State Demonstrations to Integrate Care for Dual Eligibles

Demonstration Proposal

Connecticut

Summary: In 2011, Connecticut was competitively selected to receive funding through CMS' *State Demonstrations to Integrate Care for Dual Eligible Individuals.* As part of this Demonstration, CMS provided support to the State to design a demonstration proposal that describes how it would structure, implement, and monitor an integrated delivery system and payment model aimed at improving the quality, coordination, and cost-effectiveness of services for dual eligible individuals. Through the demonstration proposal, the State must demonstrate its ability to meet or exceed certain CMS established standards and conditions including beneficiary protections. These standards and conditions include factors such as beneficiary protections, stakeholder engagement, and network adequacy among others. In order for CMS to determine whether the standards and conditions have been met, States are asked to submit a demonstration proposal that outlines their proposed approach for integrating care for dual eligible individuals. The Connecticut Department of Social Services has submitted this proposal for CMS review.

As part of the review process, CMS will seek public comment through a 30-day notice period. During this time interested individuals or groups may submit comments to help inform CMS' review of the proposal.

CMS will make all decisions related to the implementation of proposed demonstrations following a thorough review of the proposal and supporting documentation. Further discussion and/or development of certain aspects of the demonstration (e.g., quality measures, rate methodology, etc.) may be required before any formal agreement is finalized.

Publication of this proposal does not imply CMS approval of the demonstration.

Invitation for public comment: We welcome public input on this proposal. To be assured consideration, please submit comments by 5 p.m. EDT, June 30, 2012. You may submit comments on this proposal to CT-MedicareMedicaidCoordination@cms.hhs.gov.

Please note: This proposal was updated as of June 1, 2012 to correct an error in submission.

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

PROPOSAL TO THE
CENTER FOR MEDICARE AND MEDICAID INNOVATION

STATE DEMONSTRATION TO INTEGRATE CARE FOR DUAL ELIGIBLE INDIVIDUALS

Connecticut Department
of Social Services
Making a Difference

May 31, 2012

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A. Executive Summary

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

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

Connecticut MMEs face significant health status challenges related to chronic disease, incidence of Serious Mental Illness (SMI), cognitive impairment and co-morbidity of conditions. In addition, spending for Connecticut's 57,569 MMEs is 155% of the national average ($53,500 per MME as compared with $34,500), for a total cost of more than $3.4 billion per year. The high incidence of MME's co-occurring medical and behavioral health conditions, and associated costs, presents unique challenges, and also opportunities for improvement.

Under the Demonstration, Connecticut will feature two models that will rest upon the building blocks of its existing Medicaid and long-term care re-balancing reforms. These building blocks include the existing medical and behavioral health Administrative Services Organizations (ASOs), the state's Person Centered Medical Home initiative, and Money Follows the Person (MFP) program.

Model 1 (Administrative Services Organization) 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 the ASOs' 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 Neighborhood) 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 subset of the MMEs that participate in the Demonstration will be passively enrolled in HNs based on receiving primary care or behavioral health care from a participating HN provider. These MMEs will be notified by a neutral enrollment broker that they have been assigned to an HN and will have the option to decline to participate. The remaining population of MMEs, with the exception of those who are enrolled in a Medicare Advantage (MA) Plan, or aligned with an Accountable Care Organization (ACO) as of December 1, 2012, will be attributed to Connecticut's medical or behavioral health Administrative Services Organizations (ASOs) under Model 1. MMEs in both models will also be attributed to PCMH practices quarterly, based on claims history. Connecticut intends to include long-term care participants in the Demonstration contingent upon gaining a better understanding of CMS' methodology for calculating shared savings. Connecticut proposes that CMS consider adjusting PMPM targets for MMEs based on place of residence to adjust for the impact of transitions from institutional to community-based settings. Further, Connecticut plans to implement Model 1 contingent upon review and assessment of CMMI performance standards and ability to meet these standards under Model 1.

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

The Demonstration will be a key element of a laboratory environment in Connecticut in which the success of various, co-occurring value-based and/or integrated care initiatives (ICD, ACO and D-SNP) can be modeled and tested for capacity to achieve the desired results of improved care for participants, enhanced consumer satisfaction and controls on the rate of growth (and where possible, reduction) of costs of care. Principles of person-centeredness will inform every stage of implementation of the Demonstration, and the Department will use diverse means (stakeholder comment, participant focus groups, performance measures, cost and analysis of integrated Medicare and Medicaid data) to evaluate its success. The Department affirms that Connecticut will comply with CMS' Standards and Conditions for the Demonstration. The Department is seeking to enter into separate agreements with CMMI for Models 1 and 2. This will ensure that there are no financial dependencies between the models, which might otherwise compromise the State's ability to use savings to reward performance under Model 2.

Table A-1 Features of the Demonstration Proposal

Target Population	Full MMEs, age 18 – 64 and age 65 and older
Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide	63,630
Total Number of Beneficiaries Eligible for Demonstration	57,569

Geographic Service Area	• Administrative Services Organization (ASO) model will operate statewide • Health Neighborhood (HN) model will be introduced in three to five (3-5) geographic areas
Summary of Covered Benefits	• Medicaid State Plan (including 1915(i)) • Medicaid waiver services • Medicare Parts A, B and D • Adjunct services and supports (e.g. Intensive Care Management, chronic disease self-management education, nutrition counseling, falls prevention, medication management services, and potentially also, peer support and recovery assistant)
Financing Model • Is this proposal using a financial alignment model from the July 8 SMD? • Payment mechanism	• Yes. Additionally, Connecticut proposes to make performance payments to HNs that achieve benchmarks on identified performance measures. • Managed Fee-for-Service (FFS) Model
Summary of Stakeholder Engagement/ Input	• 4 meetings of Medical Assistance Program Oversight Council (MAPOC) (membership includes legislators, state agencies, stakeholders) • 12 meetings of MAPOC Complex Care Committee (CCC)(key means of gaining input from legislators, advocates, providers and consumers on overall model) • multiple meetings of work groups affiliated with CCC: Model Design, Performance Evaluation, Consumer Access (please see Section C i. and Appendix C for more detail) • consumer input through 1) 8 focus groups (71 participants) with individuals age 65+; and 2) 5 focus groups (45 participants) with individuals with disabilities who are under the age of 65 • ten-day informal comment period for CCC (April 5, 2012 – April 15, 2012) • thirty-day formal comment period (April 25, 2012 – May 25, 2012) • ongoing provider and member education sessions
Proposed Implementation Date	Model 1: January 1, 2013; Model 2: April 1, 2013[1]

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[1] Based on ongoing assessment of feasibility and status of competing initiatives, the State intends to seek CMMI approval for a later implementation date for both models, up until January 1, 2014.

B. Background

i. Overall vision and barriers to address

Connecticut's overall vision for the Demonstration is to create and enable value-based systems through which MMEs will receive integrated, holistic, person-centered services and supports that address the entirety of their needs (physical, behavioral, and non-medical). Implementation of this Demonstration will result in 1) enhanced population outcomes; 2) improved consumer care experience; and 3) controls on the rate of growth of (and if possible, reductions in) costs of care.

Key rationales for the Demonstration include the following:

- the 57,569 Connecticut MMEs represent less than one-tenth (10%) of Medicaid beneficiaries in Connecticut yet they account for thirty-eight percent (38%) of all Medicaid expenditures
- per capita spending for Connecticut MMEs is as follows: $53,500 in total; $16,500 for Medicare; and $37,000 for Medicaid
- per capita spending for Connecticut's 32,583 MMEs age 65 and over and the 24,986 MMEs with disabilities under age 65 is fifty-five percent (55%) higher than the national average
- MMEs have complex, co-occurring health conditions:
    - roughly 88% of individuals age 65 and older have at least one chronic disease, and 42% has three or more chronic diseases, accounting for 55% of total expenditures
    - 58% of younger individuals with disabilities have at least one chronic disease, accounting for 63% of the total expenditures
    - 38% have a serious mental illness (SMI)
- comparatively high spending alone on MMEs has not resulted in better health outcomes, better access or improved care experience:
    - illustratively, in state fiscal year (SFY) 2010 almost 29% of MMEs were re-hospitalized within 30 days following a discharge, and almost 10% were re-hospitalized within 7 days following a discharge
    - nationally, on average, individuals with SMI have shorter lifespans than do their peers due to side effects of medications, co-morbid medical conditions and lack of access to preventative care
    - MMEs have reported in Demonstration-related focus groups that they have trouble finding doctors and specialists that will accept Medicare and Medicaid and often do not feel that doctors take a holistic approach to their needs

Connecticut MMEs face significant barriers related to the current financing and delivery system. Broadly, these include:

- **Constraints of the current Fee-for-Service (FFS) delivery system:** The current FFS delivery system perpetuates a focus on the volume of reimbursable services rather than their value.

- **Lack of integration between Medicare and Medicaid funded services:** Lack of integration between these two programs defeats opportunities to link services and supports:

    - as MMEs transition from care setting to care setting (home to hospital, hospital to nursing facility, nursing facility to home);
    - among providers of medical, behavioral, long-term services and supports, and community-based social services (e.g. housing); and
    - lack of Medicare data prevents use of such data to support care coordination and performance measurement.

- **Lack of provider connections across the care continuum:** Providers have historically neither had the opportunity nor the means (e.g. care coordination agreements, real-time utilization data, electronic communication tools) to coordinate across disciplines. Further, providers have not typically worked in multi-disciplinary teams across types and levels of care. Coordination and communication are essential to achieve the best possible health outcomes.

- **Situational, provider-driven care planning:** Providers are typically oriented to address specific issues and concerns on an episodic basis, and have limited experience with care coordination that spans the range of presenting physical and behavioral health, as well as long-term care, needs. Further, providers have had little experience with the applied practice of person-centeredness (e.g. primacy of the patient/consumer in decision-making, need for individually-tailored communication strategies). This limits opportunities to include MMEs in care planning and to honor their values and preferences.

- **Access barriers:** Diverse access barriers inhibit MMEs' ability to get the services and supports that they need. These include, but are not limited to:

    - Barriers related to ethnicity, disability, language of origin other than English, culture, values concerning health care that depart from the "norm": *Example: MMEs with physical disabilities and Serious Mental Illness who participated in focus groups in support of the Demonstration reported that providers treat people differently on the basis of these disabilities or the associated stigma. Individuals with intellectual disabilities reported that some providers accommodate their needs and others do not. Individuals with SMI report that providers do not always take their complaints or reports of symptoms seriously.*
    - Barriers presented by out-of-pocket costs for health care that are unsupportable on a fixed income budget: *Example: MMEs who participated in focus groups in support of the Demonstration reported that the Part D co-payments that they are required to make in some cases prevent them from filling needed prescriptions.*
    - Barriers related to coverage rules: *Example: To qualify for Medicare coverage in a skilled nursing facility (SNF), an individual must have been hospitalized for at least three consecutive days and be admitted to the SNF for the condition for which he or she was hospitalized. This in some cases results in hospitalizing an individual who could otherwise be directly and effectively served by a SNF.*

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

While Connecticut has some experience with care enhancement initiatives to address access and coordination issues associated with primary care, they have operated in relative isolation with other providers, and have been unable to overcome the fragmentation that is inherent in the way in which services are currently organized and delivered. Today, no system of providers in any part of the state can measure the value they provide to MMEs. And no system of providers can tell whether they are providing better overall value over time. Connecticut proposes to overcome these barriers by comparing two key models, which are described in Section C.

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

ii. Detailed description of population

	Overall	Individuals receiving LTSS in institutional settings	Individuals receiving LTSS in HCBS settings
Overall total	57,569	17,035	15,661
Individuals age 65+	32,584	14,525	8,709
Individuals under age 65	24,985	2,510	6,952
Individuals with serious mental illness	22,158	7,746	3,329
Individuals with intellectual disabilities	9,235	1,774	5,877

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

Connecticut is made up of both urban and rural counties. The majority (74% to 78%) of MMEs reside in the urban/suburban counties of Fairfield, Hartford and New Haven, consistent with the general population centers in Connecticut. Fairfield, Hartford and New Haven have a higher proportion of elderly MMEs while the rest of the counties (Litchfield, Middlesex, New London, Tolland and Windham) experience a more even mix of MMEs as between the elderly and blind individuals and those with disabilities. The population mix by county has been fairly stable over the past three fiscal years with an overall annual average population growth of 1% for blind individuals and those with disabilities and -1% for the elderly.

The average age of MMEs is 67 years old. 57% are elderly, and 43% are blind or have a disability. The largest concentration of the elderly is over the age of 85 (36%) while the largest concentration of blind individuals and those with disabilities is between the ages of 45-54 (35%). Very few MMEs are under the age of 21. Roughly 88% of the elderly MME population has at least one chronic disease, with 42% having three or more chronic diseases, accounting for 55% of the total expenditures. The distribution of MMEs by number of chronic diseases is more evenly spread for blind individuals and those with disabilities where 58% of the population has at least one chronic disease, accounting for 63% of the total expenditures. 38% of MMEs have a serious mental illness. A greater proportion (51%) of blind individuals and those with disabilities has a serious mental illness as compared to 29% of the elderly MMEs. In addition, 31% of blind individuals and those with disabilities have an intellectual disability, compared to 5% of the elderly. In contrast, 53% of the elderly MMEs have a neurological disability, including some form of Alzheimer's disease and/or dementia.

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

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

The average per-member-per-month (PMPM) Medicaid expenditures have been fairly stable over the past three fiscal years, with an overall annual average expenditure growth of -1.3% for blind individuals and those with disabilities and 0.3% for the elderly. Medicare expenditures have increased an average of 4.4% per year.

The majority of the Medicare and Medicaid claims are for long-term services and supports. Of the $3.1 billion in combined claims for MMEs, roughly $2.2 billion, or 72%, are related to long-term services and supports (LTSS). In the elderly population, the top service category is nursing home, which accounts for 46% of the total cost, while waiver services are the top service category for blind individuals and those with disabilities, accounting for 38% of the total cost. PMPM costs vary by disease category with those with intellectual disabilities having the highest PMPM costs and those with neurological disabilities having the second highest costs.

C. Care Model Overview

i. Proposed delivery system model

Overview

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

Model 1 (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 Neighborhood): 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.

Features of the Demonstration that will support both models include:

- chronic illness self-management education activities 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 connections to other State and private services and supports that may complement Demonstration activities, including the HUD Healthy Homes Assessment.

Applicable definitions:

Intensive Care Management: For purposes of the Demonstration, ICM will be defined as a single point of coordination and accountability for supporting high risk MMEs in managing the full range of their services and supports. ICM will include, but will not be limited to, the following key elements: 1) a comprehensive face-to-face assessment of an MME's needs, addressing a broad range of domains; 2) development, implementation and monitoring of a plan of care that a) incorporates the range of services and supports that is indicated by the assessment and to which the MME consents; b) integrates physical and behavioral health care; c) includes short and long-range goals; and d) identifies a team of family/caregivers, representatives and providers who will play a role in providing the services and supports.

<u>Care Coordination:</u> For purposes of the Demonstration, care coordination will be defined as including activities conducted by telephone or in person that are designed to support the needs of:

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

<u>Lead Care Manager:</u> For purposes of the Demonstration, a Lead Care Manager will be the identified single point of contact charged with assessing the need for, coordinating and ensuring provision of all needed Demonstration services. The Lead Care Manager must be an APRN, RN, LCSW, LMFT or LPC.

