

**CONNECTICUT STATE INNOVATION MODEL INITIATIVE
COMMUNITY & CLINICAL INTEGRATION PROGRAM**

March 15, 2016

**Response to Concerns Raised by Members of the Care Management Committee
Prepared by the SIM Program Management Office in Consultation with the Department of
Social Services**

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Introduction

Care delivery and payment reforms have been well underway in Connecticut as a result of the combined efforts of Medicare, Medicaid, commercial payers, and providers, all of whom have been working to provide the tools and resources necessary to improve health care outcomes. The State Innovation Model initiative was established as a means to ensure that these reforms are informed by the diversity and expertise that exists within Connecticut's stakeholder community—consumers, consumer advocates, employers, health plans, providers, and state agencies. The SIM governance structure and advisory process promotes multi-payer alignment to so that payers and providers are pushing to achieve the same goals. We promote alignment on methods and requirements where this makes sense (e.g., quality measures, medical home, and community integration), while also promoting flexibility and innovation. Importantly, we also seek to ensure that the needs of the most vulnerable individuals who encounter barriers to healthcare are a central consideration, whether these individuals are covered by Medicaid, Medicare, or commercial insurance.

Governor Malloy applied for and received \$45 million in federal funding from the Centers for Medicare and Medicaid Innovation to help SIM achieve its objectives of better health, eliminating health inequities, engaging consumers, improving healthcare outcomes and improving affordability. The success of our application depended on the leadership of Lt Governor Wyman and the full commitment and support of many of Connecticut's key state agencies involved in health care including the Departments of Social Services, Public Health, Insurance, Mental Health and Addiction Services, and Children and Families. It also depended on the support of the stakeholder community, which continues to provide essential guidance through our governance structure on all aspects of program design and implementation.

The Community and Clinical Integration Program (CCIP) is the most recent and among the most ambitious products of our collective commitments and stakeholder advisory process. CCIP includes care delivery standards and technical assistance to a) improve care for individuals with complex health needs, b) introduce new care processes to reduce health equity gaps, and c) improve access to and integration of behavioral health services. In each of these areas, available data suggests that there are sizable opportunities to improve care, especially by helping care teams to identify cultural, language, and social factors that are barriers to care and address these barriers through community linkages and new team members such as Community Health Workers.

The CCIP program is intended to complement the Medicaid Quality Improvement and Shared Savings Program (MQISSP) and its associated requirement elements. MQISSP builds on the great success of the Department of Social Services' PCMH program, which is the foundation for the MQISSP program design, and harmonizes with other effective DSS initiatives such as the Intensive Care Management (ICM) program, the medical and behavioral health ASOs, and the Health Home initiative all of which contribute to a record of quality improvement and cost savings.¹ The combined effect of the MQISSP required elements and the CCIP standards is to strengthen the capabilities of our increasingly accountable provider community with an emphasis on care coordination, team-based care, health equity, social

¹A summary of Medicaid's many care delivery (PCMH, Intensive Care Management, health homes) and payment reform (PCMH incentives, BH and OB P4P) achievements are summarized at the following links.
https://www.cga.ct.gov/med/council/2016/0222/20160222ATTACH_DSS%20Presentation.pdf;
https://www.cga.ct.gov/med/council/2015/1211/20151211ATTACH_NGA%20high%20cost%20high%20need%20-%20FINAL.pdf

determinant risks, community integration, community health worker supports, behavioral health integration, and the care of special populations.

During the design of the CCIP, we recognized the critical role that the Medical Assistance Program Oversight Council’s Care Management Committee plays in advising the Department of Social Services on its PCMH and MQISSP initiatives, as well the supporting role that related SIM initiatives such as CCIP can play in advancing the best interests of Medicaid beneficiaries. We first engaged the Care Management Committee in this planning process in September of 2015. We provided documents, conducted presentations and webinars, reviewed and responded to public comments, and held joint meetings. Many of the comments received have been addressed in previous versions of the report. This document is intended to address the most recent concerns raised by some members of the Care Management Committee and proposes additional adjustments to the CCIP report and standards to address these concerns.

1. It is not clear on what basis the CCIP standards were selected. What is the evidence basis for these standards?

Addressing public health concerns of the state was one of the primary considerations in selecting the three CCIP core standards which aim to address: (1) support for individuals with complex health needs; (2) health disparities; and (3) behavioral health screening, access and integration. The following facts describe some of the evidence of inadequacies of Connecticut’s health care delivery system capabilities and the need for intervention:

- **Consumers in our listening forums reported difficulty navigating the current healthcare system, especially those that have complex health needs. Medicare data on readmission (including Medicare/Medicaid dual eligibles) places Connecticut in the bottom 30% of states in readmissions, avoidable ED use, and admissions for individuals with chronic conditions.²**
- **Gaps in care exist in the state along racial and ethnic lines, resulting in devastating outcomes. For example, African Americans in Connecticut die from diabetes at more than double the rate than their white counterparts.³ Connecticut consistently ranks as having among the worst health disparities in the nation.⁴**
- **Recent survey found that physicians think it is very challenging to refer individuals for behavioral health treatment at nine times the rate that they find it very challenging to refer to other specialties.⁵**
- **The Office of the Healthcare Advocate report on behavioral health identifies deficits in routine recognition of mental health needs, access to services, and a lack of integration of mental health into primary care.⁶**

