A quick snapshot of Medicaid strategies for supporting people in using Medicaid . . .

ASO Intensive Care Management

Key goal: Enabling individuals in development of health goals and improved outcomes

Who: Individuals who risk stratify as high need based on CareAnalyzer results, referrals, self-referrals

What: Care coordination; community care teams

How: Nurse care managers in geographic teams, peer supports

Person Centered Medical Homes (PCMH)

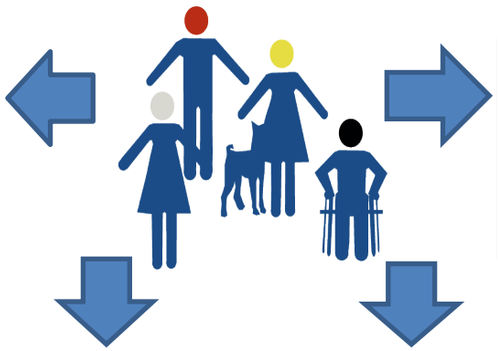
Key goal: Supporting individuals in effectively using primary care

Who: Individuals who select such practices for their care

What: Limited embedded care coordination supported by enhanced Medicaid fee-for-service payments

How: Practice elects the means of fulfilling this function

People with need for support in accessing and coordinating their services



People served by Medicaid who need community-based Long-Term Services and Supports (LTSS)

People with behavioral health conditions who receive services from Local Mental Health Authorities (LMHA)

People served by Medicaid who receive their care at Federally Qualified Health Centers and "advanced networks"

Health Homes

Key goal: Integration of behavioral health care, medical care and social services

Who: Individuals with serious and persistent mental illness served by LMHA, who have annual expenses in excess of $10,000; enrollment with provider from whom individual has received services, with opt-out

What: Care coordination team funded by Medicaid per member per month payments

How: multi-disciplinary team

Medicaid Quality Improvement & Shared Savings Initiative (MQISSP)

Key goal: Clinical and community integration

Who: Medicaid members other than those served by long-term services and supports; assignment based on retrospective examination of where individual has received care

What: Care coordination funded by Medicaid supplemental payments to FQHCs; shared savings model

How: primary care-based care team

Home and Community-Based Waivers

Key goal: Diversion of individuals from institutional care

Who: Individuals who have functional limitations that put them at risk of nursing home placement; by application

What: Care coordination and LTSS services

How: Care coordination through assigned care manager or self-direction; services provided by a range of providers

Money Follows the Person

Key goal: Community integration

Who: Individuals with need for LTSS who have been in a hospital or nursing home for three or more months; by application

What: Transition assistance, funded by a federal grant for first year; state-funded housing vouchers

How: Transition supports provided through assigned transition staff, services provided by a range of providers

Community First Choice

Key goal: Enabling individuals to self-direct services within individual budgets

Who: Individuals who are at nursing home level of care; by application

What: Self-directed PCA and related services funded under Medicaid State Plan; support from fiscal intermediary

How: Through self-direction

. . . and the means by which we are enabling providers to support those people.

Medicaid ASO Intensive Care Management

Key goal: Support providers by enabling Medicaid members to identify goals, resolving access barriers, and sharing information

Who: Nurse care managers, organized in geographic teams

What: Development of care plans, support with missed appointments and connections among services

Medicaid Person-Centered Medical Home Initiative (PCMH)

Key goal: Support providers in practice transformation work that will enable improved access to and use of primary care and improved care coordination

Who: CHN-CT (Medicaid medical ASO) practice transformation team

What: Practices on the "glide path" to PCMH receive practice transformation coaching and enhanced payments; NCQA (Level 2 or 3) recognized practices receive ongoing coaching, are eligible for performance and improvement payments and enhanced payments

Medicaid Quality Improvement & Shared Savings Initiative (MQISSP)

Key goal: Support Federally Qualified Health Centers (FQHCs) and "advanced networks" in building on PCMH practice transformation work to include integration of care as well as linkages with community partners

Who: DSS

What: Selected entities are eligible for care coordination payments (FQHCs only) and shared savings (FQHCs and advanced networks)

State Innovation Model Clinical & Community Integration Program (CCIP)

Key goal: Support MQISSP participating FQHCs and "advanced networks" in developing clinical and community integration capabilities

