

## Community and Clinical Integration Program

### Summary of Response to Concerns

The Community and Clinical Integration Program (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 (see Attachment A). The table below responds to some of the questions that we have received about the **core** standards that target these areas for improvement.

<p><b>Who developed the CCIP standards?</b></p>	<p>The SIM Program Management Office (PMO) developed the CCIP standards with the Practice Transformation Task Force (“Task Force”). This 28-member Task Force is comprised of a wide range of consumers and advocates; physicians and APRNs; a provider of behavioral health services; experts in community services, practice management and care management; a Federally Qualified Health Center; the CT Medicaid Director, DMHAS, and health plans. Consumer representatives include individuals who have experience relying on the health system for their own significant medical needs or those of a family member. The Medical Assistance Program Oversight Council (MAPOC) appointed two of the Task Force members.</p>
<p><b>What evidence are the standards based on?</b></p>	<p>A thorough planning process was undertaken in the design of the CCIP standards including an extensive literature review, Center for Medicaid and Medicare Innovation (CMMI) technical assistance, and interviews with subject matter experts and leadership teams running programs across the country and in Connecticut. Interviews and research included DSS experts and programs, Camden Coalition, which developed the approach called “hot spotting,” and the Center for Healthcare Strategies (CHCS), one of the nation’s foremost experts on Medicaid care delivery and payment reforms. References are included in Attachments B and C.</p>
<p><b>Who is required to meet the standards?</b></p>	<p>For purposes of the first wave of MQISSP, DSS and the PMO have agreed to permit applicants to choose whether or not they will be bound by the CCIP standards. The DSS MQISSP RFP will offer two tracks, from which applicants 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 and will give them the option to apply for proposed transformation awards. For the second wave MQISSP procurement, achievement of the CCIP standards, as revised, will be a condition for all MQISSP Participating Entities, including those entities that were exempt during the first wave. Practice Transformation Network initiative participants are exempt from this requirement.</p>
<p><b>Why is Medicaid the only payer requiring CCIP?</b></p>	<p>SIM states across the country use Medicaid to drive improvement in areas that are important for vulnerable populations. These areas include things like linking to community services to address social risks (e.g., housing), cultural and language appropriateness, and closing health equity gaps. In addition, Medicaid is the only payer that is receiving federal funding to support its participation in SIM reforms.</p>

<b>Do the standards only apply to Medicaid beneficiaries?</b>	No, the standards will apply to the Advanced Networks and their primary care practices and will improve services for all of the patients that they serve regardless of payer. This is similar to the DSS requirement that Advanced Networks achieve NCQA PCMH recognition. To achieve NCQA recognition, practices must improve services for all patients.
<b>Why are the standards detailed in some areas and not in others?</b>	The Task Force included detail in areas that are relatively new (e.g., integrating Community Health Workers and person-centered assessment) and less detail in areas where we are encouraging innovation or where guidelines may already exist (e.g., team-based care). The standards provide plenty of room for innovation, e.g., we help Advanced Networks identify health equity gaps and their root causes, but leave to the provider how best to close those gaps.
<b>Won't CCIP standards disrupt local coordination programs like PCMH?</b>	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 consider personal values, preferences and goals, we will work with them to include these important components of a truly person-centered assessment. In this way, the standards are flexibly applied and tailored to build on each Advanced Network's existing capabilities. 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. We have proposed other accommodations with respect to the ICM program and community initiatives, as outlined in Appendix D.
<b>Won't CCIP be costly for providers?</b>	SIM is paying for the technical assistance and peer learning support, which will help reduce the cost to all participating Advanced Networks. We are also looking at providing limited grant support to help offset the costs in the first year, for those Advanced Networks that elect to be bound by the CCIP standards. In addition, Advanced Networks 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. Finally, we have the ability to make special accommodations on a case-by-case basis, such as extending the transformation process over a longer period of time, or exempting the organization from having to make major infrastructure investments, such as in health information technology. The issue of costs is dealt with more thoroughly in Appendix E.
<b>Why are the standards voluntary?</b> <b>Won't the providers do it anyway?</b>	DSS has agreed to embed requirements related to CCIP standards within the MQISSP RFP, as described earlier, in order to ensure that providers invest in developing these capabilities. As was acknowledged by some Care Management Committee members, standards such as NCQA PCMH must be required in order to ensure that they are adopted. Although the NCQA standards have been in existence since 2008 and are generally well-regarded, less than 1/3 of Connecticut's primary care physicians are recognized medical homes. Nonetheless, DSS and the PMO are proposing an accommodation for first wave participants as described above.
<b>Who will enforce the standards?</b>	For those Advanced Networks that have elected in the first wave, and in the second wave are required to achieve or maintain compliance with CCIP standards, the PMO will monitor compliance with the standards and designate Advanced Networks in good standing, in much the same way that NCQA determines whether providers continue to qualify for PCMH recognition.

