

## Questions for Connecticut about the Standards & Conditions for its Proposed Managed Fee-For-Service Financial Alignment Demonstration

As discussed in the July 8, 2011 State Medicaid Director (SMD) letter that provided preliminary guidance on the financial alignment models, State demonstration proposals will be evaluated against the standards and conditions that CMS will require of all States seeking to participate in the demonstration.

CMS would like additional information from Connecticut about how its proposed demonstration would **ensure the provision and coordination of all necessary Medicare and Medicaid covered services, including primary, acute, prescription drug, behavioral health, and long-term services and supports.**

1. Please confirm that the proposed supplemental benefits that would be provided to Medicare-Medicaid beneficiaries in health neighborhoods are not current State Plan services. Are these services included in any current waivers?

Connecticut's proposed supplemental services under Model 2 (Health Neighborhoods, HNs) are not current State Plan services and are not, with the exception of peer support and recovery assistant services (which are covered by the DMHAS Working for Integration Support and Empowerment (WISE) waiver), included in any current waivers. HNs will not be permitted to separately procure the DMHAS WISE covered services for any client of that waiver.

Supplemental services are direct services supplied by qualified providers (e.g. registered dietitians, trained pharmacists, or individuals trained in statutorily-endorsed falls prevention protocols), and will not be provided by Lead Care Managers (LCMs). 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. HNs will also be required to propose strategies for tailoring supplemental services to best meet the needs of particular subpopulations (for example, individuals with Serious and Persistent Mental Illness, intellectual and developmental disabilities, individuals who are homeless). The proposed supplemental services include the following:

- **chronic disease self-education and management:** evidence-based practices for the chronic conditions that are most prevalent for MMEs, including, but not limited to, COPD, diabetes, and SPMI;

- **medication therapy management:** service to 1) include medication reconciliation, 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;
  - **nutrition counseling:** counseling for 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;
  - **falls prevention:** 1) services 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) services 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;
  - **peer support:** non-clinical interventions that support individuals with SMI and/or substance abuse issues by facilitating recovery and wellness programs by engaging trained, self-identified consumers who are in recovery from mental illness and/or substance use disorders, under the supervision of a behavioral health professional; and
  - **recovery assistant:** services 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.
2. Please provide additional information about how performance and APM II payments would be distributed among providers participating in health neighborhoods. Would the entire APM II go to the "lead" care manager, less a percentage of the total fee for administration? Would health neighborhoods be free to distribute the performance payment as they saw fit?

Connecticut originally intended to stream both performance and APM II payments through the Administrative Lead Agencies of each HN.

For purposes of the Demonstration, Connecticut is defining **Administrative Lead Agencies** as community-based, non-institution providers of health care services or community-based agencies with extensive knowledge or expertise in care/care management for MME population, which will serve functions in the HN relating to contracting, data collection, quality assurance, training and distribution of performance payments.

What has developed since submission of the original application is a shift in position as follows:

Connecticut now proposes to make bundled APM II payments directly through the MMIS to any Lead Care Management Entity. that employs qualified individuals selected by MMEs to serve as their Lead Care Managers.

For purposes of the Demonstration, Connecticut proposes to use the following definitions:

**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.

**Lead Care Management Entity:** A Lead Care Management Entity is any organization that is a participating, contracted provider in a Health Neighborhood, and employs qualified Lead Care Managers.

The Administrative Lead Agencies of each HN will be paid under an administrative contract with the Department of Social Services. They will also be eligible to participate in performance payments (see below).

Connecticut proposes to retain its proposed model for performance payments.

- In year 1 of the Demonstration, Connecticut will make performance payments to the Administrative Lead Agency (ALA) of each Health Neighborhood (HN) based on performance against identified measures. Connecticut will define requirements for distribution of these payments to HN providers in its contract with each ALA.
- In years 2 and 3 of the Demonstration, Connecticut will make two types of payments to the HNs:
  - **Quality Bonus Pool** payments based on performance against quality measures; and
  - **Value Incentive Pool** payments based on actuarially determined cost savings (Note: In order to receive such payments, an HN would also need to meet identified thresholds on quality measures.)