A thorough planning process was undertaken in the design of the CCIP standards. The Practice Transformation Task Force (PTTF or “Task Force”) and its design groups held more than 25 meetings to

² <http://www.commonwealthfund.org/publications/fund-reports/2014/apr/2014-state-scorecard>

³ http://www.ct.gov/dph/lib/dph/hisr/pdf/2009ct_healthdisparitiesreport.pdf

⁴ http://cdnfiles.americashealthrankings.org/SiteFiles/Reports/2015AHR_Annual-v1.pdf

⁵ http://www.healthreform.ct.gov/ohri/lib/ohri/sim/steering_committee/2015-04-09/report_physician_survey_feb_2015.pdf

⁶ http://www.ct.gov/oha/lib/oha/report_of_findings_and_recos_on_oha_hearing_1-2-13.pdf

providing advice and recommendations regarding CCIP. The standards chosen were based on capabilities that aim to address these gaps and improve health care quality and health outcomes, and reduce costs. CCIP standards are the result of an extensive review of local and national transformation efforts, including work being done in Hennepin County, through existing Community Care Teams, the Camden Coalition on hot spotting, and many others.

As part of our landscape review, interviews were also conducted with Kate McEvoy, Medicaid Director and Dawn Lambert of the Department of Social Services with a focus on Long Term Support Services, Money Follows the Person, and the Dual Eligible/Healthy Neighborhoods initiative. In addition to learning from the approaches used in these innovative programs, the Task Force developed an understanding of their specialized nature and the unique needs of the populations they serve. Adjustments were made to the Comprehensive Care Management conceptual model and corresponding standards to minimize overlap. Kate McEvoy also conducted a special webinar presentation for PTF members, which included discussion of an array of successful care delivery and/or payment reform initiatives such as the PCMH program, the Intensive Care Management Program, and the Health Home initiative.

For each capability, the following was done to ensure an evidence basis existed for each standard such as Community Health Worker deployment and behavioral health integration, and that the capability fit with Connecticut's context:

- Reviewed literature on the effectiveness of these capabilities
- Solicited Center for Medicaid and Medicare Innovation (CMMI) technical assistance
- Conducted interviews with subject matter experts and leadership teams running programs across the country and in Connecticut that were intended to achieve similar objectives
- Received input from Connecticut Stakeholders

Please refer to pages 15-19 of the [draft report](#) for a detailed description of the approach to CCIP design including the range of considerations that informed the design process. Appendix E from report contains a list of references that includes much of the evidence on which the standards were based. This Appendix is included as Attachment A to this response. Attachment B includes a list of references in support of Community Health Workers, which are a major feature of the Comprehensive Care Management and Health Equity Improvement Standards.

2. Who are the members of the Practice Transformation Task Force?

The Task Force is comprised of a wide range of consumers and consumer advocates, physicians, a provider of behavioral health services, experts in community services and care management, a Federally Qualified Health Center, an APRN, health plans, and state agencies. Consumer representatives include individuals who have experience relying on the health system for their own significant medical needs or those of a family member. Consumer advocates included individuals with expertise in school-based health, oral health, and community support services. State agency representatives included the Connecticut Medicaid Director and staff of the Department of Mental Health and Addiction Services. Prior to beginning the design of CCIP, the Task Force membership was supplemented by a specialist in care management, a cultural health organization representative with community health worker

experience, a specialist in home health and related services, a practice manager for an Advanced Network, and a psychologist with expertise in housing and homelessness. The Medical Assistance Program Oversight Council (MAPOC) appointed two of the Task Force members. The Task Force established design groups as needed to provide additional representation and expert consultation in the areas of health equity, behavioral health, and oral health.

Practice Transformation Task Force Member Listing

- **Susan Adams**
Masonicare
- **Lesley Bennett**
(Executive Team)
Stamford, CT
- **Mary Boudreau**
CT Oral Health Initiative
- **Grace Damio**
Hispanic Health Council
- **Leigh Dubnicka**
United Healthcare
- **Garrett Fecteau**
(Executive Team)
Anthem
- **David Finn**
Aetna
- **Heather Gates**
Community Health Resources
- **M. Alex Geertsma**
Community Health Center of Waterbury
- **Shirley Girouard**
Branford, CT
- **Beth A. Greig**
St. Francis Hospital and Medical Center
- **John Harper**
ConnectiCare
- **Abigail Kelly**
Chrysalis Center of CT
- **Edmund Kim**
Family Medicine Center at Asylum Hill
- **Anne Klee**
VA Connecticut Healthcare System
- **Ken Lalime**
Healthy CT
- **Alta Lash**
United Connecticut Action for Neighborhoods
- **Kate McEvoy**
Department of Social Services, Medicaid
- **Rebecca Mizrachi**
Norwalk Community Health Center
- **Douglas Olson**
Norwalk Community Health Center
- **Nydia Rios-Benitez**
Dept. of Mental Health & Addiction Services
- **Rowena Rosenblum-Bergmans**
Western Connecticut Health Network
- **H. Andrew Selinger**
ProHealth Physicians
- **Eileen Smith**
Soundview Medical Associates
- **Anita Soutier**
Cigna
- **Elsa Stone**
(Executive Team)
Pediatrics Plus
- **Randy Trowbridge**
Team Rehab
- **Jesse White-Frese**
CT Assoc. of School Based Health Centers