## Attachment A: Selected References Regarding Opportunities for Healthcare Improvement

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

[http://www.ct.gov/dph/lib/dph/state\\_health\\_planning/shipment/hct2020/hct2020\\_state\\_hlth\\_assmt\\_032514.pdf](http://www.ct.gov/dph/lib/dph/state_health_planning/shipment/hct2020/hct2020_state_hlth_assmt_032514.pdf)

[http://cdnfiles.americashealthrankings.org/SiteFiles/Reports/2015AHR\\_Annual-v1.pdf](http://cdnfiles.americashealthrankings.org/SiteFiles/Reports/2015AHR_Annual-v1.pdf)

[http://www.healthreform.ct.gov/ohri/lib/ohri/sim/steering\\_committee/2015-04-09/report\\_physician\\_survey\\_feb\\_2015.pdf](http://www.healthreform.ct.gov/ohri/lib/ohri/sim/steering_committee/2015-04-09/report_physician_survey_feb_2015.pdf)

[http://www.ct.gov/oha/lib/oha/report\\_of\\_findings\\_and\\_recs\\_on\\_oha\\_hearing\\_1-2-13.pdf](http://www.ct.gov/oha/lib/oha/report_of_findings_and_recs_on_oha_hearing_1-2-13.pdf)

## Attachment B: General References from Appendix E of the CCIP Report

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## Attachment C: References in Support of Community Health Workers

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## Attachment D: Coordination with the DSS Intensive Care Management (ICM) Program

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

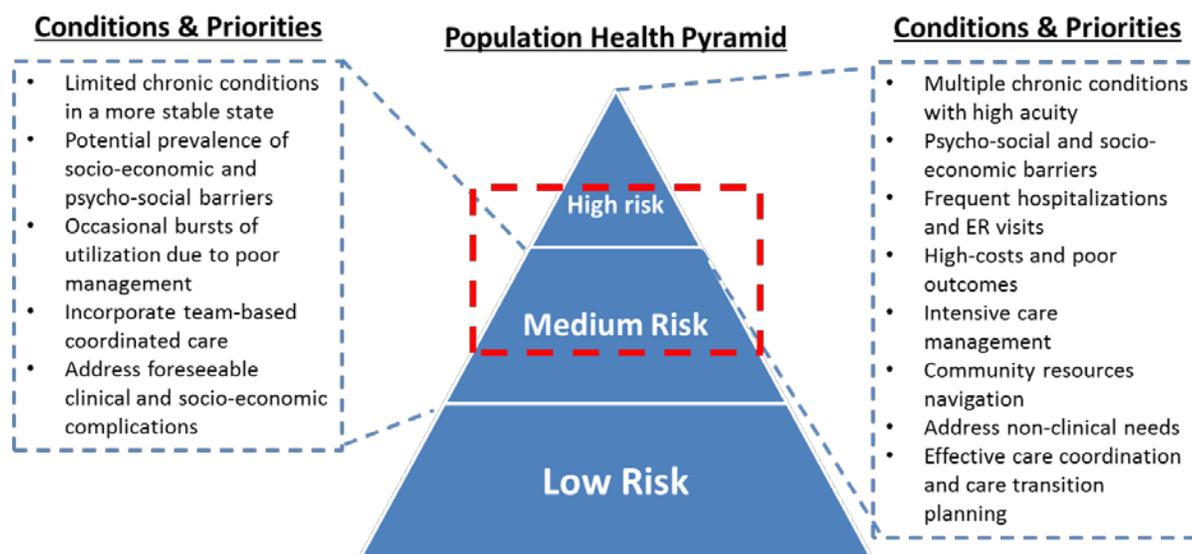
As noted earlier, the CCIP standards build on local coordination and care delivery capabilities by focusing on enhancing these capabilities to achieve the outcomes set forth in the standards. For example, if practices in an Advanced Network assess patients without considering personal values, preferences 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.

**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/m<sup>2</sup>), 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.

## Attachment E: The Cost of Meeting CCIP Standards

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. 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.