Connecticut will define requirements for distribution of both of these types of payments to HN providers in its contract with each ALA.

Please see the questions at the end of this document for further clarification about the performance payments.

3. Please explain the proposed source of funding for the APM I for Medicare-Medicaid beneficiaries, and risk-adjusted APM II? Does Connecticut propose to receive federal match for those payments?

Connecticut proposes to receive federal match for both APM I and APM II payments.

**APM I.** 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 (APMI) concurrent with implementation of the Duals Demonstration. The Department seeks to implement APM I payments and to extend the PCMH program to MMEs who participate in the Demonstration. This will be done for all qualified PCMH practices and all MMEs aligned with these practices. Connecticut seeks to receive federal match for APM I payments under Medicaid State Plan Primary Care Case Management (PCCM) [42 USC Section 1905(a) (25)] authority.

**APM II.** 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. Connecticut seeks to receive federal match for APM II payments under a hybrid of State plan Primary Care Case Management (PCCM) [42 USC Section 1905(a) (25)] and PCCM plus additional services [42 USC Section 1915(b) (3) & (4)].

4. Please provide additional information about the chronic disease self-management services that would be available to Model 2 enrollees. Would these services be provided in beneficiaries' homes or provider offices? Would they be provided on a one-on-one basis, or in groups?

Connecticut plans through a Request for Proposals to procure HNs. The RFP will establish minimum standards for providing chronic disease self-management services but will also solicit detail from HN applicants as to how each HN proposes to implement such standards and the credentials for qualified staff. Minimum standards are expected to include 1) documentation that the strategy is evidence-based; 2) identified health conditions; and 3) applied guidelines for person-centeredness (e.g. goal setting, self-direction, teaching and training).

5. Does Connecticut propose to pursue health homes expected to involve a significant number of Medicare-Medicaid beneficiaries? If so, please explain how the health homes fit into the demonstration design for Models 1 and 2, and the expected timing of Connecticut's health home State Plan Amendment (SPA) submission.

Connecticut has decided not to elect health home funding within the health neighborhood (HN) model that will be implemented under the duals demonstration. Instead, Connecticut plans to elect health home funding outside the context of the duals demonstration and to implement a number of condition-specific health homes for both dually-eligible and single-eligible individuals with Serious and Persistent Mental Illness (SPMI). We envision that Health Neighborhoods and Health Homes will be implemented at the same time, though are still establishing the timelines. We are planning for both programs to be implemented on or around January 1, 2014. DMHAS is currently working on the SPA and we hope to submit it in May or June of 2013. In order to successfully implement both the health neighborhood and health home models, Connecticut plans to:

- require participation of a Behavioral Health Partner Agency (BHPA) within the structure of the health neighborhoods;
- confirm the means by which individuals will be attributed within these models (for purposes of participation, for purposes of payment of care coordination payments) and the terms under which they can opt out;
- confirm the terms under which providers can participate in both models;

The Department proposes that clients eligible for both the Demonstration and Health Homes will be passively enrolled in to one of the programs, with client education about the potential to opt-out of that program and in to another, as applicable. *A client would not be enrolled in both the Demo and a BHH.* Among those who are dually eligible and have an SPMI diagnosis that qualifies them for a Health Home:

		<b>Client has existing relationship with Behavioral Health Home (BHH) Provider?</b>	
		<b>No</b>	<b>Yes</b>
<b>Client has existing relationship with <u>Health Neighborhood (HN) Provider?</u></b>	<b>No</b>	Client is part of Demo Model 1 (enhanced ASO), with education about opt-in to BHH or HN, as applicable.	Client passively enrolled in BHH and is NOT in the Duals Demo, with education about opting in to Model 1 or HN (if geographically available)
	<b>Yes</b>	Client passively enrolled in HN, with education about opting in to Model 1	Rules of attribution to the Duals Demonstration or BHH will be determined, and a client would receive education about other

	or BHH (if geographically available)	available options. (Note: This includes situations in which a BHH is also part of an HN, or when a client sees a BHH and another HN provider.)
--	--------------------------------------	---