<u>Person Centeredness:</u> For purposes of the Demonstration, person centeredness will be defined as an approach that:

- *provides the MME with needed information, education and support required 1) to make fully informed decisions about his or her care options and, 2) 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 1) consistent with his or her personal preferences, choices and strengths; and 2) implemented in the most integrated setting.*

The Building Blocks of Medicaid and Long-Term Care Re-Balancing Reforms

Two recently implemented structural features of the Connecticut Medicaid program will support the aims of the Demonstration: transition of medical services to an ASO and implementation of the PCMH initiative. Additionally, Connecticut's extensive work through the Money Follows the Person (MFP) initiative, and associated nursing home diversification activities, will support the goals of the Demonstration. Furthermore, the Department is working to promote access to services by addressing delays in Medicaid application processing that have resulted from inadequate historical staffing and an antiquated eligibility system.

Recognizing opportunities to achieve better health outcomes and streamline administrative costs, Connecticut has in recent years shifted management of its Medicaid behavioral health, dental and non-emergency medical transportation (NEMT) services to ASOs. On January 1, 2012, Medicaid medical services were transitioned from a managed care infrastructure that included three capitated health plans and a small Primary Care Case Management (PCCM) pilot to a medical ASO. This extended state-of-the-art managed care services to the entire Medicaid and CHIP population. The medical and behavioral health (BH) ASOs provide a broad range of services, including: member support, ICM, predictive modeling based on Medicaid data, statewide and provider specific performance measurement and profiling, utilization management, and member grievances and appeals. The ASOs coordinate in supporting the needs of individuals with co-occurring medical and behavioral health conditions through a BH unit staffed by credentialed individuals that is co-located with the medical ASO. The medical and BH ASOs will comprise Model 1. The ASOs will also provide critical infrastructure to support Model 2. The ASOs are provided with annual performance payments contingent on meeting access and quality standards. Historically, the Department has achieved its best results when ASO and provider performance goals are in alignment. For this reason, performance targets and payments for both ASOs will be aligned with the overall performance goals of the Demonstration and with the performance goals of the HNs.

The Department also implemented its PCMH initiative on January 1, 2012. The Department is investing significant resources, both financial and technical, to help primary care practices obtain PCMH recognition from the National Committee for Quality Assurance (NCQA). Key features of practice transformation that support the goals of the Demonstration include embedding limited medical care coordination functions within primary care practices, capacity for non face-to-face and after hours support for patients, and use of interoperable electronic health records. All PCMH practices will receive performance payments in return for meeting care experience and quality targets. The Demonstration will extend the PCMH program and associated participation and performance payments to additional practices that serve MMEs with the goal of improving access to and utilization of primary, preventative care, and anticipates that a significant number of new practices will join. The enhanced capabilities afforded by PCMH recognition will support both Model 1 and Model 2.

Additionally, Connecticut's MFP has been recognized by CMS for its innovation and progress toward achievement of outcomes. To date, over 1,000 individuals have been transitioned to community living under the auspices of the program, and in 2011, Governor Malloy announced an expansion of its scope in support of transitioning 5,200 individuals by 2016. MFP will complement the work of the Demonstration by modeling best practices in person-centeredness, dignity of risk, and a values-driven care planning process, and is anticipated to serve a key role in the "learning collaboratives" that are described below in the Provider Network section. Additionally, MFP will through its nursing home modernization and diversification efforts, as well as leadership on workforce issues, help to create provider network capacity that corresponds to consumer preference in a meaningful way. In addition, there are opportunities to align with MFP in making performance payments to HNs that achieve identified benchmarks on MFP measures. Finally, consistent with the Demonstration's goal of reducing unnecessary costs associated with institutional care, MFP has a direct influence on re-balancing long-term care expenditures toward home and community-based services and supports.

Model 1 (ASO): Under Model 1, the Department, in partnership with its sister agencies DDS and DMHAS, plans to enhance the capacity of its existing medical (CHN-CT) and behavioral health (Value Options) ASOs to achieve the desired Demonstration outcomes for MMEs. Currently, the ASOs provide substantial value through Medicaid-specific predictive modeling and data analytics, member services, quality management and performance measurement. Under the Demonstration, the ASOs will also:

- integrate Medicare and Medicaid data and use state of the art information technology and analytics under both Model 1 and Model 2 to support providers' capacity to understand the profile of MMEs' utilization of services and supports, promote the use of primary preventative care, and intercept preventable episodes including unnecessary use of emergency departments and acute hospitalization;

- provide technical assistance in support of significantly expanding the number of primary care practice participants in Connecticut's PCMH initiative with the goal of equipping these practices to respond in a timely, person-centered manner to MME patients and to help them manage co-morbid chronic conditions through preventative care and chronic disease self-management education;

- enhance ASO capacity to provide ICM and care coordination through additional staff and tailoring of assessment, monitoring and coordination processes to support the needs and preferences of MMEs; and
- use integrated data to support statewide performance measurement and reporting, including, but not limited to, quality management initiatives focused on such areas as chronic pain management, connection to aftercare, chronic obstructive pulmonary disease (COPD), congestive heart failure, SMI, dementia, and diabetes.

Quality management activities by the ASOs will specifically examine the care provided to MMEs, stratify data by various subsets of the MME population, and identify opportunities for intervention.

Model 2 (Health Neighborhood): Under Model 2, the Department and its state agency partners plan to develop standards for and to procure three to five (3-5) Health Neighborhoods (HN). HNs will be comprised of 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 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.

Each HN will be required to identify a Lead Agency that meets requisites that will be identified in detail in the RFP but that will generally include operating capital, management capacity and ability to bring together partners across disciplines. Generally, Lead Agencies will serve administrative, fiduciary and care coordination functions. Administrative functions will include: 1) contracting among provider members of the HN; 2) management/oversight of care coordination provided by the network; 3) compliance with Department requirements; 4) support for provider members (e.g. data sharing, use of evidence-based protocols, CQI); 5) performance reporting; and 6) accountability for standards (including termination of non-performing).

Fiduciary functions will include receipt and distribution of risk-adjusted advance payments to HNs (APM II), receipt and distribution of gain sharing, if applicable. The Departments of Social Services and Mental Health and Addiction Services anticipate requiring that HNs designate a behavioral health co-Lead or partner with expertise in the provision of services and supports to individuals with SMI. The Departments acknowledge that the following issues will require further explication in the process of developing the HN RFP and the implementation plan for the Demonstration: role of Leads in providing both care coordination and direct services, the means by which the Lead Agencies will distribute start-up, APM II and performance payments, and the role of the behavioral health co-Lead or partner.

While the Department believes that Model 1 will bring value to MMEs, it is also convinced that enhancements to this model will best marry the interest in achieving improved health outcomes and care experience for MMEs with local accountability for means and costs of care. This is the key premise of Model 2, which will build upon the features of Model 1 by connecting MMEs with a neighborhood of their providers. Model 2 reflects key aspects of what MME members of Demonstration focus groups reported as being of value and concern to them:

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

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

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

Model 2 supplemental benefits[2] will include:

Chronic disease self-management education – Chronic disease self-management education will be provided to MMEs with chronic conditions (e.g. COPD, asthma, and diabetes), SMI, and co-occurring behavioral health and medical conditions with the goals of equipping them to understand the clinical profile of the condition(s) and empowering them to actively participate in managing them. Chronic disease self-management education will be a contracted service of the HN. A potential means of providing this service is to engage trained disease educators as is indicated by the presenting needs of the HN's participating MMEs.

Fall prevention intervention – A fall prevention intervention will be provided to those MMEs identified by the HN through the comprehensive assessment as likely to benefit from such activities for reasons including, but not limited to, environmental/access concerns, poly-pharmacy, cognitive impairment, and physical health conditions affecting gait and balance. A potential means of providing this is through an evidence-based protocol developed by the Yale School of Public Health.

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[2] The Department is working with DMHAS to define additional supplemental benefits that *may* be included in the APM II. These include peer support services and recovery assistant services. Peer support services are non-clinical interventions that support individuals with SMI and/or substance abuse issues by facilitating recovery and wellness. Peer support would be provided under the supervision of a behavioral health professional by trained, self-identified consumers who are in recovery from mental illness and/or substance use disorders. Recovery assistant services 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.

Nutrition counseling – Nutrition counseling will be provided to those MMEs identified by the HN through the comprehensive assessment as likely to benefit from such activities for reasons including, but not limited to, chronic conditions, obesity/overweight/ underweight, and social isolation. Nutrition counseling will be a contracted service of the HN, and could take such forms as counseling individuals with chronic conditions on 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. Potential means of providing this is through the Cooperative Extension System of the University of Connecticut, individual sessions with a registered dietician, and/or coordination with the basic nutrition assessment and counseling activities associated with congregate and home-delivered meals funded under Title III-C of the Older Americans Act.

Medication management services – Medication management services will be provided by pharmacists to those MMEs identified by the HN through the comprehensive assessment, self-referral and data mining activities that indicate poly-pharmacy or non-compliance with a prescribed medication regimen as well as co-morbid physical and behavioral health conditions. Medication management services will be a contracted service of the HN and will be defined as including medication reconciliation, medication therapy management, and medication coordination and monitoring of processes across prescribers, pharmacies and care settings. This service will feature components including 1) in-person assessment; 2) development of a medication action plan to promote self-management and patient empowerment; and 3) communication and collaboration with the MME's prescribers and other health care providers on evidence-based medication interventions. A potential means of providing this service is to purchase service from a collaborative operated by the University of Connecticut School of Pharmacy and the Connecticut Pharmacy Providers Association.

Connecticut does not propose to cover these services on a fee-for-service basis; rather, to underwrite costs through the APM II payment that is described in Section E Financing and Payment.

The Beneficiary Pathway: Models 1 and 2 Contrasted

	The Beneficiary Pathway: Models 1 and 2 Contrasted	
	Model 1 (ASO)	**Model 2 (HN)**
Enrollment and Associated Rights	Effective January 1, 2012, all Connecticut MMEs were attributed based on primary presenting diagnosis to the medical or BH ASOs. For purposes of the Demonstration, MMEs who 1) do not receive primary care from a Model 2 participating primary care or behavioral health care provider; and 2) are not enrolled in a Medicare Advantage Plan, or aligned with an Accountable Care Organization (ACO) as of January 1, 2013; will be attributed to the ASOs under Model 1. MME participants of Model 1 will receive	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 ASOs 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;

	The Beneficiary Pathway: Models 1 and 2 Contrasted	
	Model 1 (ASO)	**Model 2 (HN)**
	notice from the ASO to which they have been assigned (medical or BH) of the goals of the Demonstration. This notice will disclose: • the benefits of participating, including, but not limited to, coordination of care; • the nature of information sharing that will occur; and • the right to opt out of information sharing. MME participants of Model 1 retain the right to opt out of information sharing for purposes of the Demonstration. This is essentially co-equal with declining to participate in the Demonstration. MME participants of Model 1 retain free choice of provider. Another important feature of the Demonstration will be that the ASOs will identify MMEs who do not have a usual and customary source of primary care and will promote to them the availability of such practices, with an emphasis on practices that are participating in the Person Centered Medical Home (PCMH) initiative.	• 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. The ASOs will over the first six months of the Demonstration provide quarterly rosters of enrollees to the HNs. Further, the ASOs will establish protocols for situations in which individuals are moving from one primary care or behavioral health care provider to another (e.g. situations in which the Money Follows the Person project is assisting an MME in transitioning from a nursing facility to the community). MME participants of Model 2 will receive notice and a welcome packet from a neutral enrollment broker that they have been passively enrolled in an HN. The notice will disclose: • the benefits of participation, including, but not limited to access to the supplemental benefits that will be offered by HNs; • 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 such information as a list of provider membership in the HN, a list of qualified Lead Care Managers, and a description of how to access the supplemental benefits that will offered. Further, the welcome packet will include a

	The Beneficiary Pathway: Models 1 and 2 Contrasted	
	Model 1 (ASO)	**Model 2 (HN)**
		form asking the MME to identify his or her preferred Lead Care Manager. The MME will be asked to return this form to the neutral enrollment broker, which will follow up with the MME at specified intervals should the MME not respond. The Department will also partner with other recognized and trusted sources of information & assistance to educate participants on the benefits and obligations of Model 2. Examples of these include CHOICES (Connecticut's State Health Information Program), the Aging and Disability Resource Centers (ADRCs) and Infoline. MME participants of Model 2 retain the right to opt out of participation in an HN in which they have been passively enrolled. If an MME chooses to opt out, he or she reverts to participation under Model 1. If MME participants of Model 2 wish to opt out of information sharing for purposes of the Demonstration, he or she reverts to participation under Model 1. MME participants of Model 2 retain free choice of provider, regardless of whether a provider from which the MME wishes to receive service is participating in the HN.
ICM/Care Coordination	Under Model 1, the ASOs will run integrated Medicare and Medicaid data through a predictive modeling tool to identify high-risk MME participants of both Models 1 and 2 who could benefit from ICM services. Additionally, the ASOs will identify MMEs who require care coordination through diverse means, including MME self-referral, review of utilization data and referrals from providers. Under Model 1, the ASOs will provide both ICM and care coordination through geographic teams composed of the following 1) RN ICM Care Managers; 2) LPN	As described above, MMEs who are enrolled in an HN will be informed of the right to and will have the opportunity to select a Lead Care Manager of choice from among the network of participating HN providers. This Lead Care Manager will serve as the single point of contact for that beneficiary. Under Model 2, the HN Lead Agencies will receive monthly reports from the ASOs identifying MMEs who have been determined through predictive modeling to be high risk and in need of ICM. The Lead Agencies will be responsible for directing these reports to the appropriate sLead Care Managers. All MMEs who are identified as in need of ICM, either through the predictive modeling

	The Beneficiary Pathway: Models 1 and 2 Contrasted	
	Model 1 (ASO)	**Model 2 (HN)**
	Care Coordinators; 3) administrative care coordinators who will provide non-clinical member services support; 4) social workers; and 5) Human Services Specialists who act as liaisons for social services. All MMEs who are identified as in need of ICM, either through the predictive modeling approach described above or through self or provider referral, will be contacted by ASO ICM Care Managers to determine whether the MME wishes to participate in ICM. If the MME agrees, the ASO ICM Care manager will 1) conduct a comprehensive, in-person, home-based assessment of the MME's needs and preferences with the MME and his/her preferred representatives using an electronic care plan instrument and communication tools specifically adapted for this purpose; 2) identify any existing sources of care coordination (e.g. Medicaid HCBS waiver care coordinator, behavioral health care coordinator, Community Living Arrangement care coordination for individuals with intellectual disabilities, Money Follows the Person transition coordinators, dental ASO care coordinators, PCMH care coordinators); 3) prepare and request the MME's review and approval of a care plan; and 4) contact any and all relevant providers (including sources of care coordination) and sources of informal support (e.g. family caregivers, volunteers) to help improve coordination of existing services and, as necessary, augment the service array. MMEs who are not identified as in need of ICM through predictive modeling may self-refer for this service, and/or may identify the need for assistance from the ASO with care coordination activities including, but not limited to, referrals to medical,	approach described above or through self or provider referral, will be contacted by their identified Lead Care Managers to determine whether the MME wishes to participate in ICM. If the MME agrees, the Lead Care Manager will 1) conduct a comprehensive, in-person, home-based assessment of the MME's needs and preferences with the MME and his/her preferred representatives using an electronic care plan instrument and communication tools specifically adapted for this purpose; 2) identify any existing sources of care coordination (e.g. Medicaid HCBS waiver care coordinator, behavioral health care coordinator, Community Living Arrangement care coordination for individuals with intellectual disabilities, Money Follows the Person transition coordinators, dental ASO care coordinators, PCMH care coordinators); 3) prepare and request the MME's review and approval of a care plan; and 4) convene any and all relevant HN providers (including sources of care coordination) and sources of informal support (e.g. family caregivers, volunteers) in a multi-disciplinary, team-based approach to implementing the care plan. MMEs who are not identified as in need of ICM through predictive modeling may self-refer for this service, and/or may identify the need for assistance from their Lead Care Manager with care coordination activities including, but not limited to, referrals to medical, behavioral health, long-term services and supports and/or community-based services.