3. The CCIP standards appear only to be mandatory for Medicaid-participating providers. The PTF should consider requiring all private payers to commit to requiring non-Medicaid participating providers to fulfill the CCIP standards.

The CCIP standards are focused on accountable health care organizations, which we refer to as Advanced Networks, rather than individual practices. DSS has agreed to embed requirements related to CCIP standards within the Request for Proposals (RFP) through which DSS will procure Participating Entities for MQISSP, beginning in the first wave with a two track approach that is detailed in our response to question 10. By requiring that Advanced Networks meet the CCIP standards, Medicaid will be helping to raise the standard of care for all populations served by these organizations and their affiliated practices. The same is also true of DSS's requirement that practices achieve PCMH recognition. This requirement raises the standard of care within individual practices, regardless of whether and to what extent the individual clinicians that comprise the practice see Medicaid patients.

As noted earlier, the CCIP standards place an emphasis on individuals with complex health needs and patients with social factors that are barriers to care. These problems are especially common in low-income populations such as those served by the Medicaid program. For this reason, we believe that CCIP is a program that is very much **in the best interests of Medicaid beneficiaries** that are participating in MQISSP.

Complex health needs and social determinant risks are even more prevalent in the Medicare/Medicaid dual eligible population. This population is not eligible to participate in MQISSP. If dual eligibles are receiving care from an Advanced Network, there is a high likelihood that the individual is participating in the Medicare "ACO" Shared Savings Program. By requiring Advanced Networks to meet CCIP standards, DSS is making sure that Medicare ACOs are improving care coordination, reducing health equity gaps, addressing social determinants risks, and integrating behavioral health, all of which are of central importance for Medicare/Medicaid eligible consumers. For this reason, we believe that CCIP is a program that is very much **in the best interests of Medicare/Medicaid beneficiaries**, even if they are not participating in MQISSP.

The PMO intends to engage commercial payers in discussions about considering the CCIP standards when negotiating transformation payments with Advanced Networks. **It is important to note that some of Connecticut's commercial payers already contribute to the ability of Advanced Networks to undertake care delivery reforms by making these transformation payments.**

4. CCIP standards are inflexible, overly detailed and in some cases vague. CCIP standards fail to accommodate existing local coordination efforts and to recognize the value of local innovation standards?

The PTF's approach to supporting the improvement of care provided by Advanced Networks follows the model developed by NCQA. Using this approach, the report specifies standards and provides sufficient detail to enable the provider to understand what needs to be done or, in some cases, how to do it. The level of detail was carefully considered by the Task Force. The standards generally reflect important components of each capability. For example, the Task Force felt that community health workers are an increasingly important element of our health care teams. Simply requiring a comprehensive care team without requiring the appropriate involvement of community health workers will likely limit the effectiveness of a team in addressing social determinant risks, the need for navigation assistance, or bridging cultural or language barriers. There is strong evidence that supports the inclusion of community health workers as a major element in two of the core standards (see Attachment B).

Comment: The PTF should consider making participation in CCIP elective, and offering the technical assistance as a menu of options from which MQISSP Participating Entities could select best fit. Further, the PTF should consider writing in more flexibility in certain CCIP standards (e.g. behavioral health screening tool). Further, the SIM Program Management Office should reconsider its role as convener of the learning collaboratives, and instead permit existing networks to lead their own.

The CCIP standards build on local coordination efforts by focusing on enhancing current capabilities to achieve certain outcomes. For example, if practices in an Advanced Network assess patients without considering personal values, preferences and goals, we will work with them to include these important components of a truly person-centered assessment. Similarly, if the practices use care teams, but do not use community health workers, we will help the practices meet this element of the Comprehensive Care Team standard. In this way, the standards are flexibly applied and tailored to build on each Advanced Network's existing capabilities.

Despite the specificity contained within the standards, there remains a great deal of flexibility in how providers implement standards or achieve the goals associated with the standards. For example, we emphasize the use of continuous quality improvement techniques to identify health disparities and the use of root cause analysis to understand why those disparities exist. We are not prescriptive about how providers should address the issues that contribute to the disparities. This is one of many areas where there is plenty of room for innovation. An exception is our requirement that providers do a pilot intervention using community health workers to address at least one disparity related to chronic illness self-management. The evidence suggests that community health workers are one important means for addressing health disparities, so we aim to ensure that providers have figured out how to do this in the care of at least one clinical condition.