Who: Practice transformation vendor contracted by State Innovation Model Project Management Office

What: Technical assistance toward supporting range of identified practice transformation capabilities

State Innovation Model Advanced Medical Home (AMH) Glide Path

Key goal: Support primary care practices that are not currently medical homes in practice transformation

Who: Practice transformation vendor contracted by State Innovation Model Project Management Office

What: Technical assistance in support of a range of medical home practice capabilities

CMMI Practice Transformation Initiative

Key goal: Support FQHCs in practice transformation work and assess impact on identified health measures

Who: Community Health Center Association of Connecticut

What: Technical assistance for enhanced care delivery, integration of services and data sharing

Overview of Practice Transformation Supports for Providers

Updated November 12, 2015 (Note: For programs not yet implemented, the descriptions below summarize the current status of proposals, which are subject to change).

	Person-Centered Medical Home Program (PCMH)	Advanced Medical Home Initiative (AMH)	Medicaid Quality Improvement and Shared Savings Initiative (MQISSP)	Clinical and Community Integration Program (CCIP)	Practice Transformation Network Grant (PTN)
Lead Entity	DSS; CHN-CT (Connecticut Medicaid's medical Administrative Services Organization (ASO))	State Innovation Model (SIM) Project Management Office (PMO) through contracted practice transformation vendors (Qualidigm and Planetree for AMH Vanguard pilot)	DSS	SIM PMO through contracted technical assistance vendor (to be determined)	Community Health Center Association of Connecticut (CHC-ACT)
Goal	The Connecticut Medicaid PCMH program aims to enable comprehensive primary care for children, youth and adults through: • partnerships between individuals and their personal physicians • a whole person approach to providing and coordinating care • systematic performance of quality improvement activities with a focus on patient safety • enhanced access to care through improved access,	The goal of the AMH Program is for primary care practices to achieve medical home standards while improving the primary care experience for patients and every member of the primary care team. Required medical home capabilities include providing patient-centered access; care coordination; cultural and linguistically appropriate services; and quality improvement.	While PCMH will remain the foundation of Medicaid care delivery transformation; and Intensive Care Management (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.	CCIP's primary aims include more effectively integrating non-clinical community services into routine clinical care, methods for reducing health equity gaps in the management of chronic conditions, and improved identification of un-diagnosed behavioral health conditions with primary care treatment or referral and follow-up.	CT-PTN will build upon FQHC PCMH recognition to enhance team-based care delivery, integration of specialty/behavioral health with primary care, resource coordination and population health through training, technical assistance, data sharing and collaborative learning. CT-PTN will focus on improving health outcomes for three conditions common to health center patients: asthma, diabetes and hypertension.

	scheduling and communication				
Target Population	Medicaid members	Medicaid and commercially covered individuals	Medicaid members	Although participation in MQISSP is an eligibility requirement, the CCIP programs will be focused on improving care for all patients, regardless of their payer	Individuals served by member FQHCs
Current Status	Over 100 practices currently participate, serving over one-third of Medicaid beneficiaries.	Initial cohort of 52 "Vanguard" practices launched September, 2015.	MQISSP is scheduled to be implemented effective January 1, 2017, pending a formal request for extension of time to this date.	CCIP is scheduled to be implemented 10/1/16.	Implementation (i.e. clinician commitment began 9/28/15); learning sessions will begin January 2016
Duration	Ongoing	Three-year grant period (2016-2019)	Three-year grant period (2016-2019)	Two 15-month waves beginning 2016 and ending 2019	Four-year grant period from 9/29/15 - 9/28/19
Eligible Entities	To be eligible for enhanced fee-for-service (FFS) as well as quality performance and improvement payments, a practice must 1) either be an independent private physician or nurse practitioner practice or a hospital-based outpatient clinic; and 2) be recognized by the National Committee for Quality Assurance (NCQA) as a "Level 2" or "Level 3" PCMH. Community Health Centers, Federally Qualified Health Centers (FQHC) and hospital-based clinics are eligible to participate in the PCMH Accreditation Program and to receive technical assistance.	Practices that are: • not currently recognized under an existing national medical home standard including NCQA 2011 or 2014 (Practices that have NCQA 2008 are permitted to apply); and • have an established ONC-certified Electronic Health Record	FQHCs and "advanced networks" selected by Request for Proposal (MQISSP Participating Entities) MQISSP Participating Entities can include: • a Federally Qualified Health Center, or • an "advanced network", defined as: 1) One or more DSS PCMH program participants plus specialists (physical health, behavioral health and oral health providers); 2) One or more DSS PCMH program participants plus specialists and hospitals; or 3) A Medicare Accountable Care Organization (ACO) that includes a DSS PCMH	MQISSP Participating Entities	13 CHCACT members active at the time of submission of the grant application plus two FQHCs approved in 2015 that became members in July 2015, for a total of 15 FQHCs.