<b>Feature</b>	<b>Health Neighborhood (3-5 will be procured)</b>	<b>Health Home (number to be determined)</b>
<b>Provider composition</b>	Broad range of medical, behavioral health, and long-term services and supports.	Care team selected from among three options identified in State Medicaid Director letter. Teams will be based at behavioral health care providers.
<b>Population served</b>	All Connecticut individuals who 1) are dually eligible for Medicare and Medicaid (older adults, individuals with physical disabilities, individuals with SPMI, individuals with intellectual disabilities), except those served by a Medicare Advantage plan or Accountable Care Organization; and 2) have received their primary care from a HN participating provider in the twelve months preceding implementation.  Each HN is anticipated to serve a minimum of 5,000 individuals.	Individuals with an identified SPMI who are either eligible for Medicaid only, or eligible for Medicare and Medicaid. The population might further be limited by geography, and outreach or passive-enrollment can differ according to other population characteristics (e.g. utilization, costs).
<b>Method of attribution</b>	Individuals who have received their 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 of the Demonstration will be passively enrolled with that HN and will have the opportunity to opt out.	Individuals determined eligible for BHHs (see above) who have received their behavioral health care from a BHH provider within the twelve months preceding implementation will be auto enrolled in the BHH and will have the opportunity to opt out or choose another BHH provider.
<b>Care coordination</b>	Proposes to permit participants to	The health home care team will

<p><b>model</b></p>	<p>select a Lead Care Manager from among a list of qualified participating members of the HN. This LCM will be the single point of contact for a multi-disciplinary team of providers, whose goal it is to integrate the beneficiary's medical, behavioral and long-term services and supports through a person-centered care plan. The LCM will identify and facilitate referral to appropriate supplemental services.</p>	<p>provide the 6 covered HH services with the goal of integrating the beneficiary's behavioral health, medical and community services and supports through a person-centered care plan.</p>
<p><b>Means of paying for care coordination</b></p>	<p>Connecticut proposes to make a PMPM payment that will incorporate the costs of care coordination (APM 2). We are also currently reviewing the best means through which to pay for supplemental services.</p>	<p>Connecticut will make a PMPM payment to the behavioral health entity in support of the costs the 6 core health home services.</p>

CMS would like additional information from Connecticut about how its proposed demonstration would **offer mechanisms for person-centered coordination of care and include robust and meaningful mechanisms for improving care transitions (e.g., between providers and/or settings) to maximize continuity of care.**

6. Please provide additional detail about how team-based care would occur in health neighborhoods.

Team-based care through the HNs will be enabled through the following strategies:

- requiring HNs to satisfy, and build upon through innovation, requisites related to provider composition, care coordination contracts among providers, training, means of providing care coordination, and beneficiary protections;
- requiring HN providers to participate in training curricula developed by the DSS, DMHAS and DDS, in collaboration with consumers and stakeholders;
- requiring HNs to indicate in their RFP responses how they will implement Connecticut's statement of values regarding the applied practice of person-centeredness; and

- requiring HNs to indicate in their RFP responses how they will address access barriers faced by various populations that will be served by the Demonstration.

### **Provider Requisites**

Connecticut will require HNs to satisfy and build upon threshold standards for all aspects of the team-based care coordination model.

Each HN will be required to demonstrate participation by a required set of provider members, and may also build upon these standards by incorporating participation by other adjunct participant members. A detailed description of these requirements is provided in the answer to Question 16.

Each HN will also be required to enter into standard care coordination agreements provided by the State of Connecticut with all member providers that detail terms including, but not limited to:

- means of communication between MMEs, Lead Care Managers (LCMs), primary care, specialists and other providers;
- means of consultation among MMEs, LCMs and members of MMEs' multi-disciplinary care teams;
- role definitions in situations of care transition (e.g. from primary care to specialist, from specialist to secondary/tertiary specialist, from setting to setting).