	The Beneficiary Pathway: Models 1 and 2 Contrasted	
	Model 1 (ASO)	**Model 2 (HN)**
	behavioral health, long-term services and supports and/or community-based services. This role will be performed, respectively, by the ASO LPN Care Coordinators, administrative care coordinators and/or human services specialists. The ASOs' member services center will route the inquiry appropriately within the care team so that the assignment process will be invisible to the MME.	
Provision of Services/Strategies for Integration of Services and Supports	Under Model 1, MMEs will continue to have access to the full range of Medicaid fee-for-service funded services and supports, including, but not limited to, medical, behavioral health, therapies, pharmacy, dental, transportation, and durable medical equipment. Further, MMEs will remain affiliated with any Medicare Part D plan in which they have enrolled. Model 1 will include PCMH-participating primary care practices, which have obtained NCQA medical home recognition. Features of PCMH practices that will 1) support the goals of the Demonstration concerning care outcomes; and 2) address access barriers that have historically resulted in unnecessary use by MMEs of the ED, include enhanced office hours, non face-to-face means of connecting with patients, practice-based medical care coordination, and use of electronic health records. PCMH and other practices will receive learning collaborative training in topics including, but not limited to: • applied practice of person-centeredness; • disability culture; • strategies for engaging with individuals with SMI and intellectual disabilities;	Under Model 2, MMEs will continue to have access to the full range of Medicaid fee-for-service funded services and supports, including, but not limited to, medical, behavioral health, therapies, pharmacy, dental, transportation, and durable medical equipment. Further, MMEs will remain affiliated with any Medicare Part D plan in which they have enrolled. Model 2 will include PCMH-participating primary care practices, which have obtained NCQA medical home recognition. Features of PCMH practices that will support the goals of the Demonstration concerning care outcomes and address access barriers that have historically resulted in unnecessary use by MMEs of the ED include enhanced office hours, non face-to-face means of connecting with patients, practice-based medical care coordination, and use of electronic health records. PCMH and other practices will receive learning collaborative training in 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. Additionally, Model 2 will feature a number of supplemental services (described in detail

	The Beneficiary Pathway: Models 1 and 2 Contrasted	
	Model 1 (ASO)	**Model 2 (HN)**
	and • connecting with the range of non-medical services and supports. The ASOs will be responsible for several key strategies to support integrating Medicare and Medicaid services and supports. 1) The ASOs will enable providers to access portals through which providers can view utilization data on their panels of MME patients. 2) The ASOs will provide technical assistance to PCMH participating primary care practices to enhance their capacity to provide timely, person-centered support to MME patients.	earlier in this section). Each HN will be required to identify the means through which it will offer the following to MMEs: - chronic illness self-management education - fall prevention - nutrition counseling - medication management services. - other services to be determined, potentially including peer support and recovery assistant services The ASOs will support the HNs in achieving goals related to integration of Medicare and Medicaid services and supports: 1) The ASOs will enable HN providers to access portals through which providers can view utilization data on their panels of MME patients. 2) The ASOs will provide technical assistance to PCMH participating primary care practices that are HN members to enhance their capacity to provide timely, person-centered support to MME patients.
Member Services	Under Model 1, the ASOs will through their existing call centers support MMEs with information & assistance on benefits, referrals to specialists and adjunct social services supports, and intake of complaints and grievances. As is described in the Beneficiary Protections section, Connecticut will seek in partnership with CMS to implement a unified grievance and appeal process as between Medicare and Medicaid, to streamline and universalize the process for MMEs.	Under Model 2, an MME's identified Lead Care Manager will act as his or her point of contact for all of the issues identified at left and will either 1) support the MME directly, e.g. with a referral to social services supports; and/or 2) liaise with the ASO call center in support of an MMEs need for information on benefits, referral to a specialist and/or registering a complaint or grievance. As is described in the Beneficiary Protections section, Connecticut will seek in partnership with CMS to implement a unified grievance and appeal process as between Medicare and Medicaid, to streamline and universalize the process for MMEs.

What will this mean in practice?

An older adult with COPD who lives alone and who has experienced multiple unexplained falls and associated hospitalizations within the past six months will be able to work with her 1915(c) waiver care manager and a team of providers (e.g. primary care physician, cardiologist, pharmacist, home health nurse and occupational therapist) to examine the reasons for the falls and implement interventions that will reduce or eliminate the risk of falling and the need for hospitalization.

A younger individual diagnosed with schizophrenia who also has diabetes and COPD, but is not connected with any regular source of physical health care, will be able to work with his Lead Care Manager to enlist a multi-disciplinary team within the Health Neighborhood to learn strategies for understanding his conditions and how to manage them effectively.

Providers that have historically had few opportunities and tools to do so will have the means and opportunity to be in direct contact and to collaborate.

Geographic Service Area

As previously stated, Model 1 will operate statewide. Model 2 will be introduced in three to five (3-5) geographic areas, and may be expanded in the future if the desired outcomes are achieved.

Provider Networks

A broad array of providers has participated in the planning phase of the MME Integrated Care Demonstration. For the first time, medical, behavioral and non-medical providers will under the Demonstration have state-provided administrative resources and financial incentives to partner in support of improved health outcomes and consumer satisfaction among MMEs.

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

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

The central strength of both the Enhanced ASO and HN models is a provider network that has the range and depth of capacities necessary to respond to the totality of an MME's needs. Provider networks will receive ongoing support through the above activities, as well as through a "learning collaborative" approach that will enhance the capacity of providers to overcome historical "silos" of expertise and emphasis and recognize the applied value of a multi-disciplinary approach. DDS and DMHAS, as well as other partners, will provide expert support in development of curriculum for and facilitating learning collaborative sessions. Examples of this include:

- benefitting from DDS', DMHAS' and the Money Follows the Person Program's extensive experience with the applied practice of person-centeredness;
- on behalf of individuals with intellectual disabilities: 1) exploring practice protocols for delivery of behavioral modification services that do not immediately default to use of medication as compared to other strategies; and 2) identifying means of increasing access to and effective utilization of dental services;
- on behalf of individuals with SMI, training for primary and specialty care providers in communicating with, understanding the capabilities and legal rights of, and effectively serving the needs of individuals with SMI.

ii. Proposed benefit design

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

iii. Description of new supplemental benefits

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

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

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

iv. Evidence-based practice

The foundation of Connecticut's approach to enhancing its FFS system for MMEs is delivery of evidence-based coordinated care. Four key elements of this approach include: 1) use of evidence-based data analytic methods to identify high-risk MMEs who can benefit from care coordination activities; 2) use of chronic illness self-management training strategies that are supported by clinical evidence for MMEs with chronic conditions; 3) use of evidence-based approaches to integrating medical and behavioral health care; and 4) use of evidence-based measures to assess provider performance (please see Appendix E for examples).

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

v. Context of other Medicaid initiatives and health care reform

We anticipate that the Demonstration will be one of several initiatives that include MMEs with the goal of improving care experience, quality and cost. The Department recognizes that a sub-set of the MME demonstration population could be attributed through the means described in the Shared Savings Program ACO Rule to Accountable Care Organizations (ACOs). While several Connecticut groups are in the process of ACO formation, none are likely to qualify as ACOs as of the start of the Demonstration. Accordingly, the Department's preference is that MMEs who have been attributed to the Demonstration remain attributed to the Demonstration throughout its three year term, even if such individuals receive their primary care from practices that become ACOs. Further, the Department will identify and exclude any MMEs who are or become enrolled with Medicare Advantage plans at any time during the Demonstration. The Demonstration will also enable the Department to include participating MMEs in its PCMH initiative. The Department will use an attribution model to align MMEs with participating PCMH practices in order to make advanced payments and performance payments on their behalf. Finally, as noted previously, the Demonstration will also enable highest and best use of 1915(c) HCBS and 1915(i) state plan amendment extension services for MMEs who meet functional participation criteria.

D. Stakeholder Engagement and Beneficiary Protections

i. Stakeholder engagement during the design phase

Over the last eight months, Connecticut has undertaken a robust stakeholder engagement process that has included legislators, consumers, advocates, family members and providers and has yielded substantive and actionable input on the design of the Demonstration. State agency partners including

DMHAS and DDS have been and will continue to be active participants in all aspects of Demonstration design and implementation that are noted below.

Stakeholder input has and will continue to be essential to the success of the Demonstration.

a. Stakeholder meetings and active web site

Key means of having engaged stakeholders include the following:

- The Department has made four formal presentations to and consulted ongoing with Connecticut's Medical Assistance Program Oversight Council (MAPOC). The MAPOC was originally enacted to advise the Department on its Medicaid Managed Care program, but 2010 legislation expanded its oversight authority to encompass the entire Connecticut Medicaid program. MAPOC is composed of legislators, representatives of state agencies, and appointed individuals who reflect a broad range of consumer and provider interests. Minutes of meetings and materials presented to MAPOC are memorialized on its web site: http://www.cga.ct.gov/ph/medicaid/. Please see Appendix B for a list of the MAPOC membership.

- The Department has worked regularly and directly with the MAPOC committee of cognizance: the Complex Care Committee (CCC). MAPOC leadership charged CCC with oversight of the Department's planning process for the Demonstration. The CCC, which meets monthly, provided advice, expert support and comment on each of the design features of the Demonstration. See Appendix C for a schedule of CCC meetings and topics covered.

- The Department also worked regularly and directly with three key work groups of the CCC (see Appendix D for a schedule of work group meetings):

    - The Model Design Work Group was charged with developing the overall Demonstration design including the responsibilities of contracted entities, infrastructure, reimbursement, enrollment, and relationship to other initiatives. Key points of concern for this work group included the methods of enrolling MMEs in HNs and sharing savings with HNs. The Department sought to respond to these concerns by engaging Mercer to make two technical presentations (a webinar and an in-person meeting) on these topics.

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

    - The Consumer Access Committee of MAPOC offered recommendations on protections for MMEs that are captured in Section D.ii.

b. Additional Consumer input

Consumers and consumer advocates who are members of the CCC and its work groups provided valuable feedback on every aspect of the planning phase for the Demonstration. Additionally, the Department conducted 13 focus groups to gain additional learning on key topics from MMEs and their family members. These included 8 focus groups with 71 participants age 65+; and 5 focus groups with 45 participants addressing the needs of younger individuals with disabilities (three groups including individuals with intellectual disabilities and their family members, one group including individuals with SMI, and one group including individuals with physical disabilities).

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

c. Public Comment

Prior to the formal comment period in Connecticut, the Department shared the document with over 125 stakeholders to solicit comment. The Department held a meeting with the CCC on April 12th and the MAPOC on April 13, 2012 to discuss comments and incorporate stakeholder input prior to the issuance of the formal thirty-day comment period. Connecticut has complied with all CMS requirements related to posting notice of the draft Demonstration proposal and conducting a thirty-day public comment period. Connecticut published a notice in the Connecticut Law Journal on April 17, 2012 announcing the proposal, provided tribal notice, and commenced the public comment period on April 25, 2012. Connecticut also sought comment through two public meetings held on May 21, 2012 and May 22, 2012, and engaged in extensive discussion of the proposal with the Money Follows the Person Steering Committee and the Behavioral Health Council and an affiliate committee. A summary of public comments received is included as Appendix F.

ii. Beneficiary Protections

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

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

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

Further, the Department will establish clear standards for such customer services aspects as 1) outreach and education materials to guide MMEs who are considering whether to remain in an HN; 2) roles of the ASO and HN, respectively, in responding to MMEs' care and services-related inquiries and requests for information and referral to clinicians or other providers; 3) means of providing language interpretation services; and 4) means of accommodating individuals with disabilities (e.g. TTY/TDD, accessible formats). DDS and DMHAS will partner with the Department to ensure that consumer materials are clear and accessible for individuals with intellectual disabilities and individuals with SMI.

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

iii. Ongoing stakeholder input

The Department, in partnership with DDS and DMHAS, plans to utilize multiple means of obtaining continued feedback on the implementation and ongoing operation of the Demonstration. Formal feedback will be solicited through 1) monthly meetings of the MAPOC; 2) town hall meetings with MMEs and advocates to introduce the concept of the HNs; 3) consumer focus groups; and 4) educational meetings with the broad range of provider associations that have participated in the planning period. Additionally the Department will continue provide progress reports and solicit input from the CCC and its Model Design, Consumer Protection, and Performance Measurement workgroups.

E. Financing and Payment

i. State-level payment reforms, Payments to providers

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

Table 1: Payment Streams: Timing and Type of Reimbursement

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

** Only Health Neighborhoods meeting pre-established criteria will be eligible for start-up payments*

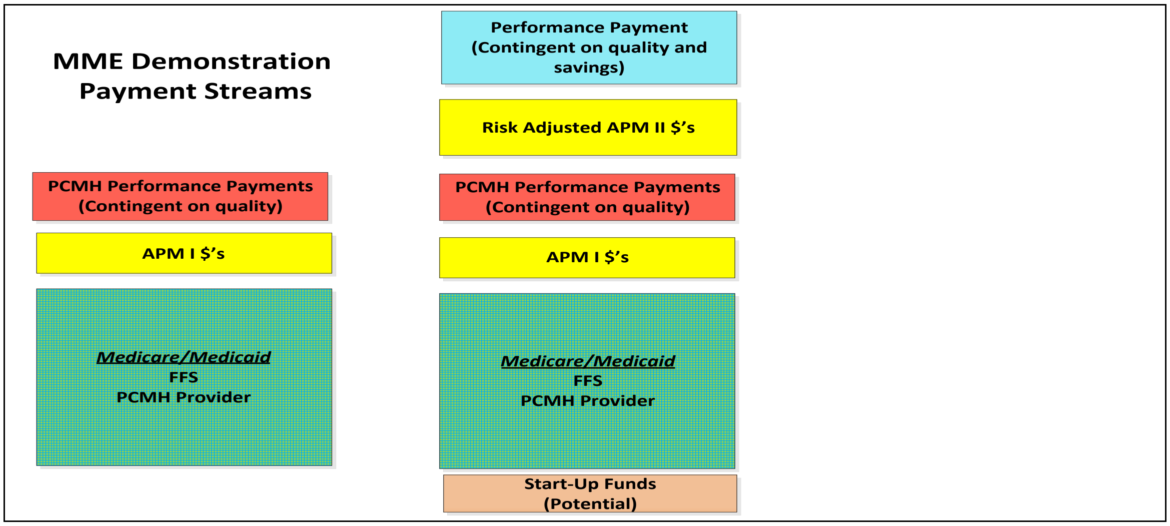
Consistent with a managed fee-for-service environment, the main reimbursement mechanism will be fee-for-service payments based on the established Medicare and Medicaid payment methods for both Model 1 and Model 2. To address program requirements for PCMH and Health Neighborhood providers, the Demonstration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

Table 2: Payment Streams: Source and Description

Payment Stream and Source of Funding	**Description**
1. Start-Up Payment Funding – State/Federal Administrative Matching Funds	The Demonstration will make available Start-up Supplemental Payments as a prospective payment to approved Health Neighborhoods only. The Demonstration intends the start-up supplemental payment to offset a portion of the costs associated with developing and implementing a Health Neighborhood.
2a. APM I Funding – State/Federal Projected Savings	Connecticut is currently administering a PCMH program. PCMH qualified practices receive a combination of enhanced FFS and PMPM performance incentives. Connecticut anticipates converting this program from enhanced FFS to advanced bundled payments (APM1) concurrent with the Integrated Care Demonstration. The Department will introduce APM I and will extend the PCMH program to the MMEs that participate in the Demonstration. This will be done for all qualified PCMH practices and all members aligned with these practices.
2b. Risk Adjusted APM II Funding – State/Federal Projected Savings	Connecticut will introduce risk-adjusted APM II under the Demonstration. This payment will bundle reimbursement for intensive care management, nutritionist consultation, pharmacist consultation, and chronic disease self-management education, and possibly, peer support and recovery assistant services. APM II will be paid to HNs for MMEs aligned with the HNs. Extension to single-eligible individuals (MEs) is under consideration.
3. FFS Payments	The Demonstration will utilize the existing Medicare and Medicaid payment methods
4a. PCMH Performance Payment Program Funding –Projected Savings	The Demonstration will extend the state's PCMH Performance Program to Demonstration participants. The program will reward providers for providing the highest quality care in the most efficient and effective settings. The payments will be based on PCMH-specific performance against benchmarks (performance incentive payment) and improvement (performance improvement payment) over time.
4b. HN Performance Payment Program Funding –Projected Savings	In year one, the State will establish a Performance Payment Pool that will be funded based on the actuarially determined savings in aggregate amongst all participating HNs. Payments from the pool will be based solely on HN performance on quality measures. For the second and third year, <u>the state will establish a Quality Bonus Pool and a Value Incentive Pool</u>. 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. The calculation of the actuarially sound PMPM targets will include adjustments such as for medical cost trend, program changes, administration

Payment Stream and Source of Funding	Description
	expenses, and offsets such as advanced payments.