There are a few areas where our standards are quite prescriptive, such as the use of the PHQ-9 for depression screening and the effectiveness of treatment or what's called depression remission. There

are good reasons to avoid requiring the use of a specific instrument. For example, there are often multiple standardized tools available to suit a particular purpose, practices may prefer to select a tool based on their view of a particular tool's strengths, and the pace of advancements in measurement science is such that new and better tools may arise in a relatively short span of time. These are among the reasons that DSS's policies generally support flexibility in choice of screening tool. In fact, DSS's recommendations in this regard are the reason that the Quality Council endorsed a DSS customized measure of pediatric behavioral health screening rather than the only NQF endorsed measure, which requires the use of the Pediatric Symptom Checklist.

In the case of adult depression screening and CCIP standards, the Task Force wished to promote the adoption of the PHQ-9, which is a depression assessment tool that has become the national standard for depression outcome measurements. The PHQ-9 is the only instrument that meets the requirements of the new NQF endorsed measures for depression screening and remission (NQF 0710 and 1885). The inclusion of the PHQ-9 in our standards aligns the Advanced Network's care process with the measures recommended by the SIM Quality Council for use in value-based payment. It also aligns with the recently released recommended core measure set of the Core Quality Measures Collaborative, led by America's Health Insurance Plans, CMS, NQF and Chief Medical Officers and involving national physician organizations, employers, and consumers.⁷ The Core Quality Measures Collaborative recommends the use of both NQF 0710 and 1885 in value-based payment contracts with ACOs and PCMH.⁸

The use of the PHQ-9 and the development of measures that rely on the PHQ-9 is a major advance in measuring the quality of care for depression. Currently, the most widely used method for measuring quality of care for depression is a measure of whether individuals are taking their medication (Anti-Depressant Medication Management (NQF 0105)). By promoting the use of the PHQ-9 for initial screening and testing for depression remission, it will finally become possible to reward providers for the effectiveness of their treatment because the quality score is based on measured improvement in depression screening. This step forward in depression measures is consistent with the recommendations of measurement experts that we move away from process measures (taking your medication) to outcome measures (depression is better).⁹ We will edit the current Behavioral Health Integration standard to provide flexibility in choice of screening instrument in pediatric settings.

Finally, our approach to establishing Community Health Collaboratives envisions building on or using local collaborative structures where they exist. In our draft report we note:

A survey of the existing health and healthcare related collaborative structures will be undertaken so that, where appropriate, our approach can mobilize existing partnerships and resources. For

⁷<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/ACO-and-PCMH-Primary-Care-Measures.pdf>

⁸<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html>

⁹ http://healthreform.ct.gov/ohri/lib/ohri/work_groups/quality/2014-09-03/rwjf_406195_performance_measures_brief.pdf

example, there are collaboratives in Connecticut that are comprised of diverse stakeholder groups focused on supporting more effective care transitions and reduced readmissions.

The PMO does not intend to have the transformation vendor serve as convener where an acceptable alternative already exists. Moreover, we intend to learn from the successful pediatric care coordination collaboratives that have already been established in several communities throughout the state using an approach developed by the Help Me Grow Foundation.

5. Meeting CCIP standards will be costly for providers, and there is no identified funding source for providers. How does the program take this into account and what types of support is provided?

We recognize that there are additional costs associated with meeting the CCIP standards. For a number of reasons, we believe that it is reasonable to expect Advanced Networks to make these investments and we also believe that there are ways some of these costs can be offset as follows:

- We are relying to some extent on the willingness of organizations to incur some costs in their efforts to meet the standards with the expectation that there will be a return on investment in the form of shared savings. This is the same thinking that Medicare used for the Pioneer ACO and Medicare SSP initiatives. Many of the organizations that participated in these programs, especially the Pioneer ACO program, achieved significant shared savings that helped offset their investments in organizational improvement. Notably, organizations that participate in CCIP will have the opportunity to recoup their investments in all of their shared savings program arrangements, whether Medicare, Medicaid or commercial.
- Part of the cost of transformation is offset by providing free technical assistance. CCIP participating entities will have access to SIM funded technical assistance resources and learning collaborative support. The subject matter expertise, guided transformation planning and assistance, and structured peer-to-peer learning will be at no cost to the Advanced Networks.
- In addition, we will be seeking authority from CMMI to provide transformation awards, likely no more than \$500k (and potentially dependent on size of the Advanced Network and population served), which should mitigate some of the expenses they incur.

We also recognize that the CCIP standards are new and that there is value in a staged approach to implementation—one that allows time to make program adjustments before all MQISSP Participating Entities are required to meet the standards. DSS and the PMO have developed a two track approach that allows applicants in the first wave to choose whether or not they will be bound by the CCIP standards (see response to question 10.) Our proposed approach to CCIP also provides some flexibility that can lessen the cost of transformation including the following:

- We propose to introduce community health workers and the health equity pilot in a limited subset of practices so that the return on investment (quality and cost) can be demonstrated before adopting these interventions more widely.

