

State of Connecticut:
Implementation Support for State Demonstrations to Integrate Care for Medicare-
Medicaid Enrollees
3/19/13 DRAFT

(Note: funding opportunity information available at:
<http://www.grants.gov/search/search.do?mode=VIEW&oppId=212713>)

1. Proposed Approach

1.1 Introduction

The health care delivery system in the United States of America, including the health care delivery system for the disenfranchised, has come under increasing scrutiny for high costs and poor accountability on outcomes in relation to the delivery systems in the other developed countries. These issues are pertinent even in the Medicare and Medicaid programs where the government does exercise some of the same rate-setting controls on costs that are common in other countries where the government is the dominant payer. Despite the fact that both Medicare and Medicaid have administrative cost ratios much lower than in private insurance, both program struggle to contain costs, especially where they intersect in the domain for individuals who are Medicare-Medicaid Enrollees (MMEs).

While we make available to these individuals access to the most technologically developed, expensive health care delivery system in the world for them to use without substantial consumer financial contribution, they are often expected to navigate on their own an environment that often includes substandard or inaccessible housing, limited access to healthy food, lack of transportation, loneliness, isolation and despair. For individuals who have intellectual or cognitive disabilities, Serious and Persistent Mental Illness (SPMI), and/or limited English proficiency, merely understanding their role in healthcare and the wellness process may be an enormous challenge. In terms of the twin objectives of diagnosing and treating disease episodes on the one hand and coordinating care and promoting wellness on the other, the US health care system can be said to be at the same time *over-developed* in terms of the escalating and inflationary technologies applied to disease; and *under-developed* in terms of the care coordination and supports provided to the most at-risk members of society.

Connecticut's Demonstration to Integrate Care for Medicare-Medicaid Enrollees seeks to address this dysfunctional dichotomy by enabling person-centered, multi-disciplinary care coordination that will impact both Medicare and Medicaid services and programs by reducing unnecessary areas of over-treatment and/or duplication *and* by integrating medical, behavioral, supplemental and social services to promote a healthier MME population.

1.2 Delivery System Model

For full discussion of the costs and demographic makeup of the current Connecticut (MME) population, please see the “Background” section (Section B) in the proposal that was submitted to CMMI in May, 2012.

Connecticut intends to integrate non-medical, medical, and behavioral Medicare, Medicaid, and supplemental services for MMEs through two models that will rest upon the building blocks of its existing Medicaid and long-term care re-balancing reforms:

Model 1 (Enhanced Administrative Services Organization): Model 1 will seek to improve health outcomes and care experience of MMEs by enhancing the strengths of Connecticut’s medical and behavioral health ASOs. This model will focus upon expanding and tailoring current Intensive Care Management (ICM) and care coordination capabilities to meet the needs and preferences of MMEs, integrating Medicare data within existing Medicaid-focused predictive modeling and data analytics, as well as enhancing provider use of the same, in support of better integration.

Model 2 (Health Neighborhoods): Model 2 will launch a new local, person-centered, multi-disciplinary provider arrangement called the Health Neighborhood (HN). This model will focus upon local accountability among providers working together consistent with a MME’s values and preferences through connections that will include care coordination agreements and electronic communication tools, to achieve better integration. A Lead Care Manager within the HN will be the single point of contact for this model. Supplemental services included in the model are chronic disease self-education and management, medication therapy management, nutrition counseling, falls prevention, peer support, recovery assistance.

Features of the Demonstration that will support both models include:

- chronic illness self-management education activities based on evidence-based practices designed to support MMEs in maintaining or improving the status of chronic conditions including, but not limited to, chronic obstructive pulmonary disease (COPD), asthma, and diabetes;
- a learning collaborative approach to equip providers to connect with one another, to develop capability and cultural competency in serving the needs and preferences of MMEs, and to be knowledgeable about the full range of services and supports that are available to support the whole person needs of MMEs; and
- exploring and facilitating connections to other State and private services and supports that may complement Demonstration activities, including the HUD Healthy Homes Assessment.

