution of data points: geographic incidence of MMEs by population group, cluster analysis

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Health Neighborhood Provider Composition	What is the minimum required set of medical, BH and LTSS providers? What is the required incidence of required providers relative to the number of participating MMEs?	Each health neighborhood will be required to include membership by the following: • primary care physicians, which may include 1) independent or group internal medicine, geriatric and/or family medicine; 2) Federally Qualified Health Centers (FQHCs); and 3) hospital-affiliated outpatient clinics; • specialists including cardiologists, endocrinologists, nephrologists, podiatrists, rheumatologists, podiatrists, psychiatrists, and psychologists; • extender staff including physician assistants and Advance Practice Registered Nurses (APRN); • Behavioral health professionals which may include 1) community mental health and substance use clinics (both private non-profit and state-operated); 2) hospital-affiliated outpatient clinics; and 3) Independent practitioners; • dentists; • pharmacists; • medical transportation providers (livery, other); • community-based long-term services and supports including home health agencies, homemaker-companion agencies, and adult day care centers, • hospitals that serve the health neighborhood's coverage area; • nursing facilities; and • hospice providers. It is desirable but not required for each health neighborhood to include membership by the following: • Durable Medical Equipment (DME) providers; • Emergency Response System (ERS) providers; • hearing aid providers; • opthalmologists *The incidence of required providers relative to the number of participating MMEs is TBD.*
Health	Will we require	Each health neighborhood will be required to include membership by the following **care**

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Neighborhood Provider Composition	participation of any other types of providers? E.g.: Information & assistance/ADRC (Will we require participation of any specific providers? Will we indicate that participation other types of provider is, although not mandatory, preferable?)	**coordination affiliates**: • the Access Agency(ies) for the Connecticut Home Care Program for Elders that serves the health neighborhood's coverage area; and • the LMHA or LMHA affiliate that serves the health neighborhood's coverage area. **Care coordination affiliates** are permitted to serve as Lead Care Managers (LCM) and may receive APMII and performance payments. Each health neighborhood will also be required to include membership by the following **information & assistance affiliates**: • Infoline; • the CHOICES program that serves the health neighborhood's coverage area; and • the Aging & Disability Resource Center that serves the health neighborhood's coverage area. **Information & assistance affiliates** may participate in care coordination, but are not permitted to serve as Lead Care Managers (LCM) or to receive APMII or performance payments. It is desirable but not required for each health neighborhood to include membership by **social services affiliates**. Social services affiliates are defined as including services and supports of a non-medical nature that are of value in addressing the whole person needs of MMEs. Non-exclusive examples of these include housing organizations, home renovation/accessibility contractors, bill payment/budgeting services, employment services, and *fill in other examples?* **Social services affiliates** may participate in care coordination, but are not permitted to serve as Lead Care Managers (LCM) or to receive APMII or performance payments.
Health Neighborhood Provider Composition	Will we require participation of any other types of providers? E.g.: Contractors for supplemental services (e.g. pharmacists trained in MTM strategies, nutritionists/registered	Each HN will be required to describe the means by which it will provide supplemental services, including, but not limited to, the types of providers with which it will contract as well as the credentials of such providers to do so. Preferred, but not mandatory, descriptive characteristics for these providers include the following: • for chronic disease self-education and management: providers that employ evidence-based practices for the chronic conditions that are most prevalent for MMEs, including, but not limited to, COPD, diabetes, and SPMI; • for medication therapy management: programs that include 1) medication reconciliation,

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	dieticians)	medication therapy management, and medication coordination and monitoring of processes across prescribers, pharmacies and care settings; and 2) feature components including a) in-person assessment; b) development of a medication action plan to promote self-management and patient empowerment; and c) communication and collaboration with the MME's prescribers and other health care providers on evidence-based medication interventions; • for nutrition counseling: programs that offer counseling to individuals with chronic conditions on elements including but not limited to the interplay of diet and effective medication use, nutritional assessment to compare actual dietary intake against recommended guidelines, and education on menu planning and shopping; • for falls prevention: 1) programs designed for community-dwelling older adults that use fall intervention approaches, including physical activity, medication assessment and reduction of medication when possible, vision enhancement and home-modification strategies; and 2) programs that target new fall victims who are at a high risk for second falls and that are designed to maximize independence and quality of life for older adults, particularly those older adults with functional limitations; • for peer support: programs that engage trained, self-identified consumers who are in recovery from mental illness and/or substance use disorders, under the supervision of a behavioral health professional, to provide non-clinical interventions that support individuals with SMI and/or substance abuse issues by facilitating recovery and wellness; and • for recovery assistant: programs that include a flexible range of supportive assistance that is provided face-to-face and that enables a participant to maintain a home/apartment, encourages the use of existing natural supports, and fosters involvement in social and community activities.
Health Neighborhood Provider Composition	What are the credentials/requisites for provider participation?	• Private provider organizations (defined as non-state entities that are either nonprofit or proprietary corporations or partnerships) and CT State agencies • Medicaid performing provider in good standing • Licensure/certification in good standing • Good financial standing and no bankruptcy filing
Health Neighborhood Provider Composition	Can non-Medicaid providers (e.g. I&A, housing organizations) participate?	Yes. Non-Medicaid providers can participate as social services affiliates. See above.

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