- Our CCIP report currently allows some accommodation on the timeframe, which would allow costs to be spread out over time. Specifically, on pages 23 and 24 we say, “Additionally, the transformation vendor will assess the feasibility of the Advanced Network fulfilling the core intervention standards over the 15-month support period based on the current state of the organization’s capabilities. If it is determined by the vendor that it will not be possible to fulfill all core standards over the 15 months, the vendor and the network will prioritize which standards will be implemented first, based on the needs of the network’s population. The provider will be required to submit a plan for meeting the remaining standards on a timetable negotiated with the SIM PMO. We anticipate that the start of the 15-month period will be January 1, 2017 for the first wave, even though the technical assistance contracts are expected to be executed in October or November of 2016.
- We would consider adding language that modifies the standards if the costs associated with meeting them present an insurmountable barrier. An example would be a provider that has no analytic software that enables them to tap their EHR for health risk stratification. In this case, we might adapt the Comprehensive Care Management standard re: health risk stratification to make best efforts with claims based data, perhaps with non-automated information gathered with respect to social determinant risks.

Finally, we recognize that there may be some organizations for which the CCIP standards will be too much of a stretch. If we believe these capabilities are important to addressing the needs of patients with complex health needs, cultural/language barriers, social-determinant risks, and behavioral health conditions, it is reasonable to select for those organizations that are prepared to meet them.

6. How and by whom will the CCIP standards be enforced?

Our agreement with DSS (detailed in response to question 10 below) is that only a subset of Advanced Networks participating in wave 1 of MQISSP—those that elect to do so—will be required to achieve the core standards within 15 months of wave 1 implementation. Advanced Networks in this subset must be in good standing with respect to achieving and maintaining compliance with CCIP standards as a condition of continued participation in MQISSP. This condition is the most important means to sustain the changes in practice associate with the CCIP standards, recognizing that sustainability is a major emphasis of CMMI.

The SIM PMO will monitor program participation and designate Advanced Networks that are either a) participants in good standing with our technical assistance and making progress toward the achievement of CCIP standards, or b) have achieved compliance with the core standards. The PMO contract with the transformation vendor will include provisions for assessing participation during the transformation process and achievement of the core standards at the end of the transformation period and potentially at one or more follow-up intervals. The PMO will use this information as the basis for certification or designation and the status of each participant will be communicated to DSS at established intervals.

7. How does CCIP harmonize with the 1) existing Medicaid Intensive Care Management Program and PCMH coordination efforts; and 2) other cross-department and cross-sector initiatives e.g., around children’s mental health?

The SIM PMO proposes to make edits to the report to address these concerns, along the lines of what we describe in this response.

As noted earlier, the CCIP standards build on local coordination and care delivery capabilities by focusing on enhancing these capabilities to achieve the outcomes set forth in the standards. For example, if practices in an Advanced Network assess patients without considering personal values, preferences and goals, we will work with them to include these important components of a truly person-centered assessment. Similarly, if the practices use care teams, but do not use community health workers, we will help the practices meet this element of the Comprehensive Care Team standard. In this way, the standards are flexibly applied and tailored to build on each Advanced Network’s existing capabilities. In addition, this approach ensures that CCIP will not introduce duplicative efforts or structures.

Comment: The PTF should consider amending the CCIP report to include specific reference to these efforts, and should detail how CCIP will complement, as compared to duplicate or complicate, this existing work. A specific applied example of this is need for more detail on how the care plans required by CCIP will align with 1) care plans developed at the practice level; and 2) care plans developed by Medicaid ICM care managers.

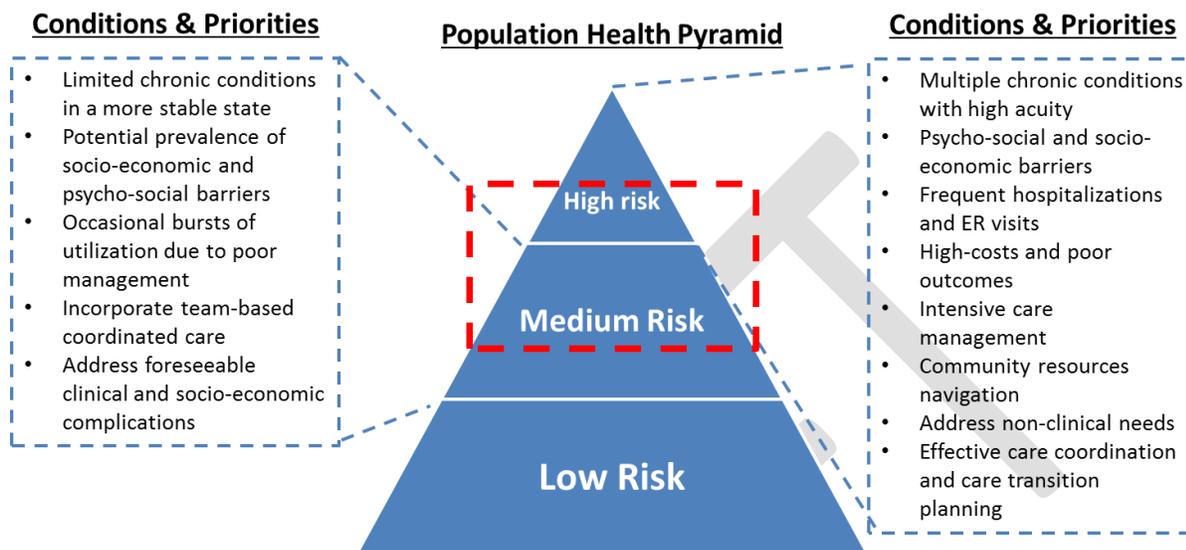
DSS PCMH Program: In developing the standards, the Task Force was aware of the foundational capabilities reflected in the NCQA PCMH model, which are also central to the AMH program (which the Task Force also designed). The CCIP standards were intended to complement the PCMH program standards, and in some cases, to require activities that under PCMH are optional. For example, PCMH standard 3.B.5 “Maintains agreements with behavioral healthcare providers” is optional in the PCMH standards, but a requirement of this type is included in the CCIP Behavioral Health Integration standard (BH.2.e) if the Advanced Network does not have behavioral health providers as part of its network.

