

Proposed Operating Authorities by Payment Type: Connecticut Duals Demonstration

| Payment Type | Description | Source of Funding | Authority |
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| Start-up payments to Health Neighborhoods | The Department seeks to make \$250,000 start-up payments to each of the Health Neighborhoods (HN) that are selected through a Request for Proposals (RFP) to fund the costs associated with developing and implementing the neighborhoods. | Duals demonstration implementation funding. | ACA authority to implement demonstration |
| APM I (PMPM payment) | Connecticut is currently administering a PCMH program. PCMH qualified practices receive a combination of enhanced FFS and PMPM performance incentives. Connecticut seeks to convert this program from enhanced FFS to advanced bundled payments (APM1) concurrent with implementation of the Duals Demonstration. The Department seeks to implement APM I payments and to extend the PCMH program to Medicare/Medicaid Eligibles (MMEs) who participate in the Demonstration (both Model 1 and Model 2). This will be done for all qualified PCMH practices and all MMEs aligned with these practices. | Federal/state matching funds | State plan 1905(a)(25) 42 CFR 440.168(a)(1) Primary Care Case Management (PCCM) |
| APM II (PMPM payment) | Connecticut seeks to introduce risk-adjusted APM II payments in order to pay for care management under the Demonstration. APM II payments will be made to providers that are acting as Lead Care Managers for MMEs who are enrolled in the HNs. APM II payments will wrap around existing sources of care coordination in order to address the entire continuum of services to be coordinated under the Demonstration. We are currently reviewing the best means through which to pay for supplemental services. | Federal/state matching funds | State plan Potential hybrid of: 1905(a)(25) PCCM + 1915(b)(3) & (4) PCCM + additional services TBD |
| Fee-for-Service Payments | The Department intends to continue making fee-for-service payments for state plan and waiver-covered services. | Federal/state matching funds | State plan and 1915(c) |
| PCMH Performance Incentives | The Demonstration seeks to extend the state's PCMH Performance Program to Demonstration participants (both Model 1 and Model 2). 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. | PCMH performance pool | Pending State Plan Amendment |
| Health Neighborhood Performance Payments | In year one, the State seeks to establish a Performance Payment Pool that will be funded based on the actuarially determined savings in aggregate amongst all participating HNs. Payments from the pool will be based solely on HN performance on quality measures. For the second and third year, the state seeks to establish a Quality Bonus Pool and a Value Incentive Pool. The state will calculate the actuarially determined savings in aggregate amongst all participating HNs and allocate a portion of the savings to each pool. The Quality Bonus Pool will be distributed based on HN-specific performance against benchmarks (performance incentive payment) and improvement (performance improvement payment) over time. The Value Incentive Pool will be distributed to each HN proportionate to its achieved cost | Demonstration savings (based on global projected expenditures for Medicare Parts A & B and Medicaid state plan and 1915(c) waivers) | ACA authority to implement demonstration |

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| savings. Shared savings will be calculated by comparing actual PMPM expenditures to actuarially sound risk adjusted PMPM benchmark targets for a comparable population. The calculation of the actuarially sound PMPM targets will include adjustments such as for medical cost trend, program changes, administration expenses, and offsets such as advanced payments. | | |
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42 U.S.C. 1905 (a)(25) & (t)

Sec. 1905. [42 U.S.C. 1396d] For purposes of this title—

(a) The term “medical assistance” means payment of part or all of the cost of the following care and services or the care and services themselves, or both ^[257] (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1), if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians’ or dentists’ services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section [1902\(a\)\(10\)\(A\)](#)) not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, who are—

(25) primary care case management services (as defined in subsection (t));

(t)(1) The term “primary care case management services” means case-management related services (including locating, coordinating, and monitoring of health care services) provided by a primary care case manager under a primary care case management contract.

(2) The term “primary care case manager” means any of the following that provides services of the type described in paragraph (1) under a contract referred to in such paragraph:

(A) A physician, a physician group practice, or an entity employing or having other arrangements with physicians to provide such services.

(B) At State option—

(i) a nurse practitioner (as described in section [1905\(a\)\(21\)](#));

(ii) a certified nurse-midwife (as defined in section [1861\(gg\)](#)); or

(iii) a physician assistant (as defined in section [1861\(aa\)\(5\)](#)).

(3) The term “primary care case management contract” means a contract between a primary care case manager and a State under which the manager undertakes to locate, coordinate, and monitor covered primary care (and such other covered services as may be specified under the contract) to all individuals enrolled with the manager, and which—

(A) provides for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment with respect to medical emergencies;

(B) restricts enrollment to individuals residing sufficiently near a service delivery site of the manager to be able to reach that site within a reasonable time using available and affordable modes of transportation;

(C) provides for arrangements with, or referrals to, sufficient numbers of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care;

(D) prohibits discrimination on the basis of health status or requirements for health care services in enrollment, disenrollment, or reenrollment of individuals eligible for medical assistance under this title;

(E) provides for a right for an enrollee to terminate enrollment in accordance with section [1932\(a\)\(4\)](#); and

(F) complies with the other applicable provisions of section [1932](#).

(4) For purposes of this subsection, the term “primary care” includes all health care services customarily provided in accordance with State licensure and certification laws and regulations, and all laboratory services customarily provided by or through, a general practitioner, family medicine physician, internal medicine physician, obstetrician/gynecologist, or pediatrician.

42 U.S.C. 1915 (b)(3) & (4)

(b) The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this title, may waive such requirements of section [1902](#) (other than subsection (s)) (other than sections [1902\(a\)\(15\)](#), [1902\(bb\)](#), and [1902\(a\)\(10\)\(A\)](#)) insofar as it requires provision of the care and services described in section [1905\(a\)\(2\)\(C\)](#)) as may be necessary for a State—

(1) to implement a primary care case-management system or a specialty physician services arrangement which restricts the provider from (or through) whom an individual (eligible for medical assistance under this title) can obtain medical care services (other than in emergency circumstances), if such restriction does not substantially impair access to such services of adequate quality where medically necessary,

(2) to allow a locality to act as a central broker in assisting individuals (eligible for medical assistance under this title) in selecting among competing health care plans, if such restriction does not substantially impair access to services of adequate quality where medically necessary,

(3) to share (through provision of additional services) with recipients of medical assistance under the State plan cost savings resulting from use by the recipient of more cost-effective medical care, and

(4) to restrict the provider from (or through) whom an individual (eligible for medical assistance under this title) can obtain services (other than in emergency circumstances) to providers or practitioners who undertake to provide such services and who meet, accept, and comply with the reimbursement, quality, and utilization standards under the State plan, which standards shall be consistent with the requirements of section [1923](#) and are consistent with access, quality, and efficient and economic provision of covered care and services, if such restriction does not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing those services and if providers under such restriction are paid on a timely basis in the same manner as health care practitioners must be paid under section [1902\(a\)\(37\)\(A\)](#).

No waiver under this subsection may restrict the choice of the individual in receiving services under section [1905\(a\)\(4\)\(C\)](#).¹³³⁶¹