	All participating practices must be enrolled as providers in the Connecticut Medical Assistance Program.		program participant Key features of the proposed provider qualifications include the following: • Participating entities must have a minimum of 2,500 attributed Medicaid beneficiaries • Participating entities must include a current participant in the DSS PCMH program • All providers in participating entities must be enrolled as Medicaid providers DSS has also sought review and comment on proposed features of leadership and advisory structure (with a particular emphasis on consumer representation), as well as requirements for connections with a range of community providers		
Means of Support	• Free multi-disciplinary practice transformation team support convened by CHN-CT toward recognition by NCQA (all participating	• 15-months of SIM-funded transformation services from Qualidigm and Planetree • Interactive learning collaborative, practice	Entities selected to participate in MQISSP (Participating Entities) will be eligible for care coordination payments (FQHCs) and, based on identified quality measures, shared savings (FQHCs and "advanced networks").	MQISSP Participating Entities will be eligible for technical assistance in developing new and advancing existing capabilities for improving care, especially for at-risk populations. The TA vendor will undertake a gap analysis to	Member FQHCs will be eligible for technical assistance support (including such elements as the To Complete Performance Index Change Package*;* quality improvement methodologies and culture;

	practices) or the Joint Commission (includes FQHCs and hospital outpatient clinics) as PCMH • Financial incentives (enhanced fee-for-service payments) for 18-24 months while practices are on the Glide Path working towards NCQA Recognition with a Community Practice Transformation Specialist (CPTS) (Please note: FQHCs are not eligible for these financial incentives) • Increased incentives (enhanced fee-for-service payments plus eligibility for performance and improvement incentives) when the practice is recognized as NCQA 2 or 3 PCMH • Ongoing, free coaching toward renewal of PCMH recognition	facilitation visits, and a variety of evidence-based Quality Improvement (QI) interventions • Support to achieve Advanced Medical Home Designation: NCQA PCMH 2014 standards level 2 or 3 with additional required elements and factors • Support to achieve Planetree Patient-Centered Bronze Recognition for excellence in patient-centered care • Eligibility for discounted NCQA application fees • Facilitation for AMH participants to enroll in the Medicaid PCMH program and thereby qualify for enhanced fees and incentive payments .		inform an implementation plan for CCIP TA. TA will support practices in meeting CCIP standards including effectively integrating non-clinical community services into routine clinical care, methods for reducing health equity gaps in the management of chronic conditions, and improved identification of un-diagnosed behavioral health conditions with primary care treatment or referral and follow-up. Further, MQISSP Participating Entities will be required to participate in local Community Health Collaboratives.	working with data and implementing effective Plan Do Study Act (PDSAs); effective care team development; risk stratification and population health management, use of Care Analyzer data and measures; use of popHealth clinical measures; defining data needs, using data extraction tools; chronic care management; primary care/behavioral health integration; primary/specialty care coordination; transitional care protocols/practices; and contributing to TCPI's knowledge management system) and will participate in learning collaboratives.
Care	Those elements that are	Those elements that are	The proposed MQISSP care	CCIP is comprised of core and	