Despite our efforts to ensure compatibility, we recognize that there may be unforeseen ways that the PCMH and CCIP standards could potentially be in conflict. For this reason, we would consider including language in the CCIP report that allows the provider to request an exemption from or adjustment to a CCIP requirement that conflicts with, or would otherwise disrupt, their activities in relations to a PCMH standard.

DSS Intensive Care Management (ICM) Program:

The CCIP Comprehensive Care Management standard aims to improve Advanced Networks’ care management services. Our work will focus on improving performance by working with Advanced Networks to make the assessment process more person-centered such as by asking about value, preferences and goals and behavioral health conditions and social factors that might affect care outcomes. We also focus on ensuring the inclusion of key members of the *comprehensive care team* when appropriate such as community health workers and behavioral health professionals. This work also includes ensuring that the medical home care plan can be extended to describe the activities of new team members, such as linking to community services. We anticipate that providers will be able to serve

more effectively individuals with complex health needs as a result of these enhancements. In essence, providers will be better able to manage the care of individuals who fall in the medium risk area of the figure below, and in some cases, even some of the higher risk individuals.



Many payers have programs that are also focused on individuals in the medium to high risk areas. For example, DSS has a successful Intensive Care Management (ICM) Program administered by the Community Health Network of Connecticut (CHNCT). The goal of this program is to support the development of health goals and improved outcomes for Medicaid beneficiaries who are identified as high need based on the results of CHNCT’s predictive modeling tool, CareAnalyzer, outside referrals, and self-referrals. The program includes nurse care managers in geographic teams as well as peer supports to help individual’s achieve their goals. In addition, ICM is not unique to the medical ASO—it is also performed by the behavioral health ASO, Beacon Health Options, and involves community care teams and peer supports. The Connecticut Dental Health Partnership (dental ASO) has a related program that employs community engagement specialists and focuses on federal grant-funded integration of dental care within pre-natal and pediatric visits.

As Advanced Networks grow their care management capabilities, the following situations might occur:

- Advanced Network identifies individuals for comprehensive care management who might otherwise have been identified and served by the CHNCT ICM Program,
- Advanced Network identifies individuals for comprehensive care management who are already being served by the CHNCT ICM Program (or the opposite),
- Advanced Network and CHNCT both identify the same high need individual at the same time.

In the first example, the team that first identifies the patient needs to consider who is best situated to address the individual’s complex health needs. This determination depends on the capabilities of the

medical home's comprehensive care team and the nature of the individual's health needs. Let's consider the following case example:

B.A. is a recently un-employed 58-year-old man with a 5-year history of type 2 diabetes. He is divorced with a daughter and several grandchildren. He was identified as a candidate for care management using health risk stratification software, which based his risk on suboptimal diabetes control and a number of co-morbidities including obesity (BMI 32.4 kg/m²), hyperlipidemia, peripheral neuropathy (distal and symmetrical by exam), hypertension (by previous chart data and exam), and elevated urine micro-albumin level. A person-centered assessment identified strengths associated with his strong investment in being a part of the lives of his grandchildren and a few friends that he sees occasionally for bowling. He had identified limitations in health literacy and attempts to lose weight and increase his exercise for the past 6 months without success. There were opportunities for improvement in the areas of self-care management and lifestyle, exercise, and understanding of diabetes. Financial difficulties placed him at risk of losing his housing and contributed to his inconsistent eating patterns as well as episodic depression.

The Advanced Network employs a nurse care manager with training in motivational interviewing. The team has access to community health worker with skills in chronic illness self-management training and the relationships with community supports such as housing. A licensed clinical social worker is also part of the team and available to see the patient at the primary care clinic or at her private office. It appears based on this presentation, that this patient's complex health needs can be effectively managed with an enhanced medical home team, which we refer to as a comprehensive care team when expanded to include the social worker, community health worker, a nutritionist and the patient's daughter. The medical home care plan has additional modules to establish goals and activities to support coordination of care, lifestyle changes, and behavioral health.