Further, HNs will be required to indicate the means through which each Administrative Lead Agency will ensure that provider members receive training to support:

- communication and connections across disciplines;
- specific expectations for the care coordination process; and
- strategies to address care coordination challenges, including, but not limited to, care transitions, urgent scenarios and situations that involve co-occurring conditions.

Additionally, HNs will be required to affirm that they will fulfill the minimum standards for care coordination established by Connecticut. These are more specifically enumerated in the Care Coordination section of Connecticut's Health Neighborhood Operating Plan, but generally include:

- standards for enrollment and choice of Lead Care Manager;
- required information disclosures;
- the initial assessment process;

- selection and composition of the members of each multi-disciplinary care team, especially in situations in which there is another source of care coordination support (e.g. a waiver care manager, LMHA case manager or MFP transition coordinator);
- development with the beneficiary of a Demonstration Plan of Care;
- guidelines for implementation, and revision, of Plans of Care; and
- standards for the level of assistance to be provided by Lead Care Managers, summarized below.

The type and frequency of care coordination support that an LCM is providing to each MME will be informed by the level of care coordination support that the MME requires. The requirements listed below will be considered to be a minimum set on which HN may build.

- **Targeted Outreach:** Targeted Outreach is a brief, focused intervention that is provided on an as-needed or situational basis. Targeted Outreach 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. The LCM must document the types of Targeted Outreach that he/she is providing to the MME on the MME's Demonstration Plan of Care.
- **Care Management:** Care Management is a periodic, intermittent support. 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). LCMs must observe the following standards in providing Care Coordination:
- **Intensive Care Management:** Intensive Care Management (ICM) is an ongoing support focused upon MMEs with unmet medical, behavioral health, LTSS or social support needs who 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.

Finally, HNs will be obligated to ensure that participants of the Demonstration are afforded various procedural protections in the care coordination process that include the beneficiary acting as the focal point of all Demonstration-related activities, choice of Lead Care Manager, right to switch Lead Care Managers, right to participate in care planning and development/approval of Demonstration Plans of Care, and right to grieve in situations in which beneficiaries do not agree with the terms of a Plan of Care.

### **Standard Training Curriculum**

Connecticut will also support team-based care coordination through development of a standard training curriculum that all HN provider members will be required to attend. Such curriculum will be developed by the participating State Departments in conjunction with consumers and stakeholders with specific knowledge of access barriers and disability culture, and will address modules including, but not limited to:

- the applied practice of person-centeredness;
- a profile of the health status of participants of the Demonstration;
- disability culture;
- communication and other access-related strategies for people with various disabilities; and
- strategies for incorporating family, next friends and proxies.

### **Statement of Values Concerning the Applied Practice of Person-Centeredness**

For the purpose of the Demonstration, Connecticut has defined person-centeredness 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.

Health Neighborhoods (HNs) must commit to the principles of and indicate the means by which they will promote and evaluate the applied practice of person-centeredness.

### **Access Barriers**

Further, the State of Connecticut is committed to remedying barriers that have historically been and are currently being faced by MMEs, including barriers related to ethnicity, disability, culture, and values concerning health care that depart from the “norm”. Non-exclusive examples of these include the following:

- MMEs with physical disabilities and Serious and Persistent Mental Illness (SPMI) report being treated differently on the basis of these disabilities and/or stigma associated with these disabilities.
- Individuals with intellectual disabilities report that providers do not always take their complaints or reports of symptoms seriously.
- Homeless individuals face unique barriers in accessing primary preventative care, managing chronic conditions and receiving support with recovery from acute events.

Finally, the State of Connecticut is committed to addressing the needs of individuals who may face barriers of access relating to communication (e.g. language of origin other than English, lack of reliable means of contact, housing impermanency), cognitive impairment (e.g. Alzheimer’s or other dementia, Acquired Brain Injury), lack of transportation, and/or functional limitation.

HNs must illustrate the strategies that they will employ to address the types of barriers identified above.