Definitions:

- **Assessment:** For purposes of the Demonstration, an Assessment is a comprehensive, multi-dimensional health assessment of domains including functional capacity, physical and cognitive status, formal and informal supports, and environment, which is used to prepare a Plan of Care.

- **Care Coordination:** Care coordination is a person-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an individual's needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an identified care coordinator following evidence-based standards of care. Care coordination support is offered to MMEs along a continuum from minimal level of assistance to intensive level of assistance, as described by the following:
 - **Targeted Outreach:** Targeted Outreach is a brief, focused support focused upon MMEs with unmet medical, behavioral health, LTSS or social support needs who either 1) are not at high risk; or 2) prefer to self-direct their own services and supports. This service can be provided either by a Lead Care Manager or can be delegated as appropriate to an extender (e.g. care manager assistant, community health or outreach liaison). Non-exclusive examples of Targeted Outreach include 1) assistance in identifying and scheduling appointments with specialists; 2) assistance in locating and procuring transportation; 3) referrals to social services supports; and/or 4) support with general information & assistance inquiries. Key goals of targeted outreach include providing needed information and improving access to services and supports.
 - **Care Management:** Care Management is a periodic, intermittent support focused upon MMEs with unmet medical, behavioral health, LTSS or social support needs that are at moderate risk. This service must be provided by a Lead Care Manager. Non-exclusive examples of Care Management activities include 1) assessment of needs to identify unmet or underserved needs; 2) engagement with the MME and members of the MME's care team to support access to needed care, assist with chronic disease self-management, and promote medication compliance; and 3) coordinate services for planned care transitions (e.g. scheduled surgery or other acute treatment). Key goals of Care Management include 1) preserving and/or improving function; 2) preventing exacerbation of presenting conditions; 3) averting crises; and 4) diverting MMEs from use of emergency departments, inpatient hospitalization and re-hospitalization, and long-term nursing home placement.
 - **Intensive Care Management:** Intensive Care Management (ICM) is an ongoing support focused upon MMEs with unmet medical, behavioral health, LTSS or social support needs that are at high risk. This service must be provided by a Lead Care Manager. Examples of ICM activities include assistance in 1) assessment of needs to identify priorities; 2) engagement with the MME and members of the MME's care team to develop near term goals relating to acute/urgent care, coordination of services across the continuum of services and supports, and chronic disease self-management; 3) coordinate services for unplanned transitions; and 4) intervene with patterns of hospitalization and re-hospitalization,

and/or inappropriate nursing home placement. Key goals of ICM include 1) stabilizing the MME's health condition; 2) achieving smooth care transitions and means of monitoring needs over time; and 3) improving the MME's capacity to self-manage chronic conditions.

- **Multi-Disciplinary Care Team:** For purposes of the Demonstration, a Multi-Disciplinary Care Team (Care Team) is defined as including an MME who is participating in the Demonstration, his/her representatives, his/her LCM and the group of HN provider members who are mutually supporting the needs, values and preferences of that MME. Each Care Team is led by the MME and his/her LCM, and is composed of all relevant provider members of the HN, as well as any involved Information & Assistance Affiliates and Social Services Affiliates.
- **Person-Centeredness:** For the purpose of the Demonstration, person-centeredness is defined as an approach that:
 - provides the Medicare/Medicaid Eligible individual (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.
- **Plan of Care (POC):** For purposes of the Demonstration, a Plan of Care is defined as a document that is completed by an Lead Care Manager in partnership with an MME and his/her chosen representatives, which articulates the MME's goals, provides an inventory of the services that are being received by the MME, identifies the members of the MME's care coordination team, and includes action steps (e.g. toward improving communication and collaboration among MME and members of the care coordination team, effectively managing chronic disease, and preventing unnecessary hospitalization and/or nursing home placement).
- **Lead Care Manager (LCM):** An LCM is responsible for assessing, coordinating and monitoring an MME's Demonstration Plan of Care (POC) for medical, behavioral health, long-term services and supports (LTSS), and social services.