If B.A.'s challenges were limited to the above, we might expect a positive outcome. The medical home's coordination enables face-to-face visits when needed, supplemented by home-visits by the community health worker focused on chronic illness self-management, including diet and exercise. If the patient had other co-occurring conditions, such as poorly controlled bi-polar disorder or abuse of chronic pain medications, or a change in condition, such as a stroke or serious cardiac problems, the complexity might require a referral to the CHNCT's ICM program, potentially with Beacon Health Options providing adjunct support. In this case, lead care coordination responsibilities might begin with or transition to the ICM care management lead, who would handle care management during the acute phase of the individual's instability or longer, if ICM level support is needed ongoing. The ICM would develop a care plan that wraps around the care plan of the medical home and includes coordination with hospital, nursing facility or local mental health authority, as needed to optimize recovery. The medical home supports such as the nutritionist and community health worker could continue to be available, however, the care management would be provided by the ICM program.

We believe that it is important that Advanced Networks participating in CCIP develop coordination protocols with CHNCT and Beacon Health Options that set mutually agreeable processes for handling the above situations. The protocols could specify, for example, how individual choice should factor into

decisions about who leads the care management process and for which individuals one or another program might be better suited.

We recognize that DSS envisions the CHNCT ICM program may be gradually reduced over time as Advanced Networks and FQHCs become better able to manage individual care management needs more effectively, including for individuals who may be high risk. However, as that process evolves, it is important that Advanced Networks, FQHCs and CHNCT can coordinate their respective efforts to ensure that the evolution occurs in a manner that is in the best interest of Medicaid beneficiaries. We look forward to learning from these important early efforts and adjusting the program to reflect what we learn.

Coordination with Other Cross-Sector Initiatives

The above example of coordinating with the DSS ICM program applies to other coordination programs that might already exist outside of the Advanced Network or FQHC. We would propose to follow a similar process in examining coordination issues that might arise with these other programs as they are identified.

For example, we have begun discussions with Connecticut Children's Medical Center (CCMH) regarding the Hartford Care Coordination Collaborative. It appears that the care coordination arrangements associated with HCCC and used by pediatric practices is effective for many children. We are prepared to continue our work with CCMC to develop any necessary coordination protocols between pediatric practices and HCCC or similar collaboratives in other regions of the state, and potentially to use our CCIP technical assistance process to expand awareness of and linkage with the HCCC and other collaboratives. Moreover, CCMC and the Child Health and Development Institute (CHDI) have offered to lend us their expertise in developing a systems approach to multi-stakeholder collaboration of the sort envisioned in the CCIP Community Health Collaboratives. We are eager to learn from their experience.

We have also had discussions with leadership at the Clifford Beers Child Guidance Clinic about their impressive work with Wraparound New Haven. This program is targeted to children with co-occurring medical and behavioral health needs and it provides a range of supports to the child and family, including assistance with social factors that might affect health care outcomes and recovery. CCIP requires that Advanced Networks and their practices develop the capability to do care coordination and to work as a medical home team. However, the standards do not require that the practice do so for all of their patients who need care coordination. It is entirely appropriate for practices to use available community resources that can meet the needs of children and families, and rely on their own resources when the needs are moderate or when community capacity is limited.

Most importantly, we believe that the CCIP process will identify more children who would benefit from available community supports such as HCCC or Wraparound New Haven, improve awareness of such supports, and foster the practices ability to effectively refer and link to these supports.

Finally, DCF has contracted with Beacon Health Options to serve as the Care Management Entity for children with serious behavioral health needs. The program includes a team of Intensive Care

Coordinators and Family Peer Specialists to provide services in accordance with the Wraparound Milwaukee model. Most of the Intensive Care Coordinators are co-located at DCF offices and only accept referrals from DCF staff. A couple of Intensive Care Coordinators identify children in emergency departments. None of the Intensive Care Coordinators accept outside referrals. This Intensive Care Coordination program is geared to the special populations that represent the tip of the above Population Health Pyramid. The Task Force has not proposed in CCIP that Advanced Networks take on the highly specialized care management needs of these and other special populations. The same is true of waiver programs administered by the Departments of Developmental Services, Social Services, and Mental Health and Addiction Services, which also focus on populations with highly specialized care coordination needs and which typically are not based on the medical home team.

We believe that all of the above underscores the importance of ensuring that practices have tools that provide up-to-date information about available community resources, the need for which will be identified in the person-centered assessments. For this reason, we will propose that access to such a directory, preferably integrated into the clinical workflow, is included in the standards.

8. The CCIP report specifically references intent to harmonize with Medicare initiatives, but makes no mention of any obligation to support the best interests of Medicaid beneficiaries.

The CCIP report will be revised to emphasize the importance of supporting the best interests of Medicaid beneficiaries. We also hope that the edits proposed in response to question #7 are responsive to this emphasis.

9. CMC is the main advisory body for MQISSP. Why isn't CMC the main advisory body for CCIP?

The Care Management Committee's relationship to CCIP is analogous to its relationship to the NCQA PCMH program. The Care Management Committee is the main advisory body with respect to the Department of Social Services PCMH program, which requires adherence to NCQA's standards for PCMH. However, the Care Management Committee is not an advisory body for NCQA or its PCMH program.

