

**Review of Public Comments to CCIP Report, First Draft (includes CHA comment submitted to DSS re: MQISSP design)**

Summary of Comments	PMO Response
<p>(1) <b>Administrative Service Organizations (ASOs)</b> – DSS has indicated that it intends to continue utilizing its existing federated approach to medical management for the four major service types, i.e., medical through Community Health Network of Connecticut (CHN), behavioral health through ValueOptions (VO), dental through BeneCare, and non-emergency medical transportation through LogistiCare. In addition, there is contemplated a Community and Clinical Integration Program (CCIP), which appears to take a completely different approach to care management; namely, the CCIP program intends that these programs be embedded in the local FQHC or Advanced Network (AN). It appears as if DSS is intending to operate for the same populations at the same time two completely different approaches to medical management which are not complimentary. Hospital-sponsored networks would prefer that the medical management function be embedded within the advanced network and funded. However, if DSS intends to maintain its federated approach and/or will not fund local medical management, then DSS should clarify that the medical management service will be made available to the local entities from the statewide organizations and that DSS will amend its contracts with those organizations to require support to the local networks.</p>	<p>The SIM PMO has consulted with DSS on this question and received the following response:</p> <p>All Connecticut Medicaid beneficiaries will, on a risk-stratified basis, continue to be eligible for Intensive Care Management (ICM) through the medical, behavioral health and dental Administrative Services Organizations (ASOs). ICM was originally designed as a more federated approach, but there are numerous existing examples of how this has already evolved to include partnerships with local providers (e.g. behavioral health community care teams that include hospital and other partners; embedding of ICM staff within hospital discharge processes). DSS does intend to continue to migrate towards more locally-based care coordination. To this end, under MQISSP, DSS will be making supplemental payments to the FQHCs that are selected by RFP to participate. These supplemental payments will support care coordination activities over and above those required for Person-Centered Medical Homes (PCMH). While PCMH will remain the foundation of care delivery transformation, and ICM will continue to be a resource to high need, high cost beneficiaries, MQISSP will incorporate new requirements related to integration of primary care and behavioral health care, as well as linkages to the types of community supports that can assist beneficiaries in utilizing their Medicaid benefits.</p> <p>The proposed MQISSP care coordination elements focus upon the following:</p> <ul style="list-style-type: none"> <li>• Behavioral and physical health integration: Care coordinator training and experience, use of screening tools, use of psychiatric advance directives, use of Wellness Recovery Action Plans (WRAPs)</li> <li>• Culturally competent services: Training, expansion of the current use of CAHPS to include the Cultural Competency Item</li> </ul>

Set, incorporation of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) standards

- Care coordinator availability and education
- Supports for children and youth with special health care needs: Advance care planning discussions and use of advance directives, incorporation of school-related information in the health assessment and health record (e.g. existence of IEP or 504)
- Competence in providing services to individuals with disabilities: Assessment of individual preferences and need for accommodation, training in disability competence, accessible equipment and communication strategies, resource connections with community-based entities

DSS will not be making care coordination payments to Advanced Networks. Our reasons for not doing so include 1) our intent to model on the original Medicare Shared Savings ACO arrangements, under which no advance care coordination payments were made; and 2) state budget constraints. Advanced Networks will, however, continue to be able to partner with ASO-based ICM staff to the mutual benefit of Medicaid beneficiaries, and to the extent that their affiliated primary care practices are participating in PCMH, also will continue to receive enhanced fee-for-service payments, performance payments and data through the Medicaid PCMH initiative.

(3) Commenter believes that CCIP's added design features should be more integrated structurally with the MQISSP program.

As currently framed, CCIP is primarily a set of standards combined with technical assistance initiative that will focus upon defined aspects of practice transformation in support of the needs of several target populations. The SIM PMO and DSS acknowledge that it will be useful to solicit further discussion on the interrelationship of CCIP, MQISSP and existing and recently initiated practice transformation and care coordination initiatives (Connecticut Medicaid PCMH and ICM; CMMI Practice Transformation Grant to FQHCs). This will occur through joint work of the MAPOC Care Management Committee and the SIM Practice Transformation Task Force.

The SIM PMO and DSS have in consultation with the Care Management

Committee of MAPOC developed a protocol document to guide communications between and joint work of that committee and of the SIM Quality and Equity & Access Councils. This document is available on the MAPOC web site under the 2/20/15 meeting materials section (“MAPOC Care Management Committee SIM Work – FINAL”) at this link:

<https://www.cga.ct.gov/med/comm1.asp?sYear=2015>

The PMO and DSS commit to revisiting this protocol to encompass shared work with the SIM Practice Transformation Task Force.

