DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

Division of Medicaid and Children's Health Operations / Boston Regional Office

January 18, 2017

Roderick L. Bremby, Commissioner
Department of Social Services
55 Farmington Avenue
Hartford, CT 06105

RE: CT SPA 17-0002 / Person-Centered Medical Home Plus (PCMH+) Program

Dear Commissioner Bremby:

We are pleased to enclose a copy of approved State plan amendment (SPA) No. 17-0002 with an effective date of January 1, 2017 as requested by your Agency.

This proposed SPA transmitted an amendment to the coverage and reimbursement sections of Connecticut's approved Title XIX State plan to establish the PCMH+ program. The PCMH+ program is being added as an Integrated Care Model within section 1905(a)(29) of the Social Security Act (Act). The PCMH+ program also involves shared savings payments and care coordination add-on payments for primary care case management services, as defined by section 1905(t) of the Act.

If you have any questions regarding this matter you may contact Robert Cruz at 617-565-1257 or by email at Robert.Cruz@cms.hhs.gov.

Sincerely,

Richard R. McGreal

Richard McGreal
Associate Regional Administrator

Enclosure

cc: Kate McEvoy, Director of Medical Administration – Health Services and Supports

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 17-0002
2. STATE: CT
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: January 1, 2017

5. TYPE OF STATE PLAN MATERIAL (Check One):
___ NEW STATE PLAN ___AMENDMENT TO BE CONSIDERED AS NEW PLAN _X_AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
Sections 1905(a)(29) and 1905(t) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2017 $2.3 million (costs)
b. FFY 2018 $1.2 million (costs)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If applicable)
Attachment 3.1-A, Page 13	New
Attachment 3.1-B, Page 12	New
Addendum Pages 16-25 to Attachments 3.1-A & 3.1-B	New
Attachment 4.19-B, Pages 30-38	New

10. SUBJECT OF AMENDMENT: Effective from January 1, 2017 through December 31, 2017, this SPA amends Attachments 3.1-A, 3.1-B, and 4.19-B of the Medicaid State Plan in order to establish the Person-Centered Medical Home Plus (PCMH+) program, which is an Integrated Care Model being implemented in accordance with section 1905(a)(29) of the Social Security Act. This SPA involves shared savings payments and care coordination add-on payments for primary care case management (PCCM) services, as defined by section 1905(t) of the Act. The federal budget impact listed above is the Department's estimate of care coordination add-on per member per month payments that will be made to PCMH+ Participating Entities that are federally qualified health centers (FQHCs). It is not possible to predict the amount of shared savings payments that may be paid because such payments will be based on Medicaid expenditures, quality measures, and measures of under-service for dates of service in calendar year 2017.

11. GOVERNOR'S REVIEW (Check One):

_X_ GOVERNOR'S OFFICE REPORTED NO COMMENT
__COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
__NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
__OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Roderick L. Bremby

14. TITLE: Commissioner

15. DATE SUBMITTED: December 29, 2016

16. RETURN TO:

State of Connecticut
Department of Social Services
55 Farmington Avenue – 9th floor
Hartford, CT 06105
Attention: Ginny Mahoney

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: December 29, 2016

18. DATE APPROVED: January 18, 2017

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2017

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Richard R. McGreal

22. TITLE: Associate Regional Administrator, Division of Medicaid and Children's Health Operations, Boston Regional Office

23. REMARKS: The state and CMS agreed to the following pen-and-ink changes to Box 8 on the Form 179:
- the page number under Attachment 3.1-A was changed from 14 to 13
- the page number under Attachment 3.1-B was changed from 14 to 12
- the Addendum page numbers under Attachments 3.1-A and 3.1-B were changed from 16-24 to 16-25
- the page numbers under Attachment 4.19-B were updated from 31-39 to 30-38

FORM HCFA-179 (07-92)

State: Connecticut
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
CATEGORICALLY NEEDY GROUP(S): ALL

29. Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary (continued)

g. Integrated care models.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided

* See Addendum to Attachment 3.1-A.

State: Connecticut
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

29. Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary

g. Integrated Care Models

1. PERSON-CENTERED MEDICAL HOME PLUS (PCMH+) PROGRAM

The overall goals of the Person-Centered Medical Home Plus (PCMH+) program are to improve health outcomes and care experience for Medicaid beneficiaries who are PCMH+ members, while building upon and preserving both the PCMH program in particular (as described in section 5 of Attachment 4.19-B), as well as overall improvement in quality, access, and cost control in Connecticut's Medicaid program. Participating Entities that meet identified benchmarks on quality measures, while also demonstrating shared savings (and complying with measures to prevent under-service) will be eligible to receive shared savings payments, all as described in more detail below and in Attachment 4.19-B.

I. Provider Qualifications

Under the PCMH+ program, the State will contract with PCMH+ Participating Entities (Participating Entities), which are Federally Qualified Health Centers (FQHCs) or Advanced Networks, each as defined below, to provide the care coordination services described below. Participating Entities must include primary care providers (primary care physicians, advanced practice registered nurses (APRNs) / nurse practitioners, and/or physician assistants) who provide primary care case management (PCCM) services in accordance with section 1905(t) of the Social Security Act (Act), which includes location, coordination and monitoring of health care services. Pursuant to section 1905(t)(2)(A)-(B) of the Act, a Participating Entity must be, employ, or contract with a physician, a physician group practice, APRNs/nurse practitioners, physician assistants, or an entity employing or having other arrangements with physicians to provide such services. The Participating Entity provides services in the following specialty areas: internal medicine, general medicine, geriatric medicine, family medicine, and pediatrics.

A. Federally Qualified Health Centers (FQHCs)

An FQHC is an entity, as defined in section 2 of Attachment 3.1-A, including an FQHC look-alike, which must:

1. Meet all requirements of an FQHC under section 1905(l)(2)(B) of the Social Security Act.
2. Meet all requirements of the Health Resources and Services Administration (HRSA) Health Center Program and have either: (A) HRSA grant funding as an FQHC under Section 330 of the Public Health Services Act or (B) HRSA designation as an FQHC Look-Alike.
3. Operate in Connecticut and meet all federal and state requirements applicable to FQHCs.
4. Be a current participant in the Department of Social Services (DSS) PCMH program (Glide Path practices are excluded) and hold current Level 2 or 3 Patient-Centered Medical Home recognition from the National Committee for Quality Assurance (NCQA) or Primary Care Medical Home certification from The Joint Commission. Glide Path practices are excluded from PCMH+ because they provide some, but not all, of the Medicaid services required for NCQA or The Joint Commission PCMH recognition. In order to qualify for Glide Path, a practice must have demonstrated to DSS that it has begun providing a more advanced standard of primary care and has committed to achieving NCQA or The Joint Commission PCMH recognition in a set period of time.
5. Identify a clinical director and senior leader to represent the FQHC and champion PCMH+ goals.