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



Model 1 – ASO and PCMH **Model 2 – Health Neighborhood and PCMH**

F. Expected Outcomes

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

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

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 ASOs 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.

The measures that are included in Appendix E are a preliminary set that will be reviewed prior to implementation to assess alignment with existing measurement sets and reduced to a smaller number that can be effectively implemented.

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

To meet these aims, the Department in partnership with DDS and DMHAS will contract with a Performance Measurement vendor to 1) validate and confirm the feasibility of the identified measures; 2) offer operational guidance on use of the identified performance measures; and 3) make recommendations on an overall strategy to evaluate Demonstration performance. The Department, 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 4) use integrated person-specific Medicare and Medicaid claims data to make comparisons on population- and diagnosis-specific bases as well as to identify interrelationships, potential for duplication and occurrence of cost shifting as between Medicare and Medicaid.

ii. Potential improvement targets

As part of the development of the Demonstration, the Department engaged in an extensive stakeholder process, described in Section D. i., to identify key performance measures to assess ASO and Health Neighborhood performance. Stakeholders used criteria including relationship to the goals of the Demonstration, emphasis on quality, and ease of implementation to select measures from among a list of 122 evidence-based, measures. During the implementation phase of the Demonstration, the Department will obtain additional input from stakeholders and clinicians to select a subset of quality performance measures from this larger list that will be the basis for performance incentive payments. Those performance measures that are not selected may, depending upon feasibility and available resources, be used as required reporting measures. The initial list of selected performance measures is included in Appendix F.

iii. Expected impact on Medicare and Medicaid costs

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

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

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

1) Hospital readmissions are frequent and costly events, particularly to Medicare. Recent Dartmouth Atlas statistics show that "roughly one in six Medicare patients wind up back in the hospital within a month after being discharged for a medical condition." The issue is even more pronounced for MMEs. In Connecticut, almost 29% of MMEs (aged and disabled) in the state fiscal year 2010, were re-hospitalized within 30 days following a discharge, and almost 10% were re-hospitalized within 7 days following a discharge. Most prevalent diagnoses for the readmissions were for shortness of breath, DM uncomplicated Type II, chest pain and abdominal pain. Research suggests that hospital readmission rates can be reduced through improved transitional care planning, timely follow-up care and persistent treatment of chronic illnesses. Increased care management and the delivery of timely, effective ambulatory care are also expected to result in reduced frequency of potentially preventable hospitalizations.

2) Research has also shown that PCMH models and increased care management results in lower use of emergency care as high frequency emergency department (ED) patients are targeted for interventions and patients without a medical home seek low acuity non-emergency care in the physician's office rather than the ED. For example, in Connecticut, the average number of outpatient ED encounters for MMEs with chronic conditions is 3.7 per year for individuals with disabilities and 2.3 for the elderly population.

3) Connecticut has acknowledged in its Long-Term Care Plan that Connecticut MMEs were historically more likely to be institutionalized than their peers in many other states. For this reason, Connecticut is through its Money Follows the Person initiative pursuing an assertive goal of transitioning 5,200 individuals from nursing facilities to the community by 2016. This will significantly re-balance Connecticut expenditures on long-term care, and has already been estimated in the Connecticut budget to yield significant savings. The nursing home population is estimated to reduce by 4% over the next three years. This 4% shift in setting for this subset of MMEs would represent a reduction in Medicaid expenditures, offset in part by an increase in Medicare Part A and Part B expenditures.

Connecticut has also developed quality measures that may produce additional sources of savings. Among these measures, medication management is one area that is expected to generate medical savings through reduction in poly-pharmacy use, offset by an improvement in medical adherence which could decrease hospitalizations and acute care expenditures under Medicare.

The current lack of integration between Medicare and Medicaid fosters cost-shifting and under-investment. For example, in Connecticut, elderly MMEs receiving home and community-based services are more costly to Medicare ($2,086 PMPM) than their counterparts residing in an institution ($1,709 PMPM). This may create an incentive to promote institutionalization of elderly MMEs in order to reduce Medicare costs. In addition to not serving members in the best way possible, this shift to institutionalization increases both state and federal spending over time. The effects are an under-investment in these important cost-effective services, missed savings potential and missed opportunities to better coordinate care and improve health outcomes for members. Even in situations in which MMEs require nursing home level of care, there will be opportunities to achieve savings. As skilled nursing facilities move towards enhancing post-acute, transitional care and preventive health care services, they can play an important role in reducing the incidence of potentially avoidable hospitalizations by providing a viable alternative to acute inpatient admission. Additionally, skilled nursing facilities can assure choice of community options post nursing facility admission and support transitions back to the community, thereby reducing Medicare-funded lengths of stay.

G. Infrastructure and Implementation

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

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

ii. Need for waivers

Connecticut will continue to administer the service array for which it has been approved under State Plan authority as well as authority related to the 1915(c) waivers. The Department has submitted a 1915(i) state plan amendment to provide LTSS for individuals age 65 years and older who do not meet institutional level of care criteria. The Department will continue to work with CMS to identify any additional authority necessary to implement its proposal to administer APM II payments to HNs and to share savings with HNs. Further, the Department plans to seek authorization from CMS to waive the threshold requirement for qualifying for Medicare coverage in a skilled nursing facility (SNF); notably, that an individual must have been hospitalized for at least three consecutive days and be admitted to the SNF for the condition for which he or she was hospitalized. Although this issue does not directly related to the need for a waiver, Connecticut is proposing through this application to include long-term care participants contingent upon gaining a better understanding of CMS' methodology for calculating shared savings. Connecticut proposes that CMS consider adjusting PMPM targets for MMEs based on setting/place of residence to adjust for the impact of transitions from institutional to community-based settings.

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

The Demonstration will serve MMEs age 18 to 64, and age 65 and older. The populations served will include individuals with Serious Mental Illness (SMI) and individuals with Intellectual and Developmental Disabilities. Participation of MMEs in the ASO model will be statewide. Participation of MMEs in HNs will be limited to service areas of the HNs. HNs will be launched on a pilot basis and tested against performance and savings measures. The Department then plans to use the knowledge gained in this pilot period to expand the initiative to serve additional MMEs and also potentially to expand the model to serve single-eligible Medicaid individuals (MEs) and convert APM II payments to a Health Home coverage option.

iv. Overall implementation strategy and anticipated timeline

The Department will in partnership with DDS and DMHAS employ an implementation strategy that systematically addresses overall Demonstration requirements, ASO requirements and Health Neighborhood requirements. Overall direction in developing and implementing the Demonstration will be provided by a Steering Committee comprised of the Department's Medical Care Administration Executive Team; representatives of the behavioral health, medical operations, dental, pharmacy, Money Follows the Person and HCBS waiver programs; DDS and DMHAS; the Office of Policy and Management, and consumers. The Department plans to build upon the current infrastructure and capabilities of its current medical and BH ASOs to serve MMEs. Further, the Department plans to procure three to five (3-5) HNs, to be overseen by HN Lead Agencies, which will serve the needs of MMEs that elect to participate within established geographic service regions. Additionally, the Department plans to procure data integration and analytics support, as well as a means through which to provide electronic communication tools to members of HNs (the Connecticut Health Information Exchange, CT HIE). 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 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. Please see **Appendix A** for more detail on roles and responsibilities of key actors in this process.

H. Feasibility and Sustainability

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

The Department has identified, and is proactively managing, the following potential barriers and challenges that could affect timely implementation.

Resource Constraints. While the State will be dedicating significant financial and in-kind support to this effort, CMS funding will represent essential support for effective implementation of new model design and value-based purchasing strategies.

Consumer Participation in HNs. In order to meaningfully measure results and to achieve system change, the Department estimates that each Health Neighborhood must serve at least 5,000 MMEs. If there is a significant incidence of opt-out, HN could fall short of the necessary participation levels. The Department intends to address these concerns through use of enrollment counseling and related consumer education materials.

Provider Participation in HNs. Related to the above concern, each HN must have robust participation by the full array of medical, behavioral and non-medical providers. Providers may struggle to understand where they fit in across a landscape that will include ACOs. The Department intends to address these concerns and to promote participation by: 1) publishing provider standards as an element of its RFP to procure HNs; 2) provider transmittals; 3) meetings with provider associations; and 4) a learning collaborative approach

Lack of Linkages Among Providers. In order to form an HN, providers must develop care coordination and shared savings agreements with providers across the spectrum of medical, behavioral and non-medical providers. Historically, there have been few opportunities to enter into multi-disciplinary care coordination arrangements. The Department intends to address this issue by: 1) publishing standards for provider agreements regarding care coordination and shared savings in its RFP to procure HNs; and 2) hosting learning collaboratives designed to develop provider relationships and educating providers to support the needs of MMEs.

Waiver Authority. As noted in Section G.ii., Connecticut anticipates the need to seek CMS approval of one or more waivers in support of its targeted APM I and II payments and proposed shared savings mechanism. This will require review by the Connecticut legislature and soliciting tribal consultation.

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

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

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

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

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

The Department anticipates that its overall model design, featuring ASO and HN configuration, will be scalable in the future to serve additional MMEs and also single-eligible individuals. Key structural elements that will support expansion include use of one predictive modeling tool for all participants that incorporates Medicare and Medicaid claims data, a universal care plan document, electronic health record and communication tools, and flexibility to expand the network of provider participants. The Department anticipates that both its overall value-based purchasing strategy and ASO and HN model design will be replicable and of interest to other states as an alternative to a managed system of care. Connecticut's value-based strategies include 1) administrative integration; 2) the use of local care delivery arrangements to integrate all Demonstration services and supports and to improve the MME's care experience; 3) information technology and analytics; and 4) use of HN performance payments to promote quality of care and positive care experience.

v. Letters of support - Please find letters of support attached in Appendix H.

I. Additional Documentation (as applicable) – Connecticut will provide additional documentation at CMS' request.

J. Interaction with Other HHS/CMS Initiatives -

By improving care coordination and appropriate follow up care during care transitions, the **Partnership for Patients** seeks to reduce hospital readmissions. Through Connecticut's practice reforms, primary care providers will be encouraged to address preventable readmissions by: 1) improving connections with inpatient providers; 2) communicating with inpatient providers about the patient's care and discharge; 3) following up in a timely manner post-discharge; and 4) developing and implementing a person-centered care plan. Building on recent efforts by the Department of Public Health's Office of Multicultural Health to comprehensively evaluate health disparities in the state, Connecticut plans to reduce disparities in line with HHS' **Action Plan to Reduce Racial and Ethnic Health Disparities.** Connecticut has leveraged a grant from the National Academy of State Health Policy to engage policy makers in Equity Learning Collaboratives, with a focus on maximizing Medicaid participation by minority populations and improving the transition to PCMHs. In 2011, the Connecticut Health Foundation joined this effort with a $100,000 grant to integrate racial and ethnic health disparities identification and reduction into the PCMH planning and implementation process. The **Million Hearts Campaign** aims to reduce the rates of heart disease and stroke by targeting the "ABCS" strategy. As one of eight states to receive funding under the Medicaid Incentives for Prevention of Chronic Disease grant program, Connecticut is in the process of implementing iQuit, a tobacco cessation program that utilizes counseling, peer coaching, and other techniques. The Demonstration will use the ASO/HN model to effectively monitor health indicators, treat high-risk patients, prevent heart disease, and refer individuals in need to tobacco cessation programs including iQuit.