(2) Commenter would like more clarification about how CCIP aligns with the MQISSP and other SIM initiatives (e.g.; QC and workforce development workgroup), how many providers will be selected, and what the selection criteria will be.

In the SIM model test grant, we are testing whether the combination of Medicaid payment reform (MQISSP) and care delivery reforms (CCIP and AMH), will accelerate advancement and improve performance for participating ANs and FQHCs. Accordingly, MQISSP participants will be required to meet CCIP standards. Like NCQA medical home standards, CCIP standards are focused on provider capabilities, rather than distinct coverage groups (e.g., Medicare, Medicaid, commercial).

The work of the Quality Council is focused more broadly on aligning payers on the quality measures that are used in Shared Savings Program arrangements, which applies to all providers in shared savings program contracts and not limited to those participating in MQISSP.

The SIM CHW Workforce initiative is focused on improving the availability of a qualified CHW workforce. CHWs are included as requirements elements under two of the CCIP standards.

DSS is responsible for the MQISSP and the criteria for selecting providers. Information regarding MQISSP model design elements developed to date (note: these are pending review and finalization) can be found at

<https://www.cga.ct.gov/med/default.asp>

(6) Commenter believes there should be clarification around the three types of care plans referenced in the report, in particular whether they are referring to the same plan, and how these plans would be shared with the patient.

The report will be edited to clarify the intent that there should be one patient care plan that is managed by the patient’s medical home. It is recommended that this same care plan be expanded to include additional components for more complex patients. CCIP is not recommending the creation of separate, or parallel, care plans for care coordination.

(1) Commenter would like to see provider focus expanded beyond FQHCs and Advanced Networks and to incorporate reproductive health providers.

The SIM model test grant does not propose to align payers around attribution processes, including which providers should be the basis for attribution. We believe that some payers have considered attribution models that extend beyond primary care provided by internists, family practitioners, pediatricians and APRNs. Reproductive health providers that wish to be considered as the basis for attribution should discuss this option directly with payers, potentially with an affiliation agreement with an Advanced Network.

The CCIP program includes complex care standards and community health collaborative standards, both of which provide the opportunity to improve linkages with other providers in the medical neighborhood including reproductive health providers such as Planned Parenthood health centers.

MQISSP has elected to focus solely on FQHCs and Advanced Networks. If the model is successful, DSS and other payers may consider expanding that frame of reference to include other types of providers.

(12) Commenter encourages the Practice Transformation Task Force to coordinate its efforts with the Department of Social Services with regard to care management.

(12) See response to #1 and 3 above.

(1) Commenter requests additional clarity around Medicaid reimbursement for eConsults and how reimbursement within CCIP program would function.

Connecticut Medicaid currently limits telemedicine to coverage of 1) electronic medication administration devices under the Medicaid State Plan; and 2) personal emergency response systems under several of the Medicaid home and community-based “waivers”.

DSS is pursuing CMS approval of a Medicaid State Plan Amendment under which FQHCs that meet specified criteria will be authorized to conduct

<p>electronic consultations for specialist services.</p>	
<p>(1) Commenter believes that there should be more clarification around the integration of CCIP with existing care coordination efforts, in particular with the PCMH program, to ensure that unnecessary duplication of efforts does not add an extra layer of burden on providers. Commenter believes that the CCIP and the SIM Advanced Medical Home Vanguard program are unintentionally undermining the PCMH program, in particular through the Comprehensive Care Teams outlined in the report.</p>	<p>The CCIP is focused on establishing a minimum standard of capabilities among ANs/FQHCs. It is not intended to supplant activities that are already in place. The transformation vendor will conduct a gap analysis at the start of its engagement in order to determine which standards or elements have already been met and which standards or elements have not been met. The transformation support will focus on those areas that have not been met. In this way, the CCIP should not disrupt existing care coordination efforts that a provider may have in place as a PCMH or otherwise.</p>
<p>(3) Commenter believes that the behavioral health standards duplicate the assistance program begun by CHNCT for Medicaid practices.</p>	<p>CCIP technical assistance to MQISSP Participating Entities will be tailored based on their needs. If a Participating Entity has already addressed behavioral health gaps, or other areas of focus that are relevant to CCIP standards, through technical assistance provided by the CHNCT PCMH team, it will not be required to accept that type of CCIP support.</p>
<p>(6) Commenter would like SIM to take more time to coordinate with DSS.</p>	<p>The PMO and DSS are preparing a request to CMMI for a full-year extension of the originally planned implementation date, in significant part, to permit more time for discussion of how MQISSP, CCIP and existing initiatives (PCMH, ICM) interrelate.</p>