Coordination Elements	embedded in NCQA Level 2 or 3, or the Joint Commission, PCMH standards	embedded in NCQA Level 2 or 3.	coordination elements focus upon the following: • 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) • Culturally competent services: Training, expansion of the current use of CAHPS to include the Cultural Competency Item 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	elective program standards. CCIP will require participating entities to meet the core standards which include the following: • Comprehensive Care Management • Health Equity Improvement • Behavioral health These core standards are designed to enhance competencies related to care management of individuals with complex needs with a focus on person-centered assessment; care plans that emphasize individual values, preferences and goals; the enhancement of the primary care teams with additional clinical and community participants; and linkages with community based services and supports. The standards also introduce processes to support continuous quality improvement aimed at reducing health equity gaps and a related intervention targeting hypertension, asthma, or diabetes. Community health workers play an important role in these standards, recognizing that community health workers can serve as a trusted partner and bridge to community services	

			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	and supports. The third of these standards focuses on individuals with unidentified behavioral health needs. The standards address screening, primary care based treatment, referral, and coordination with behavioral health care in the community. CCIP will also encourage participating entities to meet elective standards**,** which include: • Electronic Consults ("e-consults") • Comprehensive Medication Management ("CMM") • Oral Health	
Quality Measures	**Child/Adolescent Measures:** • Well-Child Visits in the First 15 Months of Life • Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life • Adolescent Well-Care Visits • Annual Dental Visit • Asthma Patients with One or More Asthma-Related ED Visit • Developmental	Please see this link for a complete list of proposed SIM quality measures: http://www.healthreform.ct.gov/ohri/lib/ohri/work_groups/quality/2015-11-18/qc_report_measure_tables_v6.xlsx	Please see this link for a complete list of proposed quality measures: https://www.cga.ct.gov/med/committees/MQ/Proposed%20Quality%20Measure%20List;%20August%2026,%202015.pdf	Please see this link for a complete list of proposed SIM quality measures: http://www.healthreform.ct.gov/ohri/lib/ohri/work_groups/quality/2015-11-18/qc_report_measure_tables_v6.xlsx	• Diabetes: Optimal Diabetes Care Composite (NQF 0729) • Asthma Composite: Optimal Asthma Care (Composite based on PQRS Asthma Measures Group) • Adult Asthma Admission Rate. **Details**: Admissions for a principal diagnosis of asthma per 100,000 population, ages 18 to 39 years. (PQI #15)

	Screening • ED Visits Ages 0-19 • Use of Appropriate Medications for People with Asthma • PCMH Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey **Adult Measures:** • Adult Diabetes LDL-C Screening • Adult Diabetes Eye (retinal) Screening • Post Hospitalization Follow-up • Follow-up after New Mental Health Diagnosis with /Medication Prescription • Cholesterol Management for Patients with Cardiovascular Conditions • ED Usage • Use of Appropriate Medications for People with Asthma • Readmission Rate - 30 days • PCMH Consumer				• Asthma Emergency Department (ED)/Urgent Care Utilization Rate. **Details**: This measure is used to assess the percent of patients who have had a visit to an (ED)/Urgent Care office for asthma in the past six months (NQMC 1615) • Asthma in Younger Adults Admission Rate. **Details**: Admissions for pediatric asthma per 100,000 population (PQI #15) • Uncontrolled Diabetes Admission Rate. **Details**: Admissions for a principal diagnosis of diabetes without mention of short-term complications per 100,000 population, ages 18 years and 18 years and older. (PQI #14) • Hypertension Admission Rate. **Details**: Admissions with a principal diagnosis of hypertension per 100,000 population,

	Assessment of Healthcare Providers and Systems (CAHPS) Survey				ages 18 years and older. (PQI #7) • Access during office hours for a medical question. **Details:** Data derived from the CAHPS on each FQHC participating in the PTN). • Cost savings are based on an iterative expansion of care management interventions over four years.
Relationship to Medicaid ASO	CHN-CT (Medicaid medical ASO) provides practice transformation coaching, ongoing support, and pushes member data to participating practices.	AMH transformation vendor will coordinate with CHN-CT to enable practices that are participating in the AMH Glide Path to apply to participate in the Medicaid PCMH Glide Path.	CHN-CT will continue to support MQISSP Participating Entities with ICM supports for high need, high cost individuals (e.g. coordination of services, referrals, support in instances in which members miss appointments or experience access barriers) and data on patient panels.	CHN-CT supports will continue to be available to MQISSP participating entities. Care teams will coordinate with ICM care managers. Other criteria may be added.	CT-PTN members will continue to rely on CHN-CT CareAnalyzer for data analytics in support of serving Medicaid members.