For a complete definition of the organizational structure and the activities to be performed, please see the Operating Plan in the Appendix.

1.3 Key Tasks

1.3.1 Overall Project Management

The Project Manager for the Connecticut Duals Demonstration will be Kate McEvoy, JD - the Interim Director of the Division of Health Services at the Connecticut Department of Social Services. Ms. McEvoy has been in her present position for over one year now. Prior to joining the management team at DSS she served as an Assistant Comptroller with responsibility for health care policy aspects of the State Employee Health Plan, and previously had over 20 years of experience in the health care field in Connecticut as an advocate.

While Kate will be the Lead Project Manager, her many other responsibilities as the Director of the Connecticut Medicaid program will necessarily limit her role. Supporting Kate in Project Management at DSS will be a full-time Project Director (TBD). Rebecca “Rivka” Weiser (Health Program Assistant II) will be devoted full-time to this project as the Project Coordinator. Additional in-house staff support will be available from the Director of Behavioral Health, the Medical Operations Divisions (Enrollment and the MMIS), the Office of Legal Council and Regulatory Affairs (Grievance, Fair Hearings, and Contracts) and the Division of Fiscal Analysis (Budget and Federal Claiming). See Staffing Chart in the Appendix.

Model Description and Enrollment:

The medical Administrative Services Organization, CHNCT, will provide predictive modeling to facilitate member enrollment in the HNs. Individuals who received primary care (or some other types of care, as described in CT’s previous application) from an HN participating provider within the twelve months preceding implementation will be passively enrolled into Model 2, the HN model, with the ability to opt out of the HN model. Individuals who did not previously receive such care from an HN provider will be passively enrolled into Model 1, the Enhanced ASO Model. During an open enrollment period, individuals would have the opportunity to choose between Demonstration models before enrollment begins.

1.3.2 Model 1 – Enhanced ASO

The Administrative Service Organization (ASO) that is currently contracted to DSS will provide: 1) predictive modeling to facilitate member enrollment in the HNs; 2) Intensive Care Management for the MME clients who enroll in Model 1; 3) the availability of linked Medicaid and Medicare data through a provider portal for Primary Care Providers (PCPs), providers and Lead Care Managers (LCMs) enrolled in the Health Neighborhoods.

The medical ASO for the State of Connecticut is the Community Health Network of Connecticut (CHNCT). Led by Sylvia Kelly (CEO), CHNCT has held a contract with DSS since the beginning on the HUSKY managed care program in 1995. Beginning on January 1, 2012, CHNCT was given the responsibility to serve as the ASO for all of the health care programs operated by DSS, including the Charter Oak Health Plan (non-

Medicaid coverage for adults), HUSKY A (Medicaid families), HUSKY B (CHIP), HUSKY C (Adult Medicaid), and HUSKY D (Medicaid long-term care, including MMEs).

CHNCT will serve as the “back office” and continue their current operations including analytics, predictive modeling, care management, and member and provider support. CHNCT’s ability to provide Intensive Care Management (ICM) for high-risk has been limited by the lack of integrated Medicare claims to use in predictive modeling. With the addition of the linked Medicare/Medicaid dataset, CHNCT will be able to expand their ICM activities to the MME population in Model 1. New care management staff will be hired for the Demonstration in order to provide ICM to this newly identified population. At the same time, these data will allow CHNCT to use powerful predictive modeling tools to facilitate member enrollment and improve overall care coordination in Model 2 (HNs).

Connecticut is fortunate to have in place longstanding contracts with ASOs for both medical and behavioral health services. Value Options has a long history with Connecticut Medicaid; first as a subcontractor with one of the managed care organizations (MCOs), and later as the ASO charged with implementing a carve-out of behavioral health services for HUSKY A and HUSKY B. In 2012, Value Options assumed responsibility for the management of behavioral health services for the entire Medicaid program, working closely with partners at the Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF).