Nonetheless, the SIM Program Management Office and the Task Force have been interested in obtaining input from the Care Management Committee with respect to CCIP standards and began the process of soliciting their input in September 2015.

10. There is insufficient time remaining before the MQISSP RFP must be finalized for members of the Care Management Committee to properly consider the CCIP standards. DSS and/or the PMO should either 1) delay the issuance of the MQISSP RFP and corresponding MQISSP implementation date, 2) delay the date on which the CCIP standards attached to MQISSP participating entities; or 3) make participation in CCIP voluntary.

DSS and the SIM Program Management Office have long recognized the importance of providing for input from the Care Management Committee as it relates to the development of CCIP standards. The Program Management Office has made considerable efforts to provide for this input including a

presentation to the CMC in September 2015, publishing or otherwise making available draft reports beginning in September, webinars in September and November 2015, and several meetings in February 2016 including a joint meeting with the Practice Transformation Task Force, a meeting with the full Care Management Committee, and a meeting with the Care Management Committee work group. In addition, the PMO has held two open comment periods: one in September-October 2015 and one which ended March 2, 2016. These activities are summarized in Attachment C.

The Department of Social Services and the SIM PMO recognize that some members of the Care Management Committee feel that there is insufficient time to resolve their concerns for the Wave 1 procurement. For this reason, the Department of Social Services and the SIM PMO carefully considered the recommendations to make the CCIP core standards voluntary or to delay the date on which the CCIP standards attach to participating entities and are proposing the following:

Proposed Implementation Strategy

The State Innovation Model (SIM)-funded Community and Clinical Integration Program (CCIP) establishes care delivery standards and will provide technical assistance (TA) in support of a) improving care for individuals with complex health needs, b) introducing new care processes to reduce health equity gaps, and c) improving access to and integration of behavioral health services. DSS has agreed to embed requirements related to CCIP standards within the Request for Proposals (RFP) through which DSS will procure Participating Entities for the Medicaid Quality Improvement and Shared Savings Program (MQISSP). DSS’ reason for doing so is that it acknowledges the value of promoting activities that will promote and support the needs of Medicaid beneficiaries who are already being served by advanced networks. DSS and the SIM PMO also agree, however, that it will be useful to test the CCIP standards to ascertain whether concerns that have been raised around cost and specificity have, or do not have, merit. Therefore, in the first wave of MQISSP procurement for the project period starting January 1, 2017, DSS and the SIM PMO have agreed permit applicant entities to choose whether or not they will be bound by the CCIP standards. The DSS MQISSP RFP will offer two tracks, from which applicant entities must choose. The first track will require Participating Entities to participate in CCIP technical assistance, but will not require demonstrated achievement of the CCIP standards as a condition for continued participation in MQISSP. The other will enable Participating Entities to indicate that they agree to be bound by CCIP standards. Over the course of the first MQISSP performance period, DSS and the SIM PMO will carefully review the experience of Participating Entities that agree to be bound by the CCIP standards, will seek additional comment on the CCIP standards, and may adjust the CCIP standards, as needed. For the second wave MQISSP procurement, achievement of the CCIP standards, as revised, will be a condition for all MQISSP Participating Entities.¹⁰

POLICY	TRACK 1	TRACK 2
CCIP commitment	Respondents commit to participate in the CCIP TA program, which will be tailored to their individual needs, but	Respondents commit to participate in the CCIP TA program, which will be tailored to their individual needs, <u>and</u>

¹⁰ As noted in the CCIP report, the core standards do not apply to entities participating in the Practice Transformation Network grants.

	are <u>not</u> required to achieve the CCIP core standards until 15 months from the start date of the second wave of MQISSP	to achieve the core CCIP standards within 15 months of the MQISSP start date (anticipated to be 1/1/17)
MQISSP RFP requirements	Respondents will be asked to describe how they will organize and manage the transformation process and work with the TA vendor to <i>make progress toward</i> the core standards	Respondents will be asked to describe how they will organize and manage the transformation process and work with the TA vendor to <i>achieve</i> the core standards
Funding	Respondents will receive no-cost TA and will have the opportunity to participate in a learning collaborative, but are not eligible for SIM-funded transformation awards	Respondents will receive no-cost TA, will have the opportunity to participate in a learning collaborative, and will have the opportunity to apply for up to \$500,000 per applicant in SIM-funded transformation awards
Compliance monitoring	Respondents will be surveyed regarding their progress on activities related to the standards, for purposes of PMO reporting to CMMI	Respondents will participate in a validation survey; achievement of standards <u>will be</u> a condition of continued participation in MQISSP
Accommodations	N/A	Providers that elect to be bound by the CCIP standards may request a waiver of specific requirements based on the following factors: <ul style="list-style-type: none"> • Excessive costs; and/or • Conflict with or disruption of existing practice transformation efforts (e.g., PCMH) Additionally, providers may request up to six months additional time to achieve standards

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Attachment C: Timeline of Key Events with Respect to Care Management Committee Input