Appendices

Appendix A. Workplan, Timeline and Roles/Responsibilities

Timeframe	**Key Activities/Milestones**
April, 2012 – May, 2012	Solicit comments on proposal • obtain key stakeholder comment on draft proposal (Medical Assistance Program Oversight Council, Complex Care Committee) • conduct formal public comment period • incorporate comments prior to submission to CMS on May 29, 2012
May, 2012 – June, 2012	Develop and implement operational standards for ASO model • outline member support services • define and develop protocols for person-centered Intensive Care Management (ICM) • establish data collection, analysis and reporting requirementsestablish protocols for collection of performance data from HNs
May, 2012 – June, 2012	Develop and implement operational standards for HN model • outline roles and responsibilities regarding enrollment (ASO, HN, enrollment counseling contractor) • define and develop standards for multi-disciplinary ICM and provider communication • identify reporting responsibilities
June, 2012 – August, 2012	Develop and implement operational standards for exchange of electronic health information • outline roles and responsibilities (ASO, HN, Health Information Exchange) • define and establish protocols for required waivers, protection of privacy and opt-out • establish incremental plan to enhance interoperability of EHR
May, 2012 – July, 2012	Develop and implement reimbursement methodology • conduct actuarial analysis of and calculate prospective infrastructure support (if any), advance payment methodology, shared savings methodology • select risk adjustment methodology • identify roles and responsibilities for making payments (Department, ASO, ACS)
June, 2012 – July, 2012	Conduct HN procurement • develop and issue procurement • evaluate procurement responses and select successful HNs • contract for HN services based on the procurement requirements • conduct Health Neighborhood readiness review

Timeframe	**Key Activities/Milestones**
May, 2012 – July, 2012	Develop and implement overall performance evaluation plan • work with expert and stakeholder groups to refine initial selections of metrics • work with contractor to define measures, expected outcomes and targets for each metric • implement various elements of performance evaluation strategy, including reporting, surveys, consumer focus groups
July, 2012 – August, 2012	Develop and seek comment on member rights and responsibilities • ASO participation • HN participation • Opt-out of HN participation, information sharing, ICM • Grievances and appeals
July, 2012 – August, 2012	Develop and implement member communication plan • draft and seek comment on member outreach materials (e.g. description of Demonstration, overview of HN participation) • establish standards and protocols for contracted enrollment counseling • draft and seek comment on Intensive Care Management (ICM) materials (e.g. care plan, member rights and responsibilities, disease management and self-care materials) • translate materials into primary languages of origin
May, 2012 – December, 2012	Draft and implement provider engagement plan • conduct educational sessions across the provider continuum • present “learning collaborative” sessions
September, 2012 – December, 2012	Collaborate with CMS to develop and finalize the Demonstration • develop comparison group methodology • identify any waivers that are needed • negotiate terms of the proposal with CMS • enter Memorandum of Understanding (MOU) with CMS by early September • enter Final Agreement with CMS by mid-October
January 1, 2012	Launch Demonstration

Entity		**Current Role**	**Anticipated/Enhanced Role**
DSS in partnership with DMHAS and DDS			
	MCA Director, Associate Directors, Medical Director, Director of Medical Care Management, Planning Specialist, Health Program Associate	MCA has directed the overall application development, coordinated state agency involvement, and convened and facilitated the process by which a broad array of stakeholders has contributed to development of model design and shared savings method.	MCA will: • provide overall administrative oversight • draft RFP standards and qualifications for HNs • establish contract scope and deliverables for ASOs and HNs • procure HNs and administer HN contracts • oversee evaluation of the Initiative • oversee implementation of value-based purchasing strategy including provider reimbursement and performance measurement.
	DFMA Director Financial & Contract Support Services Unit	DFMA has assisted in the preparatory process by modeling fiscal impact and providing oversight of budget development and actuarial work.	DFMA will provide oversight of actuarial work in support of shared savings calculations.
	OLCRAH Director Staff Attorneys	OLCRAH is instrumental in supporting MCA with SPAs and waivers, and is accountable for oversight of MME grievance and appeal processes.	OLCRAH will support MCA in 1) drafting and submission of any required waivers of Medicaid rules; 2) drafting of MME rights and responsibilities materials; 3) in conjunction with the entity designated as Ombudsman, development of uniform grievance and appeals form; and 4) ongoing administration of MME grievance and appeal processes.
	OSD Director Production and media staff	OSD supports MCA in development of consumer materials.	OSD will support MCA in drafting and focus group testing of consumer education materials regarding 1) rights and responsibilities; 2) participation in an HN; and 3) grievances and appeals.
Administrative Contractors/ Consultants			

Entity		Current Role	Anticipated/Enhanced Role
	HP	HP is responsible for processing of Medicaid claims.	Same.
	Mercer	Mercer is contracted to perform a range of actuarial services functions for the Department. Mercer has undertaken all of the data analytic work to support the application. Additional key areas of focus have included review of shared savings methods used by other integrated care initiatives and technical support to the Complex Care Committee in reviewing the Department's proposed method.	Mercer will be responsible for: • actuarial work to support establishment of risk-adjusted ASO and HN budget targets and associated savings calculations based on actual expenditures; • development of APMs for both PCMH and HN participants; and • calculation of performance incentives.
	Mercer Optumas Health Policy Matters UConn JEN	Mercer, Optumas, Health Policy Matters, UConn and JEN are contracted to support application development and associated projects including focus groups, stakeholder input, performance measurement, data integration, data analysis, and overall model design.	Consultants will provide support to the Department on various aspects of implementation, including: • development of protocols in support of administrative structure/roles and responsibilities of Department/ASO/ HNs/providers • technical specifications for performance measurement • data integration
	CT HIE	The CT HIE expects to become operational in May, 2012.	The Department intends to explore opportunities to partner with the CT HIE.
ASOs			
	CHN-CT/ Value Options	The ASOs currently serve administrative, data analytic, predictive modeling, care management, member service, provider support and technical assistance functions. The medical	The ASOs will continue to provide all listed functions. Further, the ASOs will be asked: • to expand their capacity to provide ICM by contracting for sufficient additional nurse care managers to support the incidence of MMEs identified through predictive modeling as at high risk; • to modify an existing electronic care

Entity		Current Role	Anticipated/Enhanced Role
		ASO also collects data to support PCMH performance measurement and payments	planning tool to reflect a person-centered approach • to utilize the identified electronic care coordination tool and associated provider/member alert function to further communication and to support mutuality in development of care plans; • to collect data to support evaluation of statewide ASO model participants on HN performance measures; and • to collect data from HNs and evaluate HN performance on identified Demonstration measures.
Contractors			
	Data integration JEN	The Department has received Medicare data from CMS and has through an initial data integration process produced a data profile of MMEs' service utilization and diagnostic/ demographic features.	The Department intends to continue to contract with JEN to perform data integration services in support of the ASOs and the HNs.
	Enrollment counseling/ payment of APM II ACS	N/A	The Department intends to contract with a neutral vendor (ACS) to provide counseling to MMEs who are assigned through a passive enrollment process to an HN. This counseling process will outline MMEs' option to decline to participate in an HN. Further, ACS will make APM II payments to HNs.
	Project evaluation protocol	Initial preparatory steps in support of project evaluation have included development of selection criteria for and refinement of a set of measures of quality that will be associated with performance incentives. This has been conducted	The Department intends to contract with a vendor to outline a protocol for project evaluation that will complement reporting of data on quality measures with additional means of evaluating success, such as: • cost measures; and • means of evaluating consumer satisfaction (e.g. CAHPS survey, focus groups).

Entity		Current Role	Anticipated/Enhanced Role
		by UConn, a group of expert stakeholders, and a work group of the Complex Care Committee.	

Appendix B. Stakeholder Participation

Medical Assistance Program Oversight Council (MAPOC)

Name	Organization
Catherine Abercrombie	State Representative
Sheila Amdur	Complex Care Committee - Co-Chair
Ellen Andrews	Connecticut Health Policy Project
Paula Armbruster	Quality Improvement Committee
Donna Balaski, DMD	Department of Social Services
Matthew Barrett	Connecticut Association of Health Care Facilities
Claudette Beaulieu, Deputy Commissioner	Department of Social Services
Christine Bianchi	Co-Chair, Consumer Access Committee
Mary Ellen Bocaccino	Department of Social Services
Roderick Bremby, Commissioner	Department of Social Services
Annette Buckley	HUSKY Infoline
Beth Cheney	Windham Hospital, PNC
Robin Cohen	Office of Legislative Research
Steven A. Colangelo	Department of Social Services
Renee Coleman-Mitchell	Department of Public Health
Michelle Cook	State Representative
Betty Davis	HRSA
David S. Dearborn	Department of Social Services
Gail Digioia	CHN-CT
Paul Dileo, Deputy Commissioner	Department of Mental Health & Addiction Services
Judy Dowd	Office of Policy & Management
Evelyn Dudley	Department of Social Services
Astread Ferron-Poole	Department of Social Services
Anne Foley	Office of Policy & Management

Appendix B. Stakeholder Participation

Medical Assistance Program Oversight Council (MAPOC)

Name	Organization
Uma Ganesan	Department of Social Services
Heather Greene	Co-Chair, Consumer Access Committee
Alex Geertsma, MD	Commission on Children
Colleen Geib	CMS
Theresa Gerratana	State Senator
Lile Gibbons	HS Commission
Jason Gott	Department of Social Services
The Reverend Bonita Grubbs	Christian Community Action
William Halsey	Department of Social Services
Toni Harp	State Senator
Colleen Harrington	Department of Mental Health & Addiction Services
Jennifer Hutchinson	Department of Mental Health & Addiction Services
Walter Jeffrey	BHP OC
Susan Johnson	State Representative
Robert Kane	State Senator
Mark Keenan	Department of Public Health
Sylvia Kelly	CHN-CT
Jacqueline Kozin	Office of the State Comptroller
Donald Langer	Americhoice UHC
Sharon Langer	Connecticut Voices for Children
Mary Alice Lee	Connecticut Voices for Children
Steven Mackinnon	Xerox Services
Kathleen Martin	Designee for Rep. Perillo
Julie McCarthy	CMS
Kate McEvoy	Department of Social Services
Susan R. McGuire	Department of Social Services

Appendix B. Stakeholder Participation

Medical Assistance Program Oversight Council (MAPOC)

Name	Organization
Marty Milkovich	BeneCare
Jeanne Milstein	Office of the Child Advocate
Craig Miner	State Representative
Marie Montemagno	CMS
Margaret Morelli	Long-Term Care Advisory Council
Mary F. Moriarty	CMS
Anthony Musto	State Senator
Vickie Nardello	State Representative
Cliff O'Callahan, MD	Middlesex Hospital
Debra Polun / Julia Evans Starr	Connecticut Commission on Aging
Deb Peorio	SBHC
Pat Rehmer, Commissioner	Department of Mental Health & Addiction Services
Elizabeth Ritter	State Representative
Chris Savold	BeneCare
Mark Schaefer, Ph.D.	Department of Social Services
Linda Schofield	State Representative
Andrew Selinger, MD	ProHealth FP
Kelly Sinko	Department of Social Services
Maureen Smith	Care Commission
Richard Spencer	Department of Social Services
Joan Soulsby	Office of Policy & Management
Carol Trapp	Xerox Services
Carolyn Treiss	Department of Social Services
Victoria Veltri	Office of the Healthcare Advocate
Peter Villano	State Representative
Toni Walker	State Representative

Appendix B. Stakeholder Participation

Medical Assistance Program Oversight Council (MAPOC)

Name	Organization
David Weizenbaum	Department of Social Services
Jesse White-Frese	Connecticut School Health Centers
Tracy Wodatch	Connecticut Association for Home Care and Hospice
Barbara Wolf	Office of Policy & Management
Fredericka Wolman, MD	Department of Children & Families
Thomas Woodruff	Office of the State Comptroller
Katherine S. Yacavone	SW CHC, Inc.
Robert Zavoski, MD	Department of Social Services

Appendix B. Stakeholder Participation

Complex Care Committee

Name	Organization
Quincy Abbot	The Arc of CT
Marie Allen	Southwestern Connecticut Agency on Aging
Sheila Amdur	Complex Care Committee - Co-Chair
Ellen Andrews	Connecticut Health Policy Project
Erica Atalla	WellCare
Matthew Barrett	Connecticut Association of Health Care Facilities
Jill Benson	CHR
Michele Bissell	APT Foundation
Michael Bloom	RSL Lobbyist
Carol Bohnet	Allied Community Resources
Mark Borton	Equity Health Partners
Kathy Bruni	Department of Social Services
Sheldon Bustow	Hospital for Special Care
Alyse Chin	Department of Mental Health & Addiction Services
Molly Cole	Connecticut Council on Developmental Disabilities
Elizabeth Collins	Yale-New Haven Hospital & BHP OC
Brian Cournoyer	Connecticut Hospital Association
Mary Ann Cyr	CHN-CT
Kathleen Demers	Day Kimball
Marilyn Denny	Greater Hartford Legal Aid
Paul Dileo, Deputy Commissioner	Department of Mental Health & Addiction Services
Jennifer Dinwoodie	AmeriChoice
Marcia Dufore	NCRMHB
Nora Duncan	The ARC of CT

Appendix B. Stakeholder Participation

Complex Care Committee

Name	Organization
Julie Evans Starr	Commission on Aging
Teri Edelstein	Connecticut Community Providers Association
Anne Elwell	Qualidigm
John Erlingheuser	AARP
Janie Fay	VNA CH Care
Jojn Fecteau	Department of Mental Health & Addiction Services
Ken Ferrucci	Connecticut State Medical Society
Bill Fiocchetta	Mercy Community Health Network
Anne Foley	Office of Policy and Management
Stephen Frayne	Connecticut Hospital Association
Jennifer Gallagher	MedOptions
Sarah Gallagher	Corporation for Supportive Housing
Yvonne Gamelin	All About You Home Care
Uma Ganesan	Department of Social Services
Heather Gates	CHR
Julie Gelgauda	Agency on Aging of South Central Connecticut
Erica Goodman	WellCare
Elizabeth Gridley	AAY CT
Claudio Gualtieri	AARP
Neysa Guerino	Agency on Aging of South Central Connecticut
Christina Hage	Murtha Law
Karyl Lee Hall	Connecticut Legal Rights Project

Appendix B. Stakeholder Participation

Complex Care Committee

Name	Organization
Colleen Harrington	Department of Mental Health & Addiction Services
Claude Holcomb	Consumer Advocate
Deborah Hoyt	Connecticut Association of Home Care and Hospice
Jennifer Hutchinson	Department of Mental Health & Addiction Services
Annie Jacob	Department of Social Services
Matthew Katz	Connecticut State Medical Society
Brenda Kelley	AARP
David Krause	Office of Policy and Management
Nancy Krodel	AARP
Dawn Lambert	Department of Social Services
Mary Ann Langton	Connecticut Council on Development Disabilities
Stephen Larcen	Natchaug
Nancy Leonard	New England Home Care
Veronica Mansfield	Middlesex Hospital/Asthma Advisory Council
Doreen McGrath	Department of Developmental Disabilities
Kate McEvoy	Department of Social Services
Thomas Meehan, MD	Qualidigm
Pamela Meliso	Center for Medicare Advocacy
Mag Morelli	Leading Age Connecticut
Siobhan Morgan	Department of Developmental Disabilities
Kimberly Nystrom	New England Home Care
Jean Oldham	AAY Home Care
Mary Ann O'Neill	Connecticut Community Providers Association
Sherry Ostrout	Connecticut Community Care Inc.
Hyung Paek	Yale New Haven Hospital

Appendix B. Stakeholder Participation

Complex Care Committee

Name	Organization
Debra Polun	Community Health Center Association of Connecticut
Molly Rees Gavin	Connecticut Community Care, Inc.
Julie Robison	UCHC-Center on Aging
Patricia Rockwell	Senior Care Centers
Mark Schaefer, Ph.D.	Department of Social Services
Katherine Schwalbe	SEIU
Noreen Shugrue	UCHC - Center on Aging
Henrietta Small	Community Mental Health Affiliates, Inc.
Marie Smith	UCONN School of Pharmacy
Debra Soucey	Athena Health Care
Kim Sprague	CHIME
Judith Stein	Center for Medicare Advocacy
Hillary Teed	Connecticut Community Providers Association
Sheldon Toubman	New Haven Legal Assistance
Mike Towers	Xerox Services
Carol Trapp	Xerox Services
Sue Turi	Board Member, CT-USPRA
Jan Van Tassel	Connecticut Legal Rights Project
Peter Villano	State Representative, Complex Care Committee - Co-Chair
Matt Vinikas	CHC, Inc.
Deborah Watson	Bridgeport Hospital Foundation
Brad Weekes	Kowalski Group
Rivka Weiser	Department of Social Services

Appendix B. Stakeholder Participation

Complex Care Committee

Name	Organization
J.D. White	WellCare
Tracy Wodatch	Connecticut Association of Home Care and Hospice
Randy Wojnarowicz	WellCare
Alicia Woodsby	Partnership for Strong Communities
Robert Zavoski, M.D.	Department of Social Services
Katie Zito	Magellan Health

Appendix B. Stakeholder Participation

Model Design Work Group

Name	Organization
Sheila Amdur	Complex Care Committee, Co-Chair
Ellen Andrews	CT Health Policy Project
Doug Arnold	MPS Physicians
Evelyn Barnum	Community Health Center Association of Connecticut
Matthew Barrett	Connecticut Association of Health Care Facilities
Sheldon Bustow	Hospital for Special Care
Molly Cole	Connecticut Developmental Disabilities Council
Kathleen Demers	Day Kimball
Paul Dileo	Department of Mental Health & Addiction Services
Anne Elwell	Qualidigm
Ken Ferrucci	Connecticut State Medical Society
Bill Fiocchetta	Mercy Community Health Network
Stephen Frayne	CT Hospital Association
Sarah Gallagher	Corporation for Supportive Housing
Uma Ganesan	Department of Social Services
Colleen Harrington	Department of Mental Health & Addiction Services
Deborah Hoyt	Connecticut Association of Home Care and Hospice
Jennifer Hutchinson	Department of Mental Health & Addiction Services
Matthew Katz	Connecticut State Medical Society
Ken Lalime	Connecticut State Medical Society - IPA, Inc.
Paul Liistro	Arbors of Hop Brook
Mark Masselli	Community Health Center
Kate McEvoy	Department of Social Services

Appendix B. Stakeholder Participation

Model Design Work Group (cont.)