B. Advanced Networks

An Advanced Network is a provider organization or group of provider organizations that must include one or more physician group(s) (primary care physician(s), APRN(s), and/or physician assistant(s)), APRN group(s), individual physician(s), and/or individual APRN(s) (a "practice") that practices primary care and is currently participating in the DSS PCMH program (other than a Glide Path practice), as described in section 5 of Attachment 4.19-B. Glide Path practices are excluded from PCMH+ because they provide some, but not all, of the Medicaid services required for NCQA PCMH recognition. In order to qualify for Glide Path, a practice must have demonstrated to DSS that it has begun providing a more advanced standard of primary care and has committed to achieving NCQA or The Joint Commission PCMH recognition in a set period of time. Acceptable options for Advanced Network composition include:

1. One or more DSS PCMH practice(s);
2. One or more DSS PCMH practice(s) plus specialist(s), which could include physical health, behavioral health, and oral health providers;

3. One or more DSS PCMH practice(s) plus specialist(s), which could include physical health, behavioral health, and oral health providers, and one or more hospital(s); or
4. A Medicare Accountable Care Organization (ACO) that includes one or more DSS PCMH practice(s).

Advanced Networks must designate an Advanced Network Lead Entity that is a provider or provider organization participating in the Advanced Network. The Advanced Network Lead Entity must designate a clinical director and a senior leader, ensure that the required Enhanced Care Coordination Activities are implemented as intended, and receive any shared savings achieved and distribute the shared savings to Advanced Network participating providers according to its plan, which must be approved by DSS. If the Advanced Network is comprised of more than one provider organization, the Advanced Network Lead Entity must have a contractual relationship with all other Advanced Network participating providers that meet requirements established by DSS.

C. Requirements for All Participating Entities

In addition to complying with the requirements specific to only FQHCs or Advanced Networks, all Participating Entities, whether FQHCs or Advanced Networks, must also demonstrate to DSS, through the state's procurement process, that they:

1. Have at least 2,500 DSS PCMH program attributed Medicaid beneficiaries who are eligible for PCMH+ at the time that DSS assigns beneficiaries to the Participating Entity using the methodology detailed in Attachment 4.19-B.
2. Ensure that only providers enrolled in Connecticut Medicaid are providing Medicaid services to PCMH+ members.
3. Meet DSS's requirements for maintaining an oversight body that monitors the Participating Entity's implementation of PCMH+.
4. Have appropriate organizational capacity, including governance and oversight, for implementing PCMH+.
5. Will ensure and promote transparency, community participation, and PCMH+ member participation in the operation of PCMH+.
6. Have a planned and documented approach for providing Enhanced Care Coordination Activities (see Section B) and, in the case of FQHCs, Care Coordination Add-On Payment Activities (see Section B).

7. Will support the integration of behavioral health services and supports into existing operations.
8. Will develop and maintain contractual or informal written partnerships with local community partners in order to impact social determinants of health, promote physical and behavioral health integrated care, and assist beneficiaries in utilizing their Medicaid benefits.
9. Have a planned and documented approach to monitor and improve the quality of care provided to PCMH+ members, including a plan to monitor, prevent, and address under-utilization of medically necessary services.
10. Will participate in quality measurement activities as required by DSS.
11. Will participate in program oversight activities conducted by DSS or its designee to ensure compliance with program requirements.
12. Comply with all requirements of DSS's procurement process for PCMH+.
13. Will not limit a beneficiary's ability to receive services from a provider that is not affiliated with the Participating Entity.
14. Will require any non-DSS PCMH primary care practices within the Participating Entity to become a DSS PCMH practice within eighteen (18) months of the start of the first PCMH+ Performance Year. DSS may extend this timeframe for PCMH recognition based on good cause outside of the Participating Entity's control, including, but not limited to, NCQA approval delays, electronic health records (EHR) system vendor delays, or resignation of staff members who are key to the NCQA or other accreditation processes. Practices that do not achieve this milestone will be issued a corrective action plan. The corrective action plan will establish timeframes for the practice(s) to address gaps in order to become a DSS PCMH practice. DSS will monitor compliance with the corrective action plan until DSS PCMH status has been reached. Non-compliance with corrective action plans will result in termination of the Participating Entity's PCMH+ contract with DSS, and ineligibility to receive any PCMH+ shared savings payments for that performance year.
15. Will not distribute shared savings to any individual practitioner within the Participating Entity using any factors that would reward such individual for his or her specific contributions to the overall savings generated by the Participating Entity.

State: Connecticut
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

II. Service Description: Care Coordination

Participating Entities that meet quality benchmarks described below will be eligible to receive shared savings payments based on the shared savings calculation for their assigned PCMH+ members, as described in Attachment 4.19-B.

All Participating Entities provide Enhanced Care Coordination Activities to beneficiaries assigned to the Participating Entity to improve the quality, efficiency, and effectiveness of care delivered to PCMH+ members. Participating Entities that are FQHCs will also provide Care Coordination Add-On Payment Activities in addition to the Enhanced Care Coordination Activities. The Enhanced Care Coordination Activities and Care Coordination Add-On Payment Activities have been updated as of January 1, 2017 and apply to Performance Years beginning on or after that date and a description of those activities are posted on DSS's website at: http://www.ct.gov/dss/pcmh+.