The linked data will be provided under an agreement with JEN Associates. JEN has completed a linked Medicare-Medicaid dataset for 2010 and will provide a similar dataset for 2011 prior to the project implementation date. The ability of CHNCT to share the analysis of this data on individuals and peer comparisons with providers and care managers via CHNCT’s provider portal will be crucial for successful coordination of services across Medicare and Medicaid in Model 1, and even more critical in Model 2.

1.3.3 Model 2 – Health Neighborhoods

Under Model 2, DSS will conduct a procurement to secure contracts with the Health Neighborhoods (HNs). HNs will be comprised of a wide array of providers, such as primary care (independent practitioners, FQHCs, clinics) and physician specialty practices, behavioral health providers, LTSS providers, hospitals, nursing facilities, home health providers, hospice providers, pharmacists and identified affiliate service providers (e.g. housing providers, volunteer organizations).

The potential venues for the Health Neighborhoods will be identified in the MME cluster analysis that has been performed by JEN Associates, which identified groups of MMEs who are served by overlapping sets of common providers. The JEN linked dataset that will provide the basis for this analysis is a key element in program design and rate setting.

The Department will outline in the RFP the minimum required array of providers, the incidence of providers relative to the number of MMEs who will be served, and the role of affiliate service providers. Health Neighborhoods accepted as a result of the procurement process will be eligible to receive a start up payment of up to \$250,000, adjusted for the anticipated size of the enrolled population, to support start-up activities of HNs, including activities such as contracting and connecting providers across disciplines, provider and client education, and data and quality oversight infrastructure.

1.3.3.1 Health Neighborhood Formation and Start Up

Under a separate contract with an impartial third party (such as Qualidigm), DSS will secure management resources to assist the selected HN Administrative Lead Agencies with the technology and the legal requirements (i.e. Data Use Agreements) necessary to share PHI on enrolled members from the provider portal at CHNCT to providers and care coordinators in the Health Neighborhood. The impartial third party will also be tasked with supporting providers in connective with each other across disciplines. This support will be crucial, as the HNs will need to have agreements with an array of participating providers across disciplines that are sufficient to ensure coordinated care for their enrollees.

1.3.4 Systems and Financial Support - Hewlett Packard (MMIS)

In the managed fee-for-service model, the MMIS is the entity that is responsible for adjudicating provider claims and providing cost and utilization data to the Department and CHNCT. Hewlett Packard (HP) and its predecessor (EDS-Electronic Data Systems) has been the incumbent MMIS contractor since the first certified system in 1985.

Under Model 1, the MMIS will continue to be responsible for all state plan and HCBS waiver fee-for-service payments, and will be responsible for the enhanced care coordination payments (APM 1) made directly to the designated patient-centered medical homes (PCMH) for the delivery of enhanced primary care to the MME population.

Under Model 2, HP's role would be similar in that it will be responsible for fee-for-service state plan and waiver service payments and the APM 2 payments that will be paid to the Lead Care Management Agencies in the Health Neighborhoods. These payments will differ from the APM 1 payments by procedure code and content. They will include reimbursement for the care coordination activities undertaken by the Lead Care Managers (LCMs).

We are still in conversation with HP about the how these APM 2 payments will be issued. Our current thinking is that:

1. An administrative fee will be made to the HN under a direct contract with the Department. This fee, in combination with the start-up funds provided by the demonstration grant, will compensate the activities of the Administrative Lead Agency.

2. The Administrative Lead Agency and Lead Care Management Agencies (which employ LCMs) will be enrolled in the MMIS as billing providers.
3. LCMs will be enrolled with the MMIS as performing providers as part of each Health Neighborhood and will receive per member per month APM 2 payments as reimbursement for care coordination.
4. LCMs will refer to and arrange for previously described supplemental services (e.g., falls prevention and nutrition counseling) for MMEs. The Department is currently reviewing the best means through which to pay for supplemental services.
5. APM 2 payments will be risk-adjusted by the actuarial consultants (Mercer) to more accurately reflect the level of need of the HN members.