Pamela Meliso	Center for Medicare Advocacy
Mag Morelli	Leading Age Connecticut
Kathy Pajor	Beechwood Rehabilitation
Debra Polun	Community Health Center Association of Connecticut
Meryl Price	Health Policy Matters
Jack Reed	Pro-Health Physicians
Molly Rees Gavin	Connecticut Community Care, Inc.
Mark Schaefer, Ph.D.	Department of Social Services
Bob Smanik	Connecticut State Medical Society-IPA, Inc.
Michael Taylor	Hill Health Center
Hillary Teed	Connecticut Community Providers Association
Sheldon Toubman	New Haven Legal Assistance
Alicia Woodsby	Partnership for Strong Communities

Appendix B. Stakeholder Participation

Performance Measurement/Expert Work Group

Name	Organization
Matthew Barrett	Connecticut Association of Health Care Facilities
Julia Evans Starr	Connecticut Commission on Aging
Rick Fortinsky	UCONN Center on Aging
John Freedman, MD	Freedman Health Care
Claudio Gualtieri	AARP
Colleen Harrington	Department of Mental Health & Addiction Services
Claude Holcomb	Consumer
Peter Love	UCEDD
Maureen McCarthy	Connecticut Association for Health Care Facilities
Kate McEvoy	Department of Social Services
Tom Meehan, MD	Qualidigm
Darlene O'Connor	JEN Associates
Deb Polun, Chair	Community Health Center Association of Connecticut
Ronald Preston	Consultant
Meryl Price	Health Policy Matters
Margaret Rathier	UCONN Center on Aging
Molly Rees Gavin	Connecticut Community Care, Inc.
Karen Smith	CHN-CT
Marie Smith	UCONN School of Pharmacy
Minakshi Tikoo	UCONN Center on Aging
Susan Turi	Consumer

Appendix C. Stakeholder Engagement

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

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

Appendix D. Key Focus Group Themes

Focus Group Questions	*Key Themes: Focus Groups with Older Adults Age 65+*	*Key Themes: Focus Groups with Individuals with Disabilities 18-64*
I. Current Experience With the Health Care System		
What happens when you go to the doctor?	• Most participants consistently see an office-based PCP and have between one and four specialists in different practices and/or locations • Some change doctors due to rotation of newer/younger docs • Many reported issues with distance to their practitioner and transportation issues • Where alternatives to using the ER exist, participants are willing to use them	• Multiple providers are the norm • Widespread access problems; hard to find providers who accept Medicare/Medicaid • Major issue with dental care; some young adults have not seen a dentist in 3-5 years • Individuals with DD and individuals with SPMI may present differently; it is especially hard to find providers who understand the needs of these populations with special needs • Pediatric to adult care: difficult to find competent providers to treat people with disabilities • Most want to visit the same doctor or clinic that is aware of their medical history, which is typically complex
If you stayed in a hospital/nursing home in the past year, how did your providers help you prepare to go home?	• Many described positive transitions BUT some noted insufficient services at home after the transition • Communication problems between the nursing home and home services for those transitioning from a nursing home were noted	• Many described positive transitions from hospitals to home • Providers who serve individuals with DD noted resistance by hospital staff to engage in discharge planning • Major issues with transition planning from hospital to group home for individuals with DD
What happens when your doctor prescribes a medication?	• Most doctors explain the basics (e.g. dosage) • Most rely on pharmacists for any medication questions • Visiting nurses help educate consumers re: medications • A few had interpretation issues due to language barriers	• Similar to older adults, most doctors explain the basics and most participants rely on pharmacists for questions • Parents of individuals with DD mentioned lack of communication between providers and specialists, and concern about contraindications • Nurses educate staff and families for 24-hour group home, BUT those with less than 24-hour support receive insufficient education and help

II. Care Coordination Questions		
Do you think your doctors talk to one another re: your care? (Asked of individuals 65 years of age only)	• Doctors do communicate -- via fax or EHR • Communication between physicians and other healthcare providers is very important • Important for a relative to be involved (but not necessarily to be involved themselves) • Doctors generally do not communicate with homecare providers (except with visiting nurses)	• *N/A*
Have you seen a written plan for your medical care and other services? (Asked of individuals 65 years of age only)	• Confusion as to what a care plan was; participants reported seeing documents re: homecare; medications, schedule; other medical records • Opinions on who should be involved in designing a care plan varied from not wanting anyone other than the consumer involved to wanting at least one relative involved • Caregivers want to be involved in their relatives' care plan	• *N/A*
Who do you rely on most for day-to-day help? (Asked of individuals 65 years of age only)	• Family, care managers, Resident Service Coordinators (RSCs) find help that includes Visiting Nurse, companion, Activities of Daily Living (ADL)/Instrumental ADLs (IADLs) help and housekeeping • Persons on CT Home Care Program for Elders had more help at home, including Long-term Services and Supports (LTSS), transportation, medical issues and emergency services • Participants noted that "Gatekeepers" (family, RSCs, care managers) can be both helpers and obstacles to care and supports	• *N/A*
If you wanted to see a doctor about your mental health, would you know where to go? (Asked of individuals 65	• Yes, (with many participants indicating they use services) consumers know where to go for mental health care • Most people go to their primary care doctor, social worker, or resident services coordinator for a referral • Some consumers did not know who to approach for emotional care and some	• *N/A*

years of age only)	experienced problems accessing mental health care, e.g., physicians not taking Medicare or Medicaid	
Do multiple people coordinate your care & do you understand their roles? (Asked of 18-64 year old individuals with disabilities only)	• *N/A*	<u>General Feedback</u> • Extensive need expressed for care coordination among multiple providers, but desired coordination is frequently poor or nonexistent • People with all doctors in one practice and DD population with 24-hour coordination have far fewer issues. <u>Issues regarding insufficient care coordination</u> • Poor medication management • Finding providers who accept coverage • Lack of provider understanding exists regarding issues that individuals with DD and SPMI face • Pediatric to adult care transition • Discharge planning to group homes
Who would you like to coordinate your care? (Asked of 18-64 year old individuals with disabilities only)	• *N/A*	• Self or family member (especially parents of individuals with DD) • Group home nurse or house manager • Behavioral Health care manager or clinician
Would you mind if doctors could look at records of all your services to give you better care? (Asked of 18-64 year old individuals with disabilities only)	• *N/A*	• Answers overwhelmingly positive • Strong need expressed for making relevant information available to all doctors • Small minority would insist on individual consent each time
Would you rather have the current system or health	• *N/A*	<u>Overall responses:</u> • Substantial differences of opinion • Individuals with SPMI strongly favor health neighborhood, in concept, for

neighborhood coordinate your care? (Asked of 18-64 year old individuals with disabilities only)		better coordination of care • Health neighborhood appealing to many only if current docs participate <u>Significant reservations from individuals with DD were expressed:</u> • Fear of losing long-term docs (some out-of-state) • Providers would need to develop sensitivity to individuals with DD and would need to be trained
III. Consumer Protection		
Do you know the complaint process for problems with care and patient rights?	• Many don't know how to make a complaint or would change doctors rather than complain • Some would talk to their health care provider directly; others mentioned specific people they would ask for help • While some reported they have been told about their patient rights, many others have not	<u>How to make a complaint</u> • Additional people to ask for help: **social workers**, **psychiatrists, office manager** • Complete provider satisfaction surveys <u>Patient rights</u> • Same variety of experiences as for older adults
Are you able to choose your doctors?	• Participants reported a wide range of experiences re: choice • Specialists were generally identified through PCP referrals without choices, but many trusted PCPs to identify specialists • Others reported lack of choice in LTSS providers, and denial of requests to change • A *significant* number had been turned away by providers who don't accept Medicare or Medicaid	• Doctors change often, not by patients' choice • Doctors must be selected from limited lists; many don't take Medicare/Medicaid • Difficult to find providers with needed expertise e.g., psychiatry, dentistry or specific disability diagnoses • Doctors who take Medicaid cancel appointments when their DSS reimbursement is late • Case managers help clients find specialists
Do you think some health care providers treat people differently?	• Many reported no problem with discrimination • Others had perceived discrimination based on: Race/ethnicity; Age; use of Medicaid (or Medicare) • Others reported poor treatment, with no clear cause • A few participants felt they receive better	• Providers treat people differently based on a mental health diagnosis or disability • Individuals with DD stated that some provider accommodate behavioral issues and others refuse to provide service • Parents of individuals with DD

	treatment due to their age	negative attitudes toward themselves as parents
IV. Ideal Health Care and Service Program Question		
How would you describe an ideal health care and service program for you?	• Most agreed that they want more doctors to accept Medicaid and Medicare patients • A holistic approach to health care with their primary care and specialists located in one town, or in one location • Access to a navigator or health care advocate • A streamlined, easy process for submitting medical/prescription claims to DSS • Better information about why some people have to pay co-pays is needed to avoid confusion regarding this issue	• Similar responses to 65+ population • More providers should accept Medicare/Medicaid • Better care coordination needed, especially among medical, social services and durable equipment providers • Value ability to choose one's own PCP and specialists • More information – provide list of providers that accept Medicare/Medicaid and their backgrounds • For those who need anesthesia for routine procedures, e.g. dental and OB-GYN, allow at the same time • Simplify or eliminate Medicaid spend-down; causes considerable confusion

Appendix E. Performance Measures

As noted in the body of the application, the measures that are included here are a preliminary set that will be reviewed prior to implementation to assess alignment with existing measurement sets and reduced to a smaller number that can be effectively implemented.

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

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

Appendix F. Summary of Public Comment

Source	Summary of Comments
National Association of Chain Drug Stores (NACD) Christie Boutte, PharmD., R.Ph. Director, National & State Public Policy Received May 10, 2012	• NACD supports DSS' use of Medicare data. Medicare data is essential to integration of care for MMEs. • NACD supports DSS' position on inclusion of pharmacists. Pharmacists play a key role in medication adherence, beneficiary education and improved patient outcomes. • NACD supports use of pharmacist-provided medication therapy management (MTM) services in achieving results related to medication adherence. NACD emphasizes the value of in-person, face-to-face interventions between retail pharmacists and beneficiaries in settings that are convenient and comfortable for beneficiaries. NACD urges DSS to maximize utilization of the Part D MTM program.
CHR Health Received May 10, 2012	• CHR comments that the proposal is exciting, but also ambitious as to time frame. • CHR seeks clarification from the Department as to how the APM I & II will be distributed in the HN Model. • CHR comments that while the APM II seeks to underwrite the costs of care coordination, this may not adequately compensate actual costs. • CHR queries how providers will be supported in practice transformation associated with achieving better health outcomes. • CHR comments that the savings projections do not address reduction of nursing home admissions, and that this is key area of potential for reduction of costs. Further, CHR comments that these projections do not adequately reference the role of behavioral health interventions in achieving desired results (e.g. reduced use of ED). • CHR seeks clarification from the Department concerning its intent to serve single-eligible Medicaid beneficiaries. • CHR comments that the cluster maps appear to create geographic boundaries that may not adequately capture existing opportunities to create networks. • CHR seeks clarification from the Department on whether providers will be authorized to offer both care coordination and direct service, and comments that this is of benefit in the BH system.
Commission for Case Manager Certification Patrice Sminkey	• The Commission recommends that board certified case managers lead care coordination teams and case management teams for dual eligible individuals. • The Commission recommends that all non-licensed case managers working on the care coordination team be trained

Chief Executive Officer Received May 14, 2012	in an appropriate manner for the population being served. - The Commission believes that board certified case managers are uniquely qualified to lead teams, perform assessments, monitor progress and track outcomes for MMEs.
AARP Connecticut Brenda Kelley State Director Received May 15, 2012	- AARP brings its experience in other state integrated care initiatives and background in health and long-term care system reforms to bear on its comments. - AARP supports many components of the proposal as consistent with AARP policy principles. These include person-centered care management, individualized multi-disciplinary care coordination, and increased access to LTSS in settings less restrictive than nursing homes. - Notwithstanding, AARP has several areas of significant concern with the proposal. - AARP is concerned that features of the MME population will limit capability to engage in care planning and in pursuing grievances and appeals. AARP therefore urges clarification of a number of key areas. - AARP requests that DSS clarify its intent concerning continued free choice of provider and the passive enrollment process. AARP emphasizes that consumers should have time and information with which to make choices about participation in Health Neighborhoods. It is AARP's position that consumers should not be enrolled in an HN unless all of their providers are participating. Further, AARP asks DSS to outline how individuals will be enrolled based on source of primary care. - AARP recommends that the application be amended to provide minimum qualifications for Lead Care Managers, minimum staffing levels, and maximum care manager to beneficiary ratios. AARP further recommends requiring dissemination of comprehensive information on all available care managers within an HN as well as details of their experience, capability and availability. AARP believes that this will support informed beneficiary choice. - AARP further urges DSS to identify minimum accreditation and quality standards for provider members of HNs. - AARP further recommends that the Demonstration performance measures be amended to incorporate re-balancing goals and diverse other indicators related to health outcomes (e.g. reduced hospitalization, increased access to HCBS, increased medication compliance). - AARP further recommends that DSS incorporate additional detail on beneficiary protections and the proposed integrated grievance and appeal process. AARP expresses concern that providing financial incentives based on gross cost savings alone places MMEs at risk, and supports specifically tying

	incentives to achieving quality measures. AARP further recommends implementing a prior authorization process to prevent inappropriate underutilization of care. AARP further recommends that DSS add detail on the proposed grievance and appeal process, including specifying by what means an Ombudsman function will be incorporated. Further, AARP recommends that beneficiaries have access to independent medical assessments in support of coverage decisions. • AARP expresses concern that the proposed supplemental benefits may not be adequate to achieve the desired outcomes, and will not be of much value to nursing home residents. AARP further recommends that the State reinvest savings that are achieved under the Demonstration in improved access to and quality of HCBS. • Finally, AARP expresses concern that the proposed timeline is unrealistic and recommends that a slower pace and rollout should be considered.
Roberta Cook Barry Kasdan Marilyn Cormack CommuniCare Received May 17, 2012	• CommuniCare affirms that the Department's proposal to establish HNs is potentially a "game changer" in addressing unnecessary care, crisis-based interventions and so-called "lack of compliance" by consumers with complex health care conditions. • CommuniCare underscores that the success of the Demonstration will depend on accountability requirements for quality and performance outcomes, provider monitoring and the payment structure. • In light of the high incidence of individuals with SMI in the MME population, CommuniCare supports the concept of a BH Co-Lead in the HN Model. • CommuniCare poses a number of questions about the means by which co-Lead Agencies will be selected and held accountable over the course of the Demonstration, especially where a DMHAS LMHA is serving in this role. Further, CommuniCare expresses concerns about a DMHAS LMHA receiving APM II and/or shared savings payments. • CommuniCare underscores the need for more detail on how the APM II payments will be apportioned among members of the HNs. • CommuniCare supports the proposal to reward HN providers over the three years of the Demonstration for achieving identified benchmarks on quality measures, if even on a reduced schedule for years 2 and 3. • CommuniCare underscores that private, non-profit LMHAs could support the HN ICM and care coordination processes. • In summary, CommuniCare recommends that the Department provide detail on how leadership and management responsibilities will be allocated as between co-