7. Please explain other drivers of team-based care beyond performance payments distributed by the financial lead agency of the health neighborhood?

A key driver of team-based care beyond the performance payments will be the care coordination contracts into which all provider members of the HNs will enter. These will detail terms including, but not limited to:

- best practices and standards based the experience in other states
- means of communication between MMEs, Lead Care Managers (LCMs), primary care, specialists and other providers;
- means of consultation among MMEs, LCMs and members of MMEs’ multi-disciplinary care teams;

- role definitions in situations of care transition (e.g. from primary care to specialist, from specialist to secondary/tertiary specialist, from setting to setting).

HNs will also promote team-based care via training and best practice dissemination. Additionally, the Department will seek information in the proposal from each HN regarding additional innovative strategies to drive and promote team-based care (for example, quality reporting on providers).

8. Please explain the interaction between demonstration care managers and coordinators, and the interaction with care managers and coordinators otherwise available to Medicare-Medicaid beneficiaries, including via 1915(c) waivers.

LCMs must coordinate contacts with the MME, his/her preferred representatives and members of the care team to identify immediate and near-term strategies in support of meeting the MME's needs. The LCM must consult with the MME and his/her preferred representatives to determine the composition of the care team most relevant to the MME's needs. If the LCM is not also the MME's waiver care manager, LMHA care manager or MFP transition coordinator, that individual should be considered to be an essential member of the care team. However, for the MMEs participating in the Demonstration the LCM shall act as the Single Point of Contact among all provider members of the multi-disciplinary team.

9. Please provide additional information about the integration and coordination of community-based LTSS under Models 1 & 2.

Both models will build upon current, successful strategies including connections between the ASO and Medicaid enrolled LTSS providers, well-realized LTSS waivers, nursing home transition activities under the Money Follows the Person initiative, and care transition activities to integrate and coordinate LTSS within Demonstration Plans of Care.

In its first year of operation, the ASO has made meaningful connections with a range of Medicaid enrolled LTSS providers, including the Access Agencies that serve coordination, assessment and monitoring functions for the Medicaid elder waiver, nursing facilities, home health agencies and others. Connecticut has nine approved LTSS waivers in place that provide Home and Community-Based Services (HCBS) to older adults, individuals with intellectual disabilities, individuals with SPMI, individuals with physical disabilities, and medically fragile children. The Demonstration will for the first time enable direct integration of these supports with participants' medical and behavioral health care needs. Further, Connecticut operates a Money Follows the Person initiative that has transitioned over 1,400 individuals from institutional settings to independent living in the community. MFP will directly partner in any situation in which a Demonstration participant who has resided in a nursing facility or hospital

for at least the requisite three months wishes to plan for transition. Finally, the partners of the several Care Transitions grants that have been awarded within Connecticut are anticipated to participate in the Demonstration. These activities will support the diverse elements of Connecticut's Strategic Rebalancing Plan (released in January, 2013).

Under Model 1, the ASO will build upon the above strategies by using integrated Medicare and Medicaid data to perform predictive modeling in support of identifying the level of care coordination support that is needed by participants of the Demonstration. Further, the ASO will utilize a Demonstration assessment tool that will be synced with a uniform assessment tool that is currently being developed for all of the Connecticut LTSS waivers. This tool assesses a range of domains of need related to LTSS. Additionally, the ASO will review and adapt its Intensive Care Management (ICM) curriculum, training and strategies to reflect best practices for MMEs, including specific reference to LTSS. Finally, the ASO will continue to work directly with MFP to support the whole person needs of any MME who is transitioning to independent living. .

Under Model 2, Connecticut will require HNs to include a full complement of LTSS providers as members of their networks. As applicable, LTSS waiver care managers and MFP transition coordinators will be required members of MMEs' multi-disciplinary care teams. HNs will receive predictive modeling data from the ASO that will indicate the level of acuity of their participants, and inform the related level of care coordination support that is needed by each individual. Each individual's Lead Care Manager will either populate the above described uniform assessment tool with existing data from a LTSS waiver care plan, or if that information is unavailable or dated, complete the tool to gauge needs. The LCM will then work directly with the MME and a personally-tailored group of providers, if applicable, including the MME's waiver care manager or MFP transition coordinator, to incorporate needed LTSS within a Demonstration Plan of Care.