DSS and its MMIS vendor, HP, will be responsible for the implementation of all the defined systems requirements that touch on claims processing and reporting, including the production of data to performance monitoring and the evaluation of the demonstration

1.3.5 Systems and Member Enrollment – Xerox

Xerox, formerly ACS, has had a long and successful relationship with the Department as an independent enrollment broker dating back to the inception of managed care in 1995. Under a contract amendment, Xerox will provide enrollment services under this Demonstration, including the operation of a call center, the production and distribution of member notices, and enrollment of MMEs in Model 1 or 2 of the Demonstration and documenting choices of LCMs.

Member enrollment in this context is very different than in a capitated approach like managed care. For one thing, MME members will have the opportunity to select a different Lead Care Manager (LCM), opt out of their Health Neighborhood, or Model 2 altogether on a monthly basis. There will be no pure fee-for-service choice available for the MME population that does not involve some form of care coordination, either in Model 1 or Model 2 (members of Health Homes would receive care coordination through that model instead of the Demonstration, as described below).

1.3.6 Partnerships with the Department of Mental Health and Addiction Services (DMHAS)

DSS, DMHAS, and DDS have worked collaboratively in the development of the Demonstration. At the same time that the State is developing the Demonstration, we are working closely with (DMHAS) on a Health Home State Plan Amendment to develop behavioral Health Homes (HHs) for individuals with particular Serious and Persistent Mental Illness (SPMI) diagnoses.

The Department is sensitive to CMS concerns to not duplicate Medicaid claiming for care coordination in Models 1 and 2 with care coordination activities provided by the future HHs. MMEs who also have HH-qualifying SPMI diagnoses will be permitted to enroll up front in *either* the Demonstration or in HHs. Initial passive enrollment of these

individuals will account for existing provider relationships (HN or HH), and rules of attribution will be determined for any MMEs with linkages to both HH and HN providers (for example, accounting for the frequency/strength of the relationship with the providers). All MMEs, regardless of which program they are linked to through claims history, will be provided with further education and information in order to make a meaningful and informed choice about their preferred option to receive care coordination.

1.3.7 CMS Authorities

Upon the submission of this application to continue funding the Demonstration, DSS will immediately begin drafting the Memorandum of Understanding (MOU) with CMS in anticipation of the ultimate approval for the project. The key Terms and Conditions in the MOU will clearly identify the basis for calculation and distribution of shared savings off the agreed upon trend for Medicare and Medicaid expenditures.

DSS will also plan to undertake the development of the enhanced primary care case management (PCCM) state plan amendments to secure Medicaid funding for both APM 1 and APM 2 payments.

Finally, for those amendments to contracts that exceed \$1 million in total value (HP, Xerox, CHNCT, HNs), DSS will submit the required documentation secure federal approval.

1.3.8 Integrated Grievance and Fair Hearing Process

The Department will work with CMS to create a unified Grievance and Appeal process for Medicaid and Medicare Parts A, B, C and D based on the following principles:

Grievances

All MME enrollees will be able to file grievances, either orally or in writing, directly with the Health Neighborhood and the Division of Health Services at the Department of Social Services. Grievances will address issues around access to and treatment by care coordinators, medical providers and administrative staff of the Health Neighborhoods, CHNCT, or the Department.

Appeals

Appeals are designed to address specific denials or reductions in service as result of a notice of action issued by the Department or a Health Neighborhood.

In order to facilitate a uniform, user-friendly process, the Department will begin the Demonstration with all Medicaid and Medicare appeals and fair hearings processes in place while a unified process is developed, reviewed (including review by the Complex Care Committee and the Office of the Attorney General), and ultimately negotiated with CMS.

The Department will work to streamline and expedite appeals procedures, building upon existing protocols. The Department is also considering employing an independent Ombudsman agency.