	Lead Agencies.
Connecticut State Medical Society Michael Krinsky, MD, President Matthew Katz, MS, EVP/CEO Received May 21, 2012	• CSMS affirms that representatives of CSMS participated extensively in the planning process. • CSMS regards the planning process to have been inclusive and collaborative. • CSMS supports 1) the concept of HNs; and 2) the focus on prevention and health education, elimination of duplicative and unnecessary procedures, focus on medication management, tracking and prevention of repeat use of ED and inpatient hospitalization. • In light of the lower than anticipated confirmed number of MMEs in Connecticut and potential for limitations in the number of HNs that may present, CSMS suggests that the Department use a lower participation threshold than 5,000 for the HNs. • Although CSMS would prefer that the Department adopt an “opt-in” approach to HN enrollment, it regards the Department’s proposed “passive enrollment” as acceptable so long as there are adequate means through which to opt out. CSMS recommends that the Department limit the frequency of opt-out and re-engagement with an HN. • CSMS supports including a “payment incentive model” featuring start-up payments and gain sharing associated with achieving identified benchmarks on quality metrics. CSMS identifies the need for more detail on the proposed method of sharing any savings that derive from the Demonstration. • CSMS recommends that start-up payments go directly to HN Lead Agencies and that there be flexibility to determine how these funds will best be applied. • Although CSMS affirms the value of supporting individuals with SMI, CSMS is concerned that use of BH co-Lead Agencies will cause confusion and recommends that the Department clearly specify how the payment model will work as between co-Leads. • CSMS strongly supports the APM I payments to PCMH, as well as risk-adjusted APM II payments. • CSMS underscores ACA obligations concerning reimbursement at Medicare levels for primary care physicians and associated primary and preventative care services. • CSMS affirms that it will provide technical assistance with review of the proposed Demonstration performance measures.
The A.J. Pappanikou Center for Excellence in Developmental Disabilities (UCEDD)	• Dr. Love comments that the proposal looks good overall. • Dr. Love comments that the Department may wish to consider replacing the term “intellectual disabilities” with the more inclusive “intellectual and developmental disabilities”.

Peter Love, Ph.D. Received May 22, 2012	- Dr. Love urges the Department to further explicate what it means by "holistic" in the context of care planning. - Dr. Love further offers a number of style comments in support of clarifying the narrative.
Patricia Droney Family member and pro bono mental health advocate Received May 22, 2012	- Ms. Droney points the Department's attention to the high incidence of individuals who are institutionalized. - Ms. Droney asserts that institutionalization of individuals with psychiatric disabilities has been "initiated and continually sanctioned by CT officials" to the gain of private, for-profit providers. - Ms. Droney further asserts that DMHAS LMHA actively participate in placement of such individuals in nursing facilities. - Ms. Droney comments that Money Follows the Person is not a remedy in that it requires that individuals who have been wrongly institutionalized must overcome significant bureaucratic hurdles to participate. - Ms. Droney advocates for additional funding for transitional and supportive housing, as well as community-based services, and notes that this is not a component of the Demonstration.
Judy Stein, Esq. Executive Director Center for Medicare Advocacy Received May 23, 2012	- Ms. Stein "applauds comments submitted by the AARP", and indicates that the Center will join in formal comments that are expected to be submitted by a group of advocates. - The Center generally supports the goal of improving coordination of care for dually-eligible individuals, so long as the financing model does not result in restrictions on care. The Center also supports person-centered care and the use of integrated data and technology to support the aims of the Demonstration.
Laurie Julian Director of Public Policy Alzheimer's Association, Connecticut Chapter Received May 23, 2012	- The Association supports the Demonstration goals of integration of services and supports through data integration, ICM and care coordination, expanded access to PCMH and alignment of payment structures. - The Association further supports coordination among medical, behavioral and non-medical providers. - The Association provides a précis of data on incidence of dementia in the population, and indicates that the Demonstration has the potential, through use of care management, to improve rates of early detection and to assist in implementing interventions. - The Association has concerns about the adequacy of the available provider network and current reimbursement rates, and particularly references the scarce supply of geriatric physicians and geriatric psychiatrists. - The Association underscores that consumers should retain free choice of and access to all types of providers.

	• The Association emphasizes the importance of including a cognitive assessment in the care planning process. • The Association also emphasizes the need for consumer protections, including consumer education and a clear and understandable complaint and appeals process. • The Association also recommends that family caregivers be included in the care planning process.
Evelyn Barnum, PhD Chief Executive Officer Community Health Center Association of Connecticut Received May 23, 2012	• CHCACT affirms that it has participated in the planning process, and that this process was "extraordinarily inclusive of a broad variety of stakeholders." • CHCACT supports the proposal and the "majority of its elements". • CHCACT recommends that the Department engage in a broad educational campaign around the Demonstration for both consumers and providers. • CHCACT also recommends that the Department collaborate with the Consumer Access Committee of the Medical Assistance Program Oversight Council (MAPOC) to establish customer service standards for the Demonstration. • CHCACT also emphasizes that it will be essential for the Department to be transparent about all aspects of the financing model and beneficiary outcomes. • CHCACT urges the Department to require that each HN include FQHCs. • CHCACT recommends that the Department review the lists of stakeholders to ensure that organizational affiliations are correctly described.
Connecticut Association of Area Agencies on Aging Received May 23, 2012	• The C4A concurs with the following: the overall vision of integrated, holistic, person-centered services and supports, improved coordination between Medicare and Medicaid-funded services, maintaining the person as the center point, passive enrollment in HNs provided that education supports the process, enhanced access to supplemental services, linkages to HCBS care through various sources, and connections among providers. • C4A urges the Department to carefully craft the process of selection of a Lead Care Manager to prevent confusion with existing sources of care coordination and to support those with poor literacy or visual impairment. • C4A urges the Department to partner with CHOICES/Community Choices in the education process associated with HN enrollment. • C4A recommends that the Department take advantage of existing evidence-based health promotion programs including those targeted toward chronic disease self-management and falls prevention within the structure of the HN supplemental

	services. - C4A further recommends partnering for purposes of nutrition counseling with existing efforts funded under Title III-C of the Older Americans Act. - C4A calls the Department's attention to the fact that many Title III-C funded nutrition projects have waiting lists due to funding constraints.
Connecticut's Independent Living Centers Received May 23, 2012	- The CILs strongly encourage the Department to include CILs and the existing Aging and Disability Resource Centers (ADRCs) in both the ASO and HN models, in support of information & assistance and care coordination. - The CILs comment that they originated and have furthered strategies and terminology in support of person-centeredness, and have considerable expertise in serving the needs of individuals with a broad range of disabilities. - The CILs emphasize that the existing Connecticut ADRCs serve as single points of entry into the system of LTSS. The ADRCs provide neutral, objective information, and are staffed by individuals who have completed CHOICES training, have been certified by AIRS and have received training in chronic disease self-management and care transition interventions. - The CILs also forwarded to the Department a set of national advocacy principles drafted by disability advocates, which address such areas as choice, access to HCBS, safeguards against doing harm, person-centeredness, communication, non-discrimination and consumer safeguards. - Finally, the CILS indicate that they expect to sign on to a letter that is being prepared by a group of advocates.
Deborah Hoyt President and CEO Tracy Wodatch, RN VP of Clinical and Regulatory Services Connecticut Association of Home Care and Hospice Received May 23, 2012	- CAHCH agrees that it makes sense to take a comprehensive approach to combining care and financing for dually eligible individuals. - CAHCH asserts that creating a means through which providers can strengthen collaboration, HNs, is long overdue. - Notwithstanding, CAHCH has grave concerns about the financing model that is proposed. - Further, CAHCH urges the Department to remain flexible during the process of HN development and implementation to monitor any issues that may arise. - CAHCH recommends that providers participate in shared savings in the ASO Model, as well as the HN Model. - CAHCH generally supports the proposal to create separate pools for rewarding performance-based quality and value, but comments that more specific details will be essential. CAHCH recommends that shared savings be distributed based on a weighted methodology and adjusted over time based on risk and outliers.

	• CAHCH comments that current Medicaid reimbursement for home health pays only $.60 on the dollar, leaving shortfalls. CAHCH therefore recommends that the Department cover the supplemental services that are proposed to be offered in the HN Model, as well as social work in support of the care plan, on a fee-for-service basis. • CAHCH comments that the Demonstration presents an opportunity to leverage the existing care management expertise of home health agencies and to overcome silos that have inhibited partnerships among providers. • CAHCH requests that the Department release guidance and lessons learned on the ASO experience to date, as well as results of other states' integrated care Demonstrations. • CAHCH comments that access to care, including the non-medical supports that are covered by the Medicaid waivers, is compromised by delays in eligibility processing by the Department. • CAHCH supports passive enrollment with opt-out under the HN model, but underscores that this process must include consumer-friendly educational materials and clearly stated guidelines. • CAHCH affirms the value of a Lead Agency that has expertise in serving individuals with SMI for care coordination purposes <u>only</u>. CAHCH believes that the administrative and fiduciary responsibilities would best be handled by a non HN-affiliated entity, such as one of the ASOs. • CAHCH underscores that home health care is a key support for individuals with SMI.
Alicia Woodsby, MSW Deputy Executive Director Partnership for Strong Communities Received May 24, 2012	• The Partnership affirms its focus upon fostering vibrant communities, eliminating homelessness and supporting the needs of individuals with SMI, substance abuse disorders and other chronic health needs who are experiencing housing instability. • The Partnership supports the concept of HNs, and the Department's overall goal to develop holistic, person-centered services and supports to address the full range of MMEs' needs. The Partnership comments that this population requires improved coordination and systems integration. • The Partnership particularly supports the focus on improved quality of care, performance measures and monitoring and incentivizing improved health outcomes. • To address historical barriers related to housing instability, the Partnership underscores the need for the Department to incorporate non-medical providers within HNs. In support of this recommendation, the Partnership includes source material profiling the complex care and social services needs

	of individuals who experience housing instability and homelessness. • The Partnership supports including peer support and recovery assistants as covered supplemental services under the HN model, and recommends also covering community support services and including a pilot medical respite transitional housing program. • The Partnership recommends that the Department clarify the types of providers that will be required to participate in HNs, and underscores that the array should include community-based housing, BH and SA providers. • The Partnership recommends that the Department conduct a transportation availability assessment. Further, the Partnership recommends that the Department include a performance measure related to housing status and housing stability. • The Partnership suggests that the areas in which the Demonstration aims to achieve cost savings (e.g. reduction in ED use) are demonstrably linked with housing stability. On this basis, the Partnership recommends that the Department set aside a portion of any savings that are achieved for housing subsidies targeted toward individuals with complex health care needs who are homeless or at risk of homelessness.
Stephen Frayne Senior Vice President, Health Policy Connecticut Hospital Association Received May 24, 2012	• CHA is committed to working with the Department to develop a demonstration that provides a seamless continuum of services, but as presented, CHA does not support the proposal and requests that unless the Department addresses four key concerns, CMMI not approve it. • CHA recommends that the Department use shared savings that are achieved by the Demonstration to cover Medicare deductible and co-pay amounts that are not covered by the state where what Medicare has reimbursed for a service exceeds the Medicaid reimbursement rate for that service. • CHA urges the Department to replace the existing set of proposed performance measures with those identified in the CMS Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults. • In light of the fact that Connecticut-specific performance standards have not yet been released by CMS, CHA further recommends that the Department make performance payments solely on a pay-for-reporting basis. • Finally, CHA recommends that the Department share savings under Model 1 as well as under Model 2, and that savings should be distributed based on the proportion of a provider's claims expense to the total for the model in which the provider has participated.

Mary Anne O'Neill Director of Public Policy Connecticut Community Providers Association Received May 24, 2012	• Representing organizations that provide services and supports to individuals with disabilities, substance use disorders, SMI and intellectual and physical disabilities, CCPA supports the application and applauds the Department's efforts to integrate Medicare and Medicaid medical, behavioral and long-term care services and supports, promote PCMH practice transformation and ASO capability, and information sharing. Further, CCPA supports the Department's goals of enhancing population outcomes, improving consumer care experience, and controlling the rate of growth of costs of care. Finally, CCPA commends the Department on a transparent process and willingness to revise the application consistent with comments. • CCPA does not believe that the Department's proposal to passively enroll individuals with HNs is consistent with person-centeredness, and instead recommends a voluntary opt-in process. • Further, CCPA seeks clarification on the degree of relationship with a primary care provider that would result in affiliation for purposes of passive enrollment. • Additionally, CCPA recommends that the Department ensure that consumers have sufficient information to make informed decisions about participation in the Demonstration, whether ASO or HN model. • CCPA urges the Department to provide greater detail on the predictive modeling process that will identify individuals in need of ICM, and safeguards for those who do not stratify as being in this level of need. • CCPA also urges the Department to issue clear instructions to HN Lead Agencies on how start-up and APM II payments must be distributed to HN provider members. • CCPA requests clarification on whether grant-funded services (e.g. crisis intervention, housing support) will be expanded to accommodate increased need associated with the Demonstration. • CCPA requests that DSS consider expanding the list of supplemental services that will be offered in the HN model to include other aspects such as parenting classes for younger MMEs. • CCPA underscores the need for provider education on Demonstration goals and structure. • CCPA requests clarification of both the required provider array, and required services and supports, in HNs. • CCPA urges the Department to include provider and ASO representatives on the Demonstration Steering Committee. • While CCPA supports the concept of a BH co-Lead Agency, CCPA requests clarification of the duties and allocation of

	roles between Lead Agencies and issuance of standards around the administrative and fiduciary functions. Further, CCPA identifies the need for guidance on how Lead Agencies will coordinate care that is provided by non-HN provider members. Finally, CCPA urges the Department to permit Lead Agencies to provide direct services. • CCPA supports the Department's concept of separate quality and value payment pools, and suggests that 40% of shared savings be allocated to the former and 60% to the latter. If the Department does not pursue this concept, CCPA supports the compromise position of the Complex Care Committee. • CCPA urges the Department to reduce the number of performance measures that are currently included in the application. Further, CCPA urges the Department to set minimum benchmarks of achievement on the performance measures for eligibility for shared savings.
Leslie Wood Senior Director, State Advocacy PhRMA Received May 24, 2012	• PhRMA strongly supports the Department's efforts to improve care coordination for MMEs. • PhRMA reflects back a summary of major elements of the Department's proposal. • PhRMA expresses concern about the scope and pace of implementation, especially with respect to establishing necessary structures and shifting provider culture in support of the needs of medically vulnerable beneficiaries. • PhRMA encourages the Department focus upon a limited subset of the MME population with the HN population to test the efficacy of the model before expanding it more broadly. • PhRMA urges the Department to clarify what role the ASO will play in helping to connect individuals who do not have a usual and customary source of primary care with such a provider, and to HN, if applicable. This concern focuses on which entity will receive payment for care management. • Consistent with the Department's current plan, PhRMA recommends that individuals who are already enrolled in an SNP or MA plan, and those with Part D plans, be permitted to remain in those plans. • PhRMA applauds the Department's recognition of the need for medication therapy management (MTM) for beneficiaries, but cautions that individuals should be permitted to remain affiliated with their Part D plans. Further, PhRMA urges the Department to coordinate any HN provided MTM service with the medication management activities provided by Medicare Part D plans. • PhRMA affirms the Department's commitment to maintaining beneficiary choice of provider, and supports the Department's proposed means of passively enrolling individuals in HNs. PhRMA does, however, request