10. What proportion of Medicare-Medicaid beneficiaries does CT estimate would receive ICM?

Detailed estimates of participation in ICM will be included in Connecticut's April 1 submission.

11. Please clarify whether Model 1 Medicare-Medicaid beneficiaries would receive in-person ICM, beyond the initial in-person needs assessment.

Yes. Connecticut has contractually established standards for ICM in place with its medical ASO, CHN-CT. These will be adapted for purposes of the Demonstration to reflect the higher level of intensity that is anticipated to be required by MMEs. Consistent with best practices for the population, there will be a focus on in-person ICM.

In support of its ICM activity, CHN-CT has fully implemented a tailored, person-centered, goal oriented care coordination tool that includes assessment of critical presenting needs, culturally attuned conversation scripts as well as chronic disease management scripts. This tool will be adapted under the Demonstration to tailor it to the needs of the Demonstration, consistent with the universal core assessment tool that is being developed by Connecticut in support of its State Balancing Incentive Payments Program (BIPP) efforts. Additionally, CHN-CT has in place geographically grouped teams of nurse care managers that will be expanded under the Demonstration to support MMEs.

CHN-CT will also work collaboratively with a co-located unit of Value Options (the behavioral health ASO) to review hospitalizations and planned admissions to identify best strategies for MMEs' care.

12. What proportion of Medicare-Medicaid beneficiaries does CT estimate would be served by a PCMH during the demonstration period?

We estimate that about 20% - approximately 12,000 of 60,000 – of fully dually eligible Medicare-Medicaid enrollees are currently served by PCMH/FQHC practices. Please note that not all of these enrollees will be eligible for the Demonstration; for example, some are anticipated to be served by a Accountable Care Organizations.

13. Please provide additional information about the composition and care models of PCMHs, including any modifications for Medicare-Medicaid beneficiaries.

As of March 7, 2013, there are a total of 96 approved PCMH sites, which are associated with 386 providers. Additionally, there are 37 practices and an associated 117 providers, as well 99 FQHC's and an associated 363 providers, on the "glide path" toward PCMH recognition.

In order to qualify as a PCMH for purposes of enhanced fee-for-service payments and performance-based payments, a practice must be recognized by the National Committee for Quality Assurance (NCQA) as a Level 2 or Level 3 PCMH. The Department accepts recognition in accordance with either the 2008 or 2011 standards, and is also currently reviewing Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards as an alternate means for recognition.

PCMH care models are consistent with NCQA PCMH standards, and include the following key elements:

- enhanced medical care coordination functions;
- increased capacity for non face-to-face and after hours support for patients;

- work towards meaningful use of interoperable electronic health records;
- promotion of self-care and referrals to community resources; and
- measurement of performance and quality of care, individually and across populations.

14. Please provide additional information about the "limited medical care coordination" functions within PCMHs, and whether those functions would overlap with care coordination or ICM under Models 1 & 2.

Care coordination functions under PCMH are typically limited to referrals to and from medical specialists and adjunct providers. This function is one constituent piece of the care coordination that will be provided by ASO-associated ICM nurses (Model 1) and Lead Care Managers (Model 2). PCMH nurse care managers will be for MMEs served by PCMH practices be included as key contacts for ICM nurses (Model 1) and members of the multi-disciplinary care team coordinated by the MME and his or her LCM (Model 2).

15. Does Connecticut propose to require health neighborhoods to designate a behavioral health co-lead or partner? If so, please explain the role of that entity.

Connecticut proposes to require HNs to identify a Behavioral Health Partner Agency (BHPA). The roles contemplated for the BHPA are:

*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 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 ALA 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 ALA, 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 engagement program and materials (regarding the HN and care coordination, health education, etc.)