1.3.9 Beneficiary Protections

In addition to the Appeals and grievances described above, the Department will include the following Beneficiary Protections and status reports:

- Strict adherence to freedom of choice of providers
- Right to designate “next friends” to join in care planning
- Right to receive care consistent with the members values and preferences
- Strict adherence to Medicaid Fair Hearings and Medicare Grievances and Appeals
- HIPAA protections for PHI (Protected Health Information), including informed consent for its release
- Right to access their own health records
- Informed consent regarding participation in Intensive Care Management (ICM)
- Informed consent about enrollment and participation in a Health Neighborhood
- Compliance with all rights afforded by the Americans with Disabilities Act of 1990
- Provider compliance with standards of practice
- Provider education through learning collaboratives
- Population studies to monitor outcomes and service delivery
- Financial and medical audits
- Measures to insure that members with intellectual disabilities of SPMI are not subject to discrimination or differential treatment

1.3.9 Data Analysis and Rate Setting

One key to the overall success of the project is the linked Medicare-Medicaid dataset for 2011 claims, and other claims on an ongoing basis. JEN Associates integrated 2010 claims data prior to the expiration of their current contract in November, 2012. The Department is in the process of securing an extension of that contract to provide the 2011 integrated data. These data will provide the following:

1. A Cluster Analysis of the MMEs and their providers to identify geographic areas that will have the critical mass to support the formation of Health Neighborhoods
2. Data that CHNCT can use to provide predictive modeling for Model 1 and Model 2 in identifying the formulation of Plans of Care
3. Data to support the rate setting activities to be undertaken by Mercer on the calculation of:
 - 3.1. Trend rates for fiscal years 2014, 2015, and 2016 that will be used in the calculation of program savings and shared savings with the Health Neighborhoods in Model 2
 - 3.2. Per member per month rates for the Care Coordination activities in Model 2 (APM 2) and for PCMHs in both models (APM 1)

In order to participate in shared savings, each Health Neighborhood must meet minimum standards for quality of care and patient outcomes as described in Program Evaluation.

1.3.10 Member Outreach

The Department will prepare member notices and public outreach materials prior to the implementation of the program. In addition to written materials, the department will conduct public forums in collaboration with community based organizations and advocacy groups to educate MMEs about their options to accept or decline enrollment in a Health Neighborhood, the conditions for their approval to share health information, and the beneficiary protections afforded them in both Model 1 and Model 2, including the process for filing Grievances and Appeals. In order to provide this outreach, we will leverage our current working relationships with stakeholders that have been engaged in developing the Demonstration (e.g., advocacy groups, clinical and social service providers).

1.3.11 Program Evaluation

Specifically, the Department intends to: 1) 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; 2) identify key strategies (provider array, care coordination, communication tools, etc.) that help to achieve person-centered, integrated care within the ASO and the HNs ; and 3) identify the factors that support success and determine the means by which the Health Neighborhood model can be expanded within Connecticut or other states.

Further, the Department agrees to collect and/or provide data to CMS to inform program management, rate development and the calculation of shared savings with the health Neighborhoods including but not limited to: 1) beneficiary level expenditure data and covered benefits for most recently available three years; 2) a description of any changes to the State plan that affect MMEs during the Demonstration period (e.g., payment rate changes, benefit design, addition or expiration of waivers, etc.); and 3) State supplemental payments to providers (e.g., DSH, UPL) during the three year period.

The performance measures included in the Appendix are a preliminary and minimum set to be used by a contract vendor in Program Evaluation. The Department, in partnership with DDS and DMHAS, will also contract with an evaluator to 1) conduct studies and surveys, including, but not limited to a goal-oriented patient care study; 2) conducting annual focus groups with MMEs; 3) analyze data from the Connecticut Health Information Exchange and/or other available sources; 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. The identified savings are anticipated to be generated from key areas of intervention such as: 1) reduced hospital inpatient readmission rates; 2) reduced hospital inpatient admission rates for

potentially preventable hospitalizations; 3) reduced unnecessary emergency department (ED) use; 4) re-balancing to more community-based care, and 5) medication management.

1.3.12 Electronic Health Record Cards

The Department is in the process of implementing a full Health Information Exchange (HIX). However we do not anticipate that the HIX will be fully operational in time to support the implementation of the Demonstration in January, 2014. As an alternative, the Department will plan to secure a contract with a vendor to produce paper cards that will be encoded with PHI including the Plan of Care for each member. The data will be available to participating providers at each health care encounter using a card-reader technology.