The care coordination services provided by the Participating Entity are person-centered and fall within a broad continuum that ranges from targeted referrals to more comprehensive supports, which are (1) individually determined for each PCMH+ member based on that individual's circumstances and level of need and (2) provided proportionally within the Participating Entity's available resources for providing care coordination to that individual, as well as all individuals for which the Contractor is responsible for providing care. Each Participating Entity is required to provide Enhanced Care Coordination Activities (and, for Participating Entities that are FQHCs, also Care Coordination Add-On Payment Activities) only to the extent desired by PCMH+ members and only to the extent feasible within the Participating Entity's available resources for providing such services, as determined by the Department consistent with standards for the provision of care coordination services and in a manner sufficient to fulfill the applicable requirements of the PCMH+ program.

All Medicaid claim costs for covered services will be included in the shared savings calculations described in Attachment 4.19-B, except for: hospice; long-term services and supports (LTSS), including institutional and home and community-based services; and non-emergency medical transportation (NEMT) services. Participating Entities do not need to deliver all defined benefits; rather, the cost of all benefits provided to an assigned PCMH+ member, regardless of the specific provider that performed each service, will be included in the shared savings calculation.

State: Connecticut
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

III. Quality Measures

In addition to providing the Enhanced Care Coordination Activities (and for Participating Entities that are FQHCs, also the Care Coordination Add-On Payment Activities) in order to be eligible to receive shared savings payments, if applicable, each PCMH+ Participating Entity must also maintain and/or improve the quality of care and care experience for beneficiaries assigned to the Participating Entity, as measured by various quality measures. Specifically, in order to be eligible to receive shared savings payments, each PCMH+ Participating Entity must meet specified standards for quality measures, as described in Attachment 4.19-B. The PCMH+ quality measure set contains process and outcome measures that include measures of beneficiary experience. Of those measures, a specified subset of measures will be used in calculating various payments, as described in Attachment 4.19-B. All of the quality measures have been updated as of January 1, 2017 and apply to Performance Years beginning on or after that date and a description of those measures, including the use of each such measure in calculating shared savings payments, is posted to DSS's website at: http://www.ct.gov/dss/pcmh+.

The quality measure set will be reviewed annually and updated as deemed necessary by DSS. Changes in the measure set will be derived from recommendations generated as part of the Year 1 Program Evaluation.

IV. Measures to Prevent Under-Service

Participating Entities will be disqualified from receiving shared savings payments if they demonstrate repeated or systematic failure to offer medically necessary services or manipulate their member panel, whether or not there is evidence of intentionality. DSS uses a multi-pronged approach to identify and prevent under-service of PCMH+ members. The data points that DSS monitors under this approach include, but are not limited to: PCMH+ member grievances, provider performance on quality measures (particularly preventive care service measures), service utilization and service cost reporting, and member movement to and from PCMH+ practices. DSS will also conduct a PCMH+ member survey to evaluate the first Performance Year. Participating Entities that are found to have systematically under-served members or manipulated their panel will not be eligible for shared savings payments.

State: Connecticut
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

V. Covered Populations

For the purposes of calculating shared savings payments and Care Coordination Add-On Payments, all Connecticut Medicaid beneficiaries attributed to an FQHC that is a PCMH+ Participating Entity or attributed to a DSS PCMH practice or practice entity within an Advanced Network are eligible for PCMH+, except for the following:

1. Behavioral Health Home (BHH) participants (authorized by section 1945), as detailed in Attachment 3.1-H are excluded from PCMH+ because those individuals are eligible to receive care coordination from the health home.
2. Partial Medicaid/Medicare dual eligible beneficiaries are excluded from PCMH+ because those individuals are not eligible to receive any Medicaid benefits other than specified Medicare cost sharing, as applicable. Individuals who are participating in a Medicare Accountable Care Organization (ACO) are excluded from PCMH+ because those individuals are eligible to receive care coordination services through the ACO and because they are already participating in a shared savings program. Individuals who are enrolled in a Medicare Advantage plan are excluded from PCMH+ because those individuals are eligible to receive care coordination services through the Medicare Advantage Plan.
3. Home and community-based services section 1915(c) waiver, section 1915(i) (as detailed in Attachment 3.1-i), and section 1915(k) participants (as detailed in Attachment 3.1-K) are all excluded from PCMH+ because those individuals are all eligible to receive care coordination services in connection with the service planning process that is part of each of those programs.
4. Money Follows the Person (MFP) participants are excluded from PCMH+ because those individuals are eligible to receive care coordination services through the MFP program.
5. Residents of nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) and other long-term care institutions that are required to coordinate care for their residents are excluded from PCMH+ because those institutions are required to coordinate care for their residents and, as such, those individuals are eligible to receive such care coordination services.
6. Beneficiaries who are enrolled in Connecticut Medicaid solely to receive a limited benefit package (current limited benefit packages include family planning, breast and cervical cancer, and tuberculosis) are excluded from PCMH+ because those individuals are not eligible for the full package of Medicaid services and it is not appropriate for a PCMH+ Participating Entity to be measured for the impact of their interventions for those individuals

on Medicaid expenditures, as those individuals likely receive a variety of services from non-Medicaid sources.

7. Beneficiaries who are receiving hospice services are excluded from PCMH+ because hospice providers are required to coordinate the care of their patients and because it is not appropriate to provide incentives for shared savings within PCMH+ for individuals who are terminally ill.

The state assures that full Medicaid/Medicare dual eligible beneficiaries who do not fall within one or more of the categories listed immediately above have access to care coordination services included in PCMH+ if those individuals desire such services. Accordingly, the dual eligible individuals described in the previous sentence are excluded from PCMH+ only for purposes of calculating shared savings payments and Care Coordination Add-On Payments, but those individuals will receive Enhanced Care Coordination Activities (and, for FQHCs, also Care Coordination Add-On Payment Activities).

VI. Limitation

The provision of services under PCMH+ shall not duplicate the locating, coordinating, and monitoring of health care services provided under the PCMH program, as described in section 5 of Attachment 4.19-B or as Medicaid administrative services provided by one or more of DSS's Administrative Services Organizations.

VII. Assurances

The following beneficiary protections in section 1905(t) of the Act apply to PCMH+:

1. Section 1905(t)(3)(A), which requires primary care case managers to maintain reasonable hours of operation and 24-hour availability of referral and treatment, is met because beneficiaries are afforded free choice of Medicaid providers.
2. Section 1905(t)(3)(C), which requires primary care case managers to ensure the availability of a sufficient number of health care professionals to provide high-quality care in a prompt manner, is met because beneficiaries are afforded free choice of Medicaid providers and because the PCMH+ assignment methodology ensures that only patients who have a relationship with providers in a Participating Entity are assigned to that Participating Entity.