CMS would like the following additional information from Connecticut about how its proposed demonstration would **ensure an adequate and appropriate provider network**:

16. Please provide additional information to demonstrate that provider networks, for Model 2 in particular, would be appropriate for the needs of the target demonstration population, including sub-populations of Medicare-Medicaid beneficiaries (e.g. individuals with SPMI or IDD, residing in institutional settings).

All MMEs, whether in Model 1 or Model 2, will have access to the full panel of Medicaid providers.

In addition, we are contemplating that each Health Neighborhood will be required to include membership (linked by care coordination contract) 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, but not limited to, cardiologists, endocrinologists, nephrologists, podiatrists, rheumatologists, neurologists, pulmonologists, orthopedists, and physiatrists;
- 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;
- Access Agency(ies) for the Connecticut Home Care Program for Elders and LMHA or LMHA affiliates that serves the health neighborhood's coverage area;
- dentists;
- pharmacists;
- 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;
- ophthalmologists.

*The incidence of required providers relative to the number of participating MMEs is TBD.*

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, and employment services, as well as local organizations serving minority, non-English speaking, and underserved populations.

**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 Neighborhoods will also be expected to coordinate with relevant ASOs (CHN-CT for medical, ValueOptions for behavioral health, Benecare for dental, LogistiCare for transportation) in order to facilitate clients' access to services.

17. Please clarify the meaning of "provider transmittals" (p. 34) that would help promote provider participation in health neighborhoods.

DSS regularly issues provider transmittals (notices) to Medicaid performing providers to detail changes in covered services, revisions to prior authorization requirements, updates rate schedules and provider obligations. Provider transmittals are issued in writing and electronically, and are posted to a central "HUSKY" web site:

<http://www.huskyhealthct.org/providers.html?hhNav=>

In that this is a well-recognized means of communicating with providers, Connecticut proposes to include this resource as one of many means of engaging providers in the process of forming health neighborhoods. Other means include provider forums, technical assistance support through a contractor, and Q&A documents.

CMS would like additional information from Connecticut about how the proposed demonstration would address the following issues related to **beneficiary protections**:

18. Please clarify whether Medicare-Medicaid beneficiaries eligible for enrollment with a health neighborhood would have the opportunity to opt out of the health neighborhood and into the ASO-only Model 1 in advance.

Yes. During an open enrollment period, MMEs will have the right to opt out of HN participation and participate in Model 1 in advance of when enrollment would become effective.

The State of Connecticut plans to use the following means of affiliating MMEs with HNs:

MMEs who have received their primary care or behavioral health care from an HN participating provider within the twelve months preceding implementation of the Demonstration will be passively enrolled with that HN under Model 2. The Department proposes to use a “step-wise” enrollment process under which the ASO will:

- first consider whether the individual has received care from a primary care provider (including a primary care physician, FQHC, clinic, or geriatrician), and if so, enroll on that basis;
- if not, next consider whether the individual has received care from a behavioral health care provider (including psychiatrist, psychologist or licensed clinical social worker), and if so, enroll on that basis; and if not, next consider whether the individual has received care from a specialist (including, but not limited to, a cardiologist or a nephrologist) for one or more chronic conditions, and if so, enroll on that basis.

A neutral enrollment broker will have primary responsibility for issuing initial notices and welcome packets to each MME who is passively enrolled in an HN. The notice will disclose:

- the benefits of participation, including, but not limited to, access to care coordination and supplemental services;
- the nature of information sharing that will occur;
- the nature of any shared savings agreement in which the HN is participating; and
- the right to opt out of participation in the HN.

The welcome packet will include a list of provide members of the HN, a list of qualified Lead Care Managers (LCMs), a description of the supplemental services that will be provided and a list of the providers that will supply them, a form identifying the MME’s preferred LCM, a form documenting the MME’s rights and responsibilities, and a form permitting the MME to opt out of participation in the Demonstration.

19. What protections would be in place for a Model 2 enrollee who is dissatisfied with a Lead Care Manager, and wishes to select a new Lead Care Manager?