2. Organizational Capacity

The Department of Social Services is well qualified to implement an innovative model to address the care coordination needs for the MME population. In 2012 the Department operated within a \$6.5 billion annual budget of which over 80% supported the operation of health care programs including Medicaid (Title XIX), CHIP (Title XXI), ConnPACE (Pharmacy Assistance), CADAP (CT AIDS Drug Assistance Program), and numerous state-funded programs including the Charter Oak Health Plan. Through all of these programs, DSS provides health care to 20% of the 3.5 million residents in the State of Connecticut.

In 2012 Connecticut Medicaid moved to a unique managed fee-for-service approach utilizing the services of an organization that was formerly contracted as a Managed Care Organization (MCO) to provide managed fee for service benefits to the entire Medicaid program as an Administrative Service Organization (ASO). This model offers the Department the opportunity to implement the demonstration with reduced administrative costs while ensuring strong fiscal and policy oversight to maintain provider accountability and member benefit protections without the intermediate contractor level formerly occupied by the MCOs.

Stakeholder input is crucial to the success of the project. The Department has worked closely with the Complex Care Committee of the legislative Medical Assistance Program Oversight Council (MAPOC) in the development of the Demonstration, including preparation of this application, and will continue to report to the Committee on progress of the initiative through the life of the Demonstration.

The Department will be accountable for implementation and oversight of the Demonstration, and will partner with sister agencies DDS and DMHAS in further development and monitoring of the Demonstration. Key areas of internal support include the Division of Health Services (DHS), 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); and actuarial analysis and consultation on implementation (Mercer). The Department will utilize and build upon the existing capacities of its medical (CHN-CT), and in partnership with DMHAS, Behavioral Health (ValueOptions) ASO, 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. Overall direction in developing and implementing the Demonstration will be provided by a Steering Committee, including representatives from DSS, DMHAS, DDS and OPM.

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 using a card vendor who will produce portable Electronic Health Records. Finally, the Department plans to engage an evaluation contractor through which to assess the success of the Demonstration. Implementation steps associated with enhancing the current ASO model include 1) establishing an applied definition of ICM and development of an ICM/care coordination plan; 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 CT 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 Administrative Lead Agencies, participation standards, reporting, performance metrics, and shared savings mechanism; 4) issuance of the RFP and procurement process; 5) selection of HNs and contracting; and 6) 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, and provider learning collaboratives) to inform the operations plan.

3. Evaluation and Reporting

The Department has a robust reporting structure by virtue of its contract with HP to operate the MMIS. This state of the art system is further supported through the ASO contract with CHNCT that includes a sophisticated predictive modeling tool that will provide online claims (both Medicaid and Medicare) through a provider portal to the providers and the Health Neighborhoods and support the management of the members enrolled in the enhanced ASO (Model 1). The planned functionalities for the portal will include claims information, as well as member assessments and Plans of Care.

One of the advantages of this managed fee-for-service approach is that all claims will be processed through a single vendor, the MMIS, thereby eliminating the reporting problems that can arise with the interpretation of encounter data in a traditional managed care model.

Information on expenditures and care plans will be accessible to the management staff at the Department to support the production of the semi-annual progress reports as required by CMS and the actuarial and program evaluation contractors as designated by CMS.

The Department will continue its contractual relationship with JEN Associates to produce the linked Medicare-Medicaid dataset for actuarial analysis and program management. Mercer will provide the actuarial service to calculate shared savings and provide overall project savings information to CMS.

In addition, the department will procure the services of an independent programs evaluator to monitor a comprehensive series of quality of care indicators to support continuous progress improvement throughout the life of the Demonstration. While that relationship has yet to be formalized, the Department is considering a contractual relationship with the University of Connecticut Health Center on Aging for that purpose, a distinguished academic center with a long history of research and program evaluation on health care delivery for senior citizens. See the Appendix for more information about performance measures.

4. Budget and Budget Narrative

In progress for April 1 submission

Appendices:

A. Budget

In progress for April 1 submission

B. Staffing and Organizational Chart

In progress for April 1 submission

C. Operating Plan

Operating Plan documents previously reviewed with the Complex Care Committee are planned for inclusion with the April 1 submission (with revisions).

D. Performance Measures

See below

E. Preliminary Implementation Plan

In progress for April 1 submission

F. Letters of Support

In progress for April 1 submission

Appendix D: Performance Measures:

A. Performance Measures from Washington State’s MOU

Connecticut anticipates that the following performance measures (from Washington State’s MFFS MOU) will be included in our MOU with CMS:

| Model Core Measures | Year 1 | Year 2 | Year 3 |
|--|---------------|---------------|---------------|
| All Cause Hospital Readmission (30-Day All-Cause Risk Standardized Readmission Rate – CMS) | Reporting | Benchmark | Benchmark |
| Ambulatory Care-Sensitive Condition Hospital Admission (PQI Composite #90) | Reporting | Benchmark | Benchmark |
| ED Visits for Ambulatory Care-Sensitive Conditions (Rosenthal) | Reporting | Benchmark | Benchmark |
| Follow-Up after Hospitalization for Mental Illness (NQF #0576) | Reporting | Benchmark | Benchmark |
| Depression screening and follow-up care (#0418) | | Reporting | Benchmark |
| Care transition record transmitted to health care professional (NQF #648) | | Reporting | Reporting |
| Screening for fall risk (#0101) | | | Reporting |
| Initiation and engagement of alcohol and other drug dependent treatment: (a) initiation, (b) engagement (NQF #0004) | | | Reporting |

| State-Specific Process Measures: State must select the Health Action Plan and Health Home Network Training Process Measures, and select at least one other process measure [Note: terms to be adapted for Connecticut’s Demonstration] | Year 1 | Year 2 | Year 3 |
|---|---------------|---------------|---------------|
| Health Action Plans: Percentage of beneficiaries with Health Action Plans within 60 days of beneficiary being assigned to a Care Coordination | Reporting | Benchmark | Benchmark |

| | | | |
|---|--|--|--|
| Organization (Required) | | | |
| Training: State delivery of training for Health Home Networks on disability and cultural competence and health action planning (Required) | Benchmark | Benchmark | Benchmark |
| Discharge Follow-up: Percentage of beneficiaries with 30 days between hospital discharge to first follow-up visit | Benchmark | Benchmark | Benchmark |
| Real Time Hospital Admission Notifications: Percentage of hospital admission notifications occurring within specified timeframe | Reporting | Benchmark | Benchmark |
| Percentage of health homes with an agreement to receive data from health home beneficiaries' Medicare Part D Plans | Reporting | Benchmark | Benchmark |
| State-Specific Demonstration Measures- State must select at least 3, but no more than 5 | Year 1 | Year 2 | Year 3 |
| *State-Specific Demonstration measures – Including LTSS and/or community integration measures | Specified in Final Demonstration Agreement | Specified in Final Demonstration Agreement | Specified in Final Demonstration Agreement |

**CMS will adapt base measures to incorporate a denominator relative to the Demonstration specific populations at a State level.*

- As also in Washington’s MOU, in order to assess beneficiary experience, the State will work with CMA and its contractors to implement beneficiary and caregiver surveys.

B. State-Specific Measures:

In addition to monitoring the above measures and selecting the required 3 to 5 “state-specific demonstration measures”, the Department and the program evaluator will develop a monitoring plan that will include additional performance measures. These measures will focus on areas identified by stakeholders as priorities (as in our May 2012 application), especially in areas not explicitly addressed by the above measures (such as diabetes care and medication management). We are especially interested in applying existing developed measures, as used in measure sets such as:

- The National Quality Forum’s 2012 report: “Measuring Healthcare Quality for the Dual Eligible Beneficiary Population: Final Report to HHS”;
- Medicare Accountable Care Organizations’ quality measures;
- Measures already monitored by CHNCT for our current health care programs