OFFICIAL

State: Connecticut
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

3. Section 1905(t)(3)(D), which prohibits discrimination on the basis of health status in enrollment and disenrollment, is met because Participating Entities will be prohibited by contract from activities designed to result in selective recruitment and attribution of individuals with more favorable health status.
4. Section 1905(t)(3)(F), which refers to section 1932 and requires notification to beneficiaries of the program, including how personal information will be used, and disclosure of any correlative payment arrangements, is met because DSS will notify beneficiaries that they have been assigned to a PCMH Participating Entity prior to the start of the Performance Year.

DSS makes the following assurances:

1. The PCMH+ program does not restrict members' free choice of provider as described in 42 C.F.R. § 431.51.
2. Any Advanced Network or FQHC that meets the qualifications established by DSS for a PCMH+ Participating Entity and submits a successful response to the request for proposals in accordance with DSS's procurement process will be allowed to participate in PCMH+.
3. Section 1903(d)(I), which provides for protections against fraud and abuse, is met in that all providers participating in a Participating Entity are enrolled as providers with Connecticut Medicaid and are bound by the rules of the Medicaid program.
4. Section 1902(a)(30)(A), which requires that services under PCMH+ are available to members at least to the extent they are available to the general population, is met because PCMH+ members will have free choice of Medicaid providers.

VIII. Monitoring and Reporting

PCMH+ includes a set of internal monitoring and reporting measures that will be collected and analyzed not less than quarterly. DSS will review the information and follow up with Participating Entities as needed regarding their performance. As a condition of continuing to implement PCMH+ beyond any expiration date specified in Attachment 4.19-B, if applicable, DSS will evaluate PCMH+ to determine if there has been improvement compared with past performance to determine whether the program has achieved, or needs revisions to achieve, the goals of the program, including improving health outcomes and the care experience for PCMH+ members, preserving the PCMH program in particular and the Medicaid program in general and preventing any harm to those programs and/or members of those programs.

OFFICIAL

State: Connecticut
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

DSS will:

1. Provide CMS, at least annually, with data and reports evaluating the success of the PCMH+ program against the goals of the program.
2. Provide CMS, at least annually, with updates, as conducted, to DSS's metrics.
3. Review and, if necessary, update or revise the payment methodology as part of the evaluation.
4. Make all necessary modifications to the methodology, including those determined based on the evaluation of program success. If changes to the methodology are different from the approved methodology in the applicable federal authority, then DSS will propose appropriate updates to the federal authority.

State: Connecticut
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

29. Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary (continued)

g. Integrated care models.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided

* See Addendum to Attachment 3.1-B.

State: Connecticut
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

29. Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary

g. Integrated Care Models

1. PERSON-CENTERED MEDICAL HOME PLUS (PCMH+) PROGRAM

The overall goals of the Person-Centered Medical Home Plus (PCMH+) program are to improve health outcomes and care experience for Medicaid beneficiaries who are PCMH+ members, while building upon and preserving both the PCMH program in particular (as described in section 5 of Attachment 4.19-B), as well as overall improvement in quality, access, and cost control in Connecticut's Medicaid program. Participating Entities that meet identified benchmarks on quality measures, while also demonstrating shared savings (and complying with measures to prevent under-service) will be eligible to receive shared savings payments, all as described in more detail below and in Attachment 4.19-B.

I. Provider Qualifications

Under the PCMH+ program, the State will contract with PCMH+ Participating Entities (Participating Entities), which are Federally Qualified Health Centers (FQHCs) or Advanced Networks, each as defined below, to provide the care coordination services described below. Participating Entities must include primary care providers (primary care physicians, advanced practice registered nurses (APRNs) / nurse practitioners, and/or physician assistants) who provide primary care case management (PCCM) services in accordance with section 1905(t) of the Social Security Act (Act), which includes location, coordination and monitoring of health care services. Pursuant to section 1905(t)(2)(A)-(B) of the Act, a Participating Entity must be, employ, or contract with a physician, a physician group practice, APRNs/nurse practitioners, physician assistants, or an entity employing or having other arrangements with physicians to provide such services. The Participating Entity provides services in the following specialty areas: internal medicine, general medicine, geriatric medicine, family medicine, and pediatrics.

A. Federally Qualified Health Centers (FQHCs)

An FQHC is an entity, as defined in section 2 of Attachment 3.1-A, including an FQHC look-alike, which must:

State: Connecticut
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

1. Meet all requirements of an FQHC under section 1905(l)(2)(B) of the Social Security Act.
2. Meet all requirements of the Health Resources and Services Administration (HRSA) Health Center Program and have either: (A) HRSA grant funding as an FQHC under Section 330 of the Public Health Services Act or (B) HRSA designation as an FQHC Look-Alike.
3. Operate in Connecticut and meet all federal and state requirements applicable to FQHCs.
4. Be a current participant in the Department of Social Services (DSS) PCMH program (Glide Path practices are excluded) and hold current Level 2 or 3 Patient-Centered Medical Home recognition from the National Committee for Quality Assurance (NCQA) or Primary Care Medical Home certification from The Joint Commission. Glide Path practices are excluded from PCMH+ because they provide some, but not all, of the Medicaid services required for NCQA or The Joint Commission PCMH recognition. In order to qualify for Glide Path, a practice must have demonstrated to DSS that it has begun providing a more advanced standard of primary care and has committed to achieving NCQA or The Joint Commission PCMH recognition in a set period of time.
5. Identify a clinical director and senior leader to represent the FQHC and champion PCMH+ goals.