On a monthly basis, Connecticut will permit MMEs to select another LCM within the Health Neighborhood in the event that they are dissatisfied with the level of service provided.

CMS also asks Connecticut to provide the following information about how its proposed demonstration would meet the **implementation** standard:

20. Has Connecticut learned any lessons from the last year of State FFS-oriented reform that would inform the design and/or implementation of a Managed FFS demonstration?

Connecticut has gained experience from the Intensive Care Management (ICM) model that is operated by the ASO (the Community Health Network of Connecticut). These services are targeted to individuals identified based on system analytics as high risk individuals with chronic disease. The service is not limited to MMEs. Some lessons learned in relation to ICM include the challenges of cold contacting clients for ICM, the challenges presented by incorrect contact information, the value of in-person contact, and the need for behavioral health collaboration in addressing emergency department usage.

Both Models will work to further address the latter two lessons. HNs will be able to leverage providers' existing relationships with clients in order to address the former two lessons and facilitate ICM. Additionally, another lesson from ICM to date is that addressing the person's basic human needs and immediate non-medical needs are just as important, if not more so, for a person to be able to fully engage in healthcare and health-related behavior changes. ICM in both models will focus on and address a wide range of person-centered needs.

21. When does Connecticut expect to transition from making enhanced FFS payments to advanced payments to PCMHs? When does Connecticut plan to submit the relevant State Plan Amendment(s)?

Connecticut seeks to introduce risk-adjusted APM I payments contemporaneous with implementing the Demonstration. Connecticut plans to submit the relevant SPAs as soon as it has entered into a Demonstration MOU with CMS.

22. What is the minimum number of participating health neighborhoods that Connecticut would require to implement Model 2?

Connecticut anticipates a minimum of three qualified HNs to implement Model 2.

23. What is the current timeline for Connecticut to procure health neighborhoods?

Contingent upon the timing of an MOU with CMS, Connecticut intends to procure HNs in Fall, 2013.

### **Additional CMS Questions about Value Incentive Pool**

#### **1. Please provide additional detail explaining how CT would calculate the amount of total funding in the Value Incentive Pool.**

For context, as outlined in our application, there will be 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 will 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 savings.** Shared savings will be calculated by comparing actual PMPM expenditures to actuarially sound risk adjusted PMPM benchmark targets for a comparable population.”

A portion of any shared savings / retrospective performance payment that is received by the State from CMS will be used to fund the Demonstration’s Performance Payment Pool. We are aware of the shared savings methodology outlined in Washington State’s Demonstration MOU, and anticipate that CMS’s shared savings with Connecticut will be calculated using a similar method.

The amount of the Performance Payment Pool available to Health Neighborhood (HN) Providers will be a percentage of the shared savings payment that is attributable to Model 2 (Health Neighborhoods).

In year 1, the Performance Payment Pool will be distributed solely based on HN performance on quality measures. In years 2 and 3, the Performance Payment Pool will continue to be funded by a portion of any shared savings / retrospective payment that is received by the State from CMS. The Pool in these latter years will be divided into both a Quality Bonus Pool and Value Incentive Pool (percentage to be determined).

**2. Please explain how CT proposes to fund the Value Incentive Pool (i.e. the source of funding).**

As above, a portion of any Demonstration's shared savings / retrospective performance payment received by Connecticut from CMS will fund the Value Incentive Pool.

**3. Please provide additional detail explaining how CT would calculate the amount of the performance payments made to individual health neighborhoods from the Value Incentive Pool.**

The Value Incentive Pool will represent a specified percentage (TBD) of the overall Performance Payment Pool. Payments from the Value Incentive Pool will be made to HNs that both:

1. meet particular thresholds on quality measures, to be determined; and
2. achieve savings in serving their enrolled population of Medicare-Medicaid Eligibles (MMEs).

Among HNs that meet these qualifications, we envision that the Value incentive Pool will be divided proportional to the share of savings related to a particular HN's population.