	clarification of the means by which the Department plans to ensure continuity of care if an MME's Medicare provider refuses to contract with the ASOs or an HN. Further, consistent with the Department's plan, PhRMA urges the Department to permit MME participants of HNs to see out-of-network providers.
Christopher Santarsiero Director of Public Affairs VITAS Innovative Hospice Care Received May 25, 2012	• VITAS comments that the Demonstration has the potential to integrate administrative processes for MMEs while reducing barriers to care and unnecessary duplication of services. • VITAS urges that the Department include hospice as a key component of the Demonstration, and as a working partner in planning and implementation activities. • VITAS requests that the Department clarify a number of elements of the proposal: 1) whether the Department will dictate the terms of participation for provider members of HNs, or leave this to the Lead Agencies; 2) whether HNs will be required to contract with any willing hospice provider; and 3) whether existing coverage standards, procedure, and reimbursement for Medicare and Medicaid hospice benefits will continue to attach. • VITAS recommends that the Department include a quality measure on how many individuals with chronic illnesses die without a referral to hospice.
Sarah Gallagher Director, CT Program Corporation for Supportive Housing Received May 25, 2012	• CSH leads an interagency partnership of entities involved with the development of supportive housing. • CSH supports the concept of HNs, and the Department's overall goal to develop holistic, person-centered services and supports to address the full range of MMEs' needs. CSH comments that this population requires improved coordination and systems integration. • CSH particularly supports the focus on improved quality of care, performance measures and monitoring and incentivizing improved health outcomes. • CSH supports including Community Support Services (CSP), peer support and recovery assistants as covered supplemental services under the HN model. • CSH recommends that the Department require that housing providers be included in the array of required HN providers. • CSH recommends that the Department include a performance measure related to housing status and stability. • CSH recommends that the Department set aside a portion of any savings that are achieved for housing subsidies targeted toward individuals with complex health care needs who are homeless or at risk of homelessness.
Ellen Andrews,	• The CHPP affirms that it supports moving from an antiquated fee-for-service system to a system that rewards for achieving

Executive Director CT Health Policy Project Received May 25, 2012	quality, improves health outcomes, aligns incentives between payers, encourages teamwork and care coordination across provider groups, reduces incentives for dangerous and wasteful over-treatment, and maximizes resources to ensure sustainability. • The CHPP affirms its participation as a stakeholder in the planning process. • The CHPP supports many of the concerns raised in the "advocates' comment letter". • The CHPP supports the compromise position of the Complex Care Committee with respect to premising shared savings on improved performance. • The CHPP endorses using a voluntary, opt-in process for HN participation. • The CHPP urges the Department to ensure that funds and services are shared and distributed across each HN by Lead Agencies. • The CHPP urges the Department to extend written care plans to all program participants. • The CHPP urges the Department to offer MMEs access to the same service array as between Models 1 and 2. • The CHPP urges the Department to improve the consumer protections identified in the application. • The CHPP urges the Department to cover the costs of Medicare Part D prescription drug co-payments. • The CHPP further recommends that the Department prohibit Lead Agencies from providing direct services to MMEs. • The CHPP further recommends that the Department adopt a strong, multi-method evaluation plan, that the Department share results of the same with the public and shift course to reflect areas in need of improvement. • Notwithstanding its support for the needs of individuals with SMI, CHPP expresses concern about the late emerging proposal to include a behavioral health co-Lead Agency. The CHPP's concerns center around lack of advance opportunity to vet this proposal; concern that this requirement will limit the field of respondents to an RFP; concern that this will influence the choice of medical co-Lead Agency; concern that this will inspire decision-making based on corporate interests as opposed to beneficiary needs; concern regarding the role of state-run LMHAs; concerns around the apportionment of responsibilities among the Lead Agencies and potential for conflict, confusion and/or duplication of effort; concern that this will invite proposals from other types of co-Leads; and concern that this will undermine the stated interest in unifying providers in the HN.

	- In light of the above, the CHPP recommends that the Department 1) create and monitor standards of access to and receipt of behavioral health care; 2) delay implementation of BH co-Lead Agencies pending further stakeholder comment; and 3) conduct a separate procurement for this function.
Molly Gavin Executive Director Connecticut Community Care, Inc. Received May 25, 2012	- CCCI expresses appreciation for the intense, thorough and comprehensive vetting of the application. - CCCI comments that it will be essential for the Department to establish standards for the providers that will offer ICM and care coordination. Further, CCCI points the Department's attention to existing care management associations that have expertise in the practice of community-based care management. - CCCI recommends that the Department build upon the strengths of the existing Access Agencies that provide assessment, coordination and monitoring functions associated with the Connecticut Home Care Program for Elders, as well as the existing Aging and Disability Resource Centers. - CCCI urges the Department to be attentive to the need for community-based supports to complement medical and behavioral health services. - CCCI further remarks that the success of the Demonstration will depend upon access to well educated and experienced providers. CCCI comments that there is currently a shortage of behavioral health care providers with interest and expertise in serving the needs of older adults and individuals with disabilities. - CCCI affirms its strong support for all of the goals of the Demonstration, and the identified means of achieving them, but also underscores that the inadequacy of the existing fee-for-service reimbursement structure and failure to give regular increases undermines the capacity of the provider community to fulfill these goals.
Julia Evans Starr Co-Chair Long-Term Care Advisory Council Received May 25, 2012	- The LTCAC represents consumers, providers and advocates for individuals who require long-term services and supports. - The LTCAC acknowledges the national and state paradigm shifts from segregated institutional settings to community settings, from provider oriented systems to person-centered systems, and from medical models to whole life models. - The LTCAC comments that the Department's proposal complements such paradigm change projects as medical homes and Money Follows the Person. - The LTCAC commends the Department for developing the proposal through an open process that engaged many and varied stakeholders.

	• The LTCAC believes that the Demonstration has the potential to produce a higher quality of life for MMEs while reducing the rate of increase in costs. • The LTCAC urges the Department to support expanded use of assistive technology. • The LTCAC urges the Department to adopt culture change around end-of-life issues, moving from a DNR approach to an Allow Natural Death (AND) approach. • The LTCAC urges the Department to emphasize prevention, wellness and disease management by building upon the strengths of existing community-based programs and partnering with the Department of Public Health. • The LTCAC urges the Department to promote peer provider coaching capability in support of HN development. • The LTCAC urges the Department to expand services and supports to family caregivers. • The LTCAC urges the Department to implement an evaluation system that ensures transparency and is flexible enough to evolve over the course of the Demonstration. • The LTCAC urges the Department to track those who opt out of participation (e.g. reasons for doing so). • The LTCAC urges the Department to ensure that the HN service array supports the full range of MMEs’ needs, including acquiring, restoring, maintaining and preventing deterioration of function. • The LTCAC urges the Department to cover Medicare Part D co-pays for MME participants. • The LTCAC urges the Department to promote the Demonstration to providers. • The LTCAC urges the Department to educate medical and behavioral health care providers on available community-based services and supports. • The LTCAC urges the Department to promote cultural competency, including competency in disability culture, among providers. • The LTCAC urges the Department to fully inform MME participants of HNs of their rights and obligations. • The LTCAC urges the Department to address the need for a protocol for individuals transitioning from a nursing facility to the community, or switching primary care providers, with respect to implications for HN participation. • The LTCAC urges the Department to establish protocols for situations in which an MME is seeking care from a non-HN participating provider. • The LTCAC urges the Department to ensure that the grievance and appeal process meaningfully address access

	barriers that are faced by individuals with disabilities, and that the Ombudsman be accessible and of support in navigating the process. • The LTCAC has concern about the pace of the implementation schedule. • The LTCAC supports the Department's intention to seek a waiver of the "three-day" rule associated with Medicare coverage of care in a skilled nursing facility. • The LTCAC urges the Department to direct a substantial portion of any savings that are achieved, and also savings achieved by MFP, to reinvestment in the LTSS system, with an emphasis on HCBS. • The LTCAC urges the Department to establish an APM II payment that is sufficient to compensate for the costs of care coordination. • The LTCAC recommends that the Department focus on rewarding quality, and comments that this will likely lead to cost savings. • The LTCAC urges the Department to ensure that there is transparency around the financial model. • The LTCAC urges the Department to perform system-wide analyses to explore the interrelationship between the Demonstration and other initiatives including MFP, the work that is being conducted under care transitions grants, and the Connecticut Health Information Exchange.
Sara Frankel, Esq. Program Manager for Policy and Advocacy NAMI-CT Received May 25, 2012	• NAMI-CT strongly supports the Department's efforts to integrate Medicare and Medicaid medical, behavioral health and LTSS. • NAMI-CT supports the comments that were submitted by a coalition of advocacy entities, and also strongly supports the recommendations that were submitted by the Partnership for Strong Communities. • NAMI-CT strongly supports inclusion of behavioral health providers as co-Lead Agencies in the HNs, and affirms that DSS and DMHAS have recognized the need of individuals with SMI for specialized care management support. • NAMI-CT reinforces that Lead Agencies must provide appropriate quality and access to services, and must be accountable to the HN with which they are affiliated and to the Department. • NAMI-CT reinforces that MMEs must be empowered to choose which entity will provide their care management.
Sheldon Toubman, Esq. On behalf of a coalition including: Center for Medicare Advocacy, Brain Injury Alliance	• The Coalition supports the concept of integrating care for MMEs and affirms the Department's decision not to pursue a managed care or capitated provider arrangement. • The Coalition comments that MMEs have complex needs and

of CT, Connecticut Legal Services, Advocacy for Patients with Chronic Illness, Independence Northwest, Epilepsy Foundation of CT, Greater Hartford Legal Aid, CT Health Policy Project, CT AIDS Resource Coalition, Legal Assistance Resource Center, NAMI-CT, Connecticut Legal Rights Project, CT State Independent Living Council, CT Association of Resident Service Coordinators in Housing, Connecticut Coalition on Aging, Mental Health Association of CT Received May 25, 2012	face many barriers, including poverty and medical vulnerability, to advocating for their own needs. • The Coalition challenges the assumptions that the Department has made concerning utilization based on the fact that the cost of care for Connecticut MMEs is significantly more than the national average, and proposes instead that this population faces access barriers that result in under-utilization of services. • The Coalition urges the Department to share savings on a targeted, as opposed to global, basis that is linked to such areas as ED usage. The Coalition believes that a global approach will lend itself to incenting providers to deny needed care, and that MMEs will be ill equipped to identify situations in which care is restricted. • The Coalition further urges the Department to build upon the PCMH model, which focuses upon coordination of care and rewards providers for achieving improvement on a range of quality measures. • The Coalition asserts that the Department has been unresponsive to stakeholder comment, notably with respect to the compromise position of the Complex Care Committee regarding performance payments. Further, the Coalition takes issue with the means by which the proposal to require a behavioral health co-Lead emerged. • The Coalition urges the Department to accept and incorporate the compromise position of the Complex Care Committee with respect to premising shared savings on improved performance. • The Coalition endorses using a voluntary, opt-in process for HN participation. In the absence of opt-in, the Coalition recommends that the Department provide MMEs with extensive consumer education, time and support in making decisions about whether to participate in an HN. The Coalition supports the Department's proposal to use a neutral enrollment broker for this purpose. • The Coalition comments that it is difficult to comment on the late-emerging proposal to require a BH co-Lead Agency, and notes that there are varying views on this subject. Notwithstanding this range of views, the Coalition urges that any entity seeking to be identified as a co-Lead Agency be excluded from the RFP selection process, and points to DMHAS involvement in the process of evaluating an application from a DMHAS-affiliated LMHA as an example. Further, the Coalition urges the Department to include outside representation on the RFP committee that will vet proposals from HN Lead Agencies. • The CHPP urges the Department to ensure that funds and

	services are shared and distributed across each HN by Lead Agencies. - The Coalition urges the Department to extend written care plans to all program participants. - The Coalition urges the Department to offer MMEs access to the same service array as between Models 1 and 2, either by authorizing the ASO to do so, or amending the State Plan to cover the supplemental services. - The Coalition urges the Department to improve the consumer protections identified in the application, particularly with respect to details on the proposed use of an Ombudsman function and the data (e.g. on denials of service) that will be shared with the same. The Coalition urges the Department to assign this function to a neutral, independent entity. - The Coalition urges the Department to cover the costs of Medicare Part D prescription drug co-payments.
Stephen Larcen, Ph.D. CEO Natchaug and Windham Hospitals Received May 25, 2012	- Dr. Larcen recommends that the Department consider implementing "pro-rata" thresholds for achievement of performance measures for purposes of eligibility for performance payments. - Dr. Larcen recommends that gain sharing associated with achieving cost savings start in year 1 of the Demonstration, as opposed to waiting until years 2 and 3. Further, Dr. Larcen recommends limiting the percentage of shared savings associated with quality alone to 10% of total savings, or 20% of the total gain share. - Dr. Larcen recommends that savings payments be risk adjusted. - Dr. Larcen urges the Department not to limit payments to 50% of savings achieved. - Dr. Larcen recommends against calculating savings across both models, and urges that losses in Model 1 not be applied against Model 2. - Dr. Larcen urges the Department to consider how the mechanism for shared savings will incent participation by providers.
Maureen McIntyre North Central Aging and Disability Resource Center and Eastern CT Aging and Disability Resource Network Received May 25, 2012	- The ADRC/ADRN affirms the inclusiveness of the Department's planning process, the application content and the goals of the Demonstration. - The ADRC/ADRN affirms the focus upon person-centeredness, and urges the Department to ensure that this is not simply a statement of philosophy, but that it is applied concretely through the learning collaborative model to support culture change among providers. - The ADRC/ADRN urges the Department to avail itself of

	existing services and supports that will further the aims of the Demonstration, including the existing ADRCs and their linkages in support of such initiatives as chronic disease self-management programs, MFP, and the Community-Based Care Transitions Program.
Marie Smith, PharmD UConn School of Pharmacy Margherita Giuliano, RPh, CAE CT Pharmacists Association Received May 25, 2012	• Dr. Smith and Ms. Giuliano recommend that the Department adopt an established definition of Medication Therapy Management (MTM), which is included in their comments. • Dr. Smith and Ms. Giuliano emphasize that a previous Connecticut pilot under which pharmacists provided medication management services to Medicaid beneficiaries supports the value of incorporating this service within the HN Model. Dr. Smith and Ms. Giuliano recommend that MTM be incorporated as a feature of not just the HN Model, but also for those MMEs served by the ASOs. Dr. Smith and Ms. Giuliano propose that the Department amend the State Plan to cover MTM on a fee-for-service basis. • Dr. Smith and Ms. Giuliano urge the Department to establish uniform standards for eligibility for MTM, and offer their support in doing so. • Further, Dr. Smith and Ms. Giuliano recommend that the Department establish minimum provider credentials for MTM. • Dr. Smith and Ms. Giuliano express concerns that the co-Lead Agency structure may lead to fragmentation and uncertainty. • Dr. Smith and Ms. Giuliano urge the Department to identify PharmNetEx as a qualified resource to all entities seeking to organize as HNs. • Dr. Smith and Ms. Giuliano urge the Department to adopt medication management specific performance measures, and supply recommended language.

Appendix H. Letters of Support