B. Advanced Networks

An Advanced Network is a provider organization or group of provider organizations that must include one or more physician group(s) (primary care physician(s), APRN(s), and/or physician assistant(s)), APRN group(s), individual physician(s), and/or individual APRN(s) (a "practice") that practices primary care and is currently participating in the DSS PCMH program (other than a Glide Path practice), as described in section 5 of Attachment 4.19-B. Glide Path practices are excluded from PCMH+ because they provide some, but not all, of the Medicaid services required for NCQA PCMH recognition. In order to qualify for Glide Path, a practice must have demonstrated to DSS that it has begun providing a more advanced standard of primary care and has committed to achieving NCQA or The Joint Commission PCMH recognition in a set period of time. Acceptable options for Advanced Network composition include:

1. One or more DSS PCMH practice(s);
2. One or more DSS PCMH practice(s) plus specialist(s), which could include physical health, behavioral health, and oral health providers;

3. One or more DSS PCMH practice(s) plus specialist(s), which could include physical health, behavioral health, and oral health providers, and one or more hospital(s); or
4. A Medicare Accountable Care Organization (ACO) that includes one or more DSS PCMH practice(s).

Advanced Networks must designate an Advanced Network Lead Entity that is a provider or provider organization participating in the Advanced Network. The Advanced Network Lead Entity must designate a clinical director and a senior leader, ensure that the required Enhanced Care Coordination Activities are implemented as intended, and receive any shared savings achieved and distribute the shared savings to Advanced Network participating providers according to its plan, which must be approved by DSS. If the Advanced Network is comprised of more than one provider organization, the Advanced Network Lead Entity must have a contractual relationship with all other Advanced Network participating providers that meet requirements established by DSS.

C. Requirements for All Participating Entities

In addition to complying with the requirements specific to only FQHCs or Advanced Networks, all Participating Entities, whether FQHCs or Advanced Networks, must also demonstrate to DSS, through the state's procurement process, that they:

1. Have at least 2,500 DSS PCMH program attributed Medicaid beneficiaries who are eligible for PCMH+ at the time that DSS assigns beneficiaries to the Participating Entity using the methodology detailed in Attachment 4.19-B.
2. Ensure that only providers enrolled in Connecticut Medicaid are providing Medicaid services to PCMH+ members.
3. Meet DSS's requirements for maintaining an oversight body that monitors the Participating Entity's implementation of PCMH+.
4. Have appropriate organizational capacity, including governance and oversight, for implementing PCMH+.
5. Will ensure and promote transparency, community participation, and PCMH+ member participation in the operation of PCMH+.
6. Have a planned and documented approach for providing Enhanced Care Coordination Activities (see Section B) and, in the case of FQHCs, Care Coordination Add-On Payment Activities (see Section B).

7. Will support the integration of behavioral health services and supports into existing operations.
8. Will develop and maintain contractual or informal written partnerships with local community partners in order to impact social determinants of health, promote physical and behavioral health integrated care, and assist beneficiaries in utilizing their Medicaid benefits.
9. Have a planned and documented approach to monitor and improve the quality of care provided to PCMH+ members, including a plan to monitor, prevent, and address under-utilization of medically necessary services.
10. Will participate in quality measurement activities as required by DSS.
11. Will participate in program oversight activities conducted by DSS or its designee to ensure compliance with program requirements.
12. Comply with all requirements of DSS's procurement process for PCMH+.
13. Will not limit a beneficiary's ability to receive services from a provider that is not affiliated with the Participating Entity.
14. Will require any non-DSS PCMH primary care practices within the Participating Entity to become a DSS PCMH practice within eighteen (18) months of the start of the first PCMH+ Performance Year. DSS may extend this timeframe for PCMH recognition based on good cause outside of the Participating Entity's control, including, but not limited to, NCQA approval delays, electronic health records (EHR) system vendor delays, or resignation of staff members who are key to the NCQA or other accreditation processes. Practices that do not achieve this milestone will be issued a corrective action plan. The corrective action plan will establish timeframes for the practice(s) to address gaps in order to become a DSS PCMH practice. DSS will monitor compliance with the corrective action plan until DSS PCMH status has been reached. Non-compliance with corrective action plans will result in termination of the Participating Entity's PCMH+ contract with DSS, and ineligibility to receive any PCMH+ shared savings payments for that performance year.
15. Will not distribute shared savings to any individual practitioner within the Participating Entity using any factors that would reward such individual for his or her specific contributions to the overall savings generated by the Participating Entity.

State: Connecticut
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

II. Service Description: Care Coordination

Participating Entities that meet quality benchmarks described below will be eligible to receive shared savings payments based on the shared savings calculation for their assigned PCMH+ members, as described in Attachment 4.19-B.

All Participating Entities provide Enhanced Care Coordination Activities to beneficiaries assigned to the Participating Entity to improve the quality, efficiency, and effectiveness of care delivered to PCMH+ members. Participating Entities that are FQHCs will also provide Care Coordination Add-On Payment Activities in addition to the Enhanced Care Coordination Activities. The Enhanced Care Coordination Activities and Care Coordination Add-On Payment Activities have been updated as of January 1, 2017 and apply to Performance Years beginning on or after that date and a description of those activities are posted on DSS's website at: http://www.ct.gov/dss/pcmh+.

The care coordination services provided by the Participating Entity are person-centered and fall within a broad continuum that ranges from targeted referrals to more comprehensive supports, which are (1) individually determined for each PCMH+ member based on that individual's circumstances and level of need and (2) provided proportionally within the Participating Entity's available resources for providing care coordination to that individual, as well as all individuals for which the Contractor is responsible for providing care. Each Participating Entity is required to provide Enhanced Care Coordination Activities (and, for Participating Entities that are FQHCs, also Care Coordination Add-On Payment Activities) only to the extent desired by PCMH+ members and only to the extent feasible within the Participating Entity's available resources for providing such services, as determined by the Department consistent with standards for the provision of care coordination services and in a manner sufficient to fulfill the applicable requirements of the PCMH+ program.

All Medicaid claim costs for covered services will be included in the shared savings calculations described in Attachment 4.19-B, except for: hospice; long-term services and supports (LTSS), including institutional and home and community-based services; and non-emergency medical transportation (NEMT) services. Participating Entities do not need to deliver all defined benefits; rather, the cost of all benefits provided to an assigned PCMH+ member, regardless of the specific provider that performed each service, will be included in the shared savings calculation.

State: Connecticut
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

III. Quality Measures

In addition to providing the Enhanced Care Coordination Activities (and for Participating Entities that are FQHCs, also the Care Coordination Add-On Payment Activities) in order to be eligible to receive shared savings payments, if applicable, each PCMH+ Participating Entity must also maintain and/or improve the quality of care and care experience for beneficiaries assigned to the Participating Entity, as measured by various quality measures. Specifically, in order to be eligible to receive shared savings payments, each PCMH+ Participating Entity must meet specified standards for quality measures, as described in Attachment 4.19-B. The PCMH+ quality measure set contains process and outcome measures that include measures of beneficiary experience. Of those measures, a specified subset of measures will be used in calculating various payments, as described in Attachment 4.19-B. All of the quality measures have been updated as of January 1, 2017 and apply to Performance Years beginning on or after that date and a description of those measures, including the use of each such measure in calculating shared savings payments, is posted to DSS's website at: http://www.ct.gov/dss/pcmh+.

The quality measure set will be reviewed annually and updated as deemed necessary by DSS. Changes in the measure set will be derived from recommendations generated as part of the Year 1 Program Evaluation.

IV. Measures to Prevent Under-Service

Participating Entities will be disqualified from receiving shared savings payments if they demonstrate repeated or systematic failure to offer medically necessary services or manipulate their member panel, whether or not there is evidence of intentionality. DSS uses a multi-pronged approach to identify and prevent under-service of PCMH+ members. The data points that DSS monitors under this approach include, but are not limited to: PCMH+ member grievances, provider performance on quality measures (particularly preventive care service measures), service utilization and service cost reporting, and member movement to and from PCMH+ practices. DSS will also conduct a PCMH+ member survey to evaluate the first Performance Year. Participating Entities that are found to have systematically under-served members or manipulated their panel will not be eligible for shared savings payments.

State: Connecticut
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

V. Covered Populations

For the purposes of calculating shared savings payments and Care Coordination Add-On Payments, all Connecticut Medicaid beneficiaries attributed to an FQHC that is a PCMH+ Participating Entity or attributed to a DSS PCMH practice or practice entity within an Advanced Network are eligible for PCMH+, except for the following:

1. Behavioral Health Home (BHH) participants (authorized by section 1945), as detailed in Attachment 3.1-H are excluded from PCMH+ because those individuals are eligible to receive care coordination from the health home.
2. Partial Medicaid/Medicare dual eligible beneficiaries are excluded from PCMH+ because those individuals are not eligible to receive any Medicaid benefits other than specified Medicare cost sharing, as applicable. Individuals who are participating in a Medicare Accountable Care Organization (ACO) are excluded from PCMH+ because those individuals are eligible to receive care coordination services through the ACO and because they are already participating in a shared savings program. Individuals who are enrolled in a Medicare Advantage plan are excluded from PCMH+ because those individuals are eligible to receive care coordination services through the Medicare Advantage Plan.
3. Home and community-based services section 1915(c) waiver, section 1915(i) (as detailed in Attachment 3.1-i), and section 1915(k) participants (as detailed in Attachment 3.1-K) are all excluded from PCMH+ because those individuals are all eligible to receive care coordination services in connection with the service planning process that is part of each of those programs.
4. Money Follows the Person (MFP) participants are excluded from PCMH+ because those individuals are eligible to receive care coordination services through the MFP program.
5. Residents of nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) and other long-term care institutions that are required to coordinate care for their residents are excluded from PCMH+ because those institutions are required to coordinate care for their residents and, as such, those individuals are eligible to receive such care coordination services.
6. Beneficiaries who are enrolled in Connecticut Medicaid solely to receive a limited benefit package (current limited benefit packages include family planning, breast and cervical cancer, and tuberculosis) are excluded from PCMH+ because those individuals are not eligible for the full package of Medicaid services and it is not appropriate for a PCMH+ Participating Entity to be measured for the impact of their interventions for those individuals

on Medicaid expenditures, as those individuals likely receive a variety of services from non-Medicaid sources.

7. Beneficiaries who are receiving hospice services are excluded from PCMH+ because hospice providers are required to coordinate the care of their patients and because it is not appropriate to provide incentives for shared savings within PCMH+ for individuals who are terminally ill.

The state assures that full Medicaid/Medicare dual eligible beneficiaries who do not fall within one or more of the categories listed immediately above have access to care coordination services included in PCMH+ if those individuals desire such services. Accordingly, the dual eligible individuals described in the previous sentence are excluded from PCMH+ only for purposes of calculating shared savings payments and Care Coordination Add-On Payments, but those individuals will receive Enhanced Care Coordination Activities (and, for FQHCs, also Care Coordination Add-On Payment Activities).

VI. Limitations

The provision of services under PCMH+ shall not duplicate the locating, coordinating, and monitoring of health care services provided under the PCMH program, as described in section 5 of Attachment 4.19-B or as Medicaid administrative services provided by one or more of DSS's Administrative Services Organizations.

VII. Assurances

The following beneficiary protections in section 1905(t) of the Act apply to PCMH+:

1. Section 1905(t)(3)(A), which requires primary care case managers to maintain reasonable hours of operation and 24-hour availability of referral and treatment, is met because beneficiaries are afforded free choice of Medicaid providers.
2. Section 1905(t)(3)(C), which requires primary care case managers to ensure the availability of a sufficient number of health care professionals to provide high-quality care in a prompt manner, is met because beneficiaries are afforded free choice of Medicaid providers and because the PCMH+ assignment methodology ensures that only patients who have a relationship with providers in a Participating Entity are assigned to that Participating Entity.

State: Connecticut
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

3. Section 1905(t)(3)(D), which prohibits discrimination on the basis of health status in enrollment and disenrollment, is met because Participating Entities will be prohibited by contract from activities designed to result in selective recruitment and attribution of individuals with more favorable health status.
4. Section 1905(t)(3)(F), which refers to section 1932 and requires notification to beneficiaries of the program, including how personal information will be used, and disclosure of any correlative payment arrangements, is met because DSS will notify beneficiaries that they have been assigned to a PCMH Participating Entity prior to the start of the Performance Year.

DSS makes the following assurances:

1. The PCMH+ program does not restrict members' free choice of provider as described in 42 C.F.R. § 431.51.
2. Any Advanced Network or FQHC that meets the qualifications established by DSS for a PCMH+ Participating Entity and submits a successful response to the request for proposals in accordance with DSS's procurement process will be allowed to participate in PCMH+.
3. Section 1903(d)(I), which provides for protections against fraud and abuse, is met in that all providers participating in a Participating Entity are enrolled as providers with Connecticut Medicaid and are bound by the rules of the Medicaid program.
4. Section 1902(a)(30)(A), which requires that services under PCMH+ are available to members at least to the extent they are available to the general population, is met because PCMH+ members will have free choice of Medicaid providers.

VIII. Monitoring and Reporting

PCMH+ includes a set of internal monitoring and reporting measures that will be collected and analyzed not less than quarterly. DSS will review the information and follow up with Participating Entities as needed regarding their performance. As a condition of continuing to implement PCMH+ beyond any expiration date specified in Attachment 4.19-B, if applicable, DSS will evaluate PCMH+ to determine if there has been improvement compared with past performance to determine whether the program has achieved, or needs revisions to achieve, the goals of the program, including improving health outcomes and the care experience for PCMH+ members, preserving the PCMH program in particular and the Medicaid program in general and preventing any harm to those programs and/or members of those programs.

State: Connecticut
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

DSS will:

1. Provide CMS, at least annually, with data and reports evaluating the success of the PCMH+ program against the goals of the program.
2. Provide CMS, at least annually, with updates, as conducted, to DSS's metrics.
3. Review and, if necessary, update or revise the payment methodology as part of the evaluation.
5. Make all necessary modifications to the methodology, including those determined based on the evaluation of program success. If changes to the methodology are different from the approved methodology in the applicable federal authority, then DSS will propose appropriate updates to the federal authority.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Connecticut

29. Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary (continued)

g. Integrated Care Models

1. PERSON-CENTERED MEDICAL HOME PLUS (PCMH+) PROGRAM

I. Overview

Person-Centered Medical Home Plus (PCMH+) Participating Entities that generate savings for the Medicaid program and that meet identified benchmarks on quality performance standards will be eligible to receive shared savings payments in accordance with the methodology described below, so long as they comply with measures of under-service. Shared savings payments will be made to qualifying Participating Entities following the end of a Performance Year. Once data is collected and analyzed at the end of a performance year, savings payments will be made to qualifying Participating Entities no later than the last day of December following the end of that Performance Year. If the Participating Entity is an Advanced Network, the Advanced Network Lead Entity will receive the shared savings payment and distribute the payment among its participating providers according to their participation agreements, which must be approved by DSS before any payments are made.

Shared savings payments are available to eligible Participating Entities through two savings pools. The first pool is an Individual Savings Pool, where each Participating Entity that meets the quality benchmarks will receive a shared savings payment based on a portion of the savings it achieved individually. The second pool is a Challenge Pool that aggregates all savings not awarded to Participating Entities in the Individual Savings Pool such as due to failure to meet identified benchmarks on quality performance standards or because DSS determined that the Participating Entity systematically engaged in under-service for Medicaid members. To be eligible for a Challenge Pool payment, a Participating Entity must improve quality in total year-over-year and must meet DSS's benchmarks on four Challenge Pool quality measures.

In addition, Participating Entities that are FQHCs will receive monthly per-member-per-month (PMPM) payments for Care Coordination Add-On Payment Activities that the FQHC provides to PCMH+ members, as described below.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Connecticut

PCMH+ does not change any other reimbursement methodology that is available to any provider, including providers that are PCMH+ Participating Entities (or providers that are included in PCMH+ Participating Entities, including one or more PCMH practices within a PCMH+ Participating Entity). Accordingly, applicable fee-for-service payments will continue to be made to all qualified Medicaid providers that provide any Medicaid covered service to a beneficiary assigned to a PCMH+ Participating Entity.

II. Covered Populations

For the purposes of calculating shared savings, all Connecticut Medicaid beneficiaries attributed to the Department of Social Services (DSS) PCMH program are eligible for PCMH+ except for the categories of individuals listed as excluded from PCMH+ in Attachment 3.1-A.

III. Assignment Methodology

Eligible beneficiaries (*i.e.*, excluding categories of beneficiaries listed as excluded from PCMH+ in Attachment 3.1-A) will be assigned to PCMH+ Participating Entities on the basis of the PCMH retrospective attribution methodology described in section 5 of Attachment 4.19-B. Beneficiaries may affirmatively select a PCMH practice as their primary care provider. In the absence of beneficiary selection, the PCMH attribution methodology retrospectively assigns beneficiaries to primary care practitioners based on claims volume. If a beneficiary receives care from multiple providers during a given period, the beneficiary is assigned to the practice that provided the plurality of care and, if there is no single largest source of care, to the most recent source of care.

A Participating Entity's assigned beneficiaries are the beneficiaries attributed to its PCMH practices using this methodology less beneficiaries that are not eligible for PCMH+ as provided in Attachment 3.1-A. Even if an Advanced Network includes other providers, only the beneficiaries attributed to the PCMHs (or a PCMH practice entity) in the Advanced Network will be assigned to the PCMH+ Participating Entity.

PCMH+ assignment will occur once annually, and will last for the entire Performance Year (unless during the course of the Performance Year, an individual opts out of PCMH+ or falls into a category of individuals excluded from PCMH+, as described in more detail below).

Assignment will occur on or before November 30th for each entire Performance Year starting on each following January 1st. Beneficiaries will be assigned to only one Participating Entity for each Performance Year. Any change in the beneficiary's PCMH attribution will be reflected in the following year's PCMH+ assignment.

Beneficiaries may choose to opt-out of prospective assignment to a PCMH+ Participating Entity before the implementation date of PCMH+ and also at any time throughout the Performance Year. If a beneficiary opts out of PCMH+, then that beneficiary's claim costs will be removed from the assigned Participating Entity's shared savings calculation; however, this beneficiary's quality data and applicable data regarding measures of under-service (as described in Attachment 3.1-A) will not be excluded. If a beneficiary opts out of PCMH+, the Participating Entity is not required to provide Enhanced Care Coordination Activities to that beneficiary. Additionally, if the beneficiary's assigned Participating Entity was an FQHC, then that FQHC will no longer receive the Care Coordination Add-On Payment for that beneficiary.

If, over the course of a Performance Year, a PCMH+ member moves into a population that is not eligible for PCMH+ (see Attachment 3.1-A), that change has the same effect as if an individual opts out of assignment to a PCMH+ Participating Entity, as described immediately above.

IV. Benefits Included in the Shared Savings Calculation

All Medicaid claim costs for covered services will be included in the shared savings calculations described below, except for: hospice; long-term services and supports (LTSS), including institutional and home and community-based services; and non-emergency medical transportation (NEMT) services. Participating Entities do not need to deliver all defined benefits; rather, the cost of all benefits provided to an assigned PCMH+ member, regardless of the specific provider that performed each service, will be included in the shared savings calculation.

V. Shared Savings Payment Methodology: Individual Savings Pool

A. Individual Savings Pool Quality Measures

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Connecticut

The quality measures applicable to the payment methodology are described in Attachment 3.1-A. Specified quality measures apply to a Participating Entity's Individual Savings Pool payment, other specified quality measures will be used in calculating the Challenge Pool payment, and a final category of specified measures will be reporting-only measures and will not be included in the shared savings payment calculation.

B. Individual Savings Pool Quality Scoring

The Participating Entity's shared savings payment in the Individual Savings Pool will be determined in part by the Participating Entity's total quality score. A Participating Entity's total quality score will be based on three components of quality measurement (maintain quality, improve quality, and absolute quality) for each of the nine quality measures. A maximum of one point is available for each component of quality measurement for each measure:

1. Maintain Quality: One point is awarded if a Participating Entity's Performance Year quality score is greater than or equal to its Prior Year score. (A statistically significant threshold may be established based on historical quality measure data to account for annual variation, which results in lower scores).

2. Improve Quality: A Participating Entity will earn points in accordance with the sliding scale included below based on its year-over-year performance (quality improvement trend) against the comparison group's quality improvement trend.

Improvement Above the Comparison Group's Quality Trend	**Points Awarded**
Less than or equal to Comparison Group's quality trend	0.00
Between 0.00% and 32.99%	0.25
Between 33.00% and 66.99%	0.50
Between 67.00% and 99.99%	0.75
100.00% or greater	1.00

3. Absolute Quality: A Participating Entity will earn points in accordance with the sliding scale included below for its ability to reach absolute quality targets, derived from the Comparison Group's quality scores.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Connecticut

Performance Measured as Percentile of Comparison Group Performance	Points Awarded
49.99% or less	0.00
Between 50.00% and 59.99%	0.25
Between 60.00% and 69.99%	0.50
Between 70.00% and 79.99%	0.75
80.00% or greater	1.00

To calculate each Participating Entity's total quality score, its points will be summed and then divided by a maximum score of 27 points (three possible points per quality measure with nine total quality measures). The total quality score, expressed as a percent, will be used in calculating the portion of a Participating Entity's Individual Savings Pool that will be returned to the Participating Entity as shared savings.

C. Individual Savings Pool Calculation

Each Participating Entity's Individual Savings Pool will be funded by savings it generated during the Performance Year. The 12-month period of the Performance Year will be January 1, 2017 through December 31, 2017, and the prior year will be January 1, 2016 through December 31, 2016. As described in more detail below, the calculated savings will be subject to a minimum savings rate (MSR), limited by a savings cap, and multiplied by a sharing factor to generate the available Individual Savings Pool shared savings payment amounts, if any.

For each Participating Entity, the calculation of savings will be based on the extent to which the Participating Entity achieved a lower cost trend than the Comparison Group. For the Performance Year from January 1, 2017 through December 31, 2017, the Comparison Group will consist of all FQHCs and non-FQHC full DSS PCMH practices that have at least 2,500 attributed PCMH+ eligible Medicaid members and have full PCMH status in the DSS PCMH program but are not participating in PCMH+, except that DSS may exclude one or more practices from the comparison group in order to ensure statistical validity. Based on the number of eligible FQHCs and PCMHs that elect to participate in the PCMH+ Program in Performance Years occurring after calendar year 2017, the Comparison Group may be adjusted to include additional practices to provide a Comparison Group that is sufficiently large to be statistically valid.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Connecticut

Savings will only be calculated based on PCMH+ members who remain assigned for at least 11 months of the Performance Year. Cost data of members who opt out of PCMH+ will not be used in the calculation of shared savings. In addition, to avoid unwanted bias due to outlier cases, for each PCMH+ member, annual claims will be truncated at $100,000, so that expenses above $100,000 will not be included in the calculation.

The first step in calculating savings is to derive the Prior Year Cost and the Performance Year Cost for each Participating Entity and for the Comparison Group. Risk adjustment methods (based on existing Johns Hopkins Adjusted Clinical Groups (ACG) retrospective risk scores) will be used to adjust both Prior Year and Performance Year costs for underlying differences in illness burden. The Comparison Group Trend is derived as the Risk Adjusted Performance Year Cost divided by the Risk Adjusted Prior Year Cost.

A Participating Entity's Risk Adjusted Expected Performance Year costs will be developed by multiplying the Entity's Risk Adjusted Prior Year Cost by the Comparison Group Trend. A Participating Entity's savings will be the difference between its Risk Adjusted Expected Performance Year costs and its actual Risk Adjusted Performance Year costs. Participating Entities that demonstrate losses (i.e., higher than expected expenditures for beneficiaries assigned to the Participating Entity) will not return these losses.

*Savings = (Risk Adjusted Prior Year Costs * Comparison Group Trend) – Risk Adjusted Performance Year Costs*

Minimum Savings Rate: A Participating Entity's risk-adjusted savings must meet the MSR requirement, which is greater than or equal to 2% of the expected Performance Year Costs. If a Participating Entity meets the MSR requirement, then the first-dollar savings (*i.e.*, all savings generated, including amounts below the MSR threshold) will be considered as savings. If a Participating Entity does not meet the MSR requirement, its savings will not be considered. Likewise, losses between 0% and -2% will not be considered credible when deriving the aggregate program savings.

*MSR Adj. Savings = IF (Savings ≥ 0.02 * Expected Risk Adj. Performance Year Costs, Savings, 0)*

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Connecticut

Savings Cap: A Participating Entity's savings will be capped at 10% of its Risk Adjusted Expected Performance Year Costs, so that any savings above 10% will not be included in its Individual Savings Pool.

*Capped MSR Adj. Savings = Min (MSR Adj. Savings, 0.10 * Expected Risk Adj. Performance Year Costs)*

Sharing Factor: If a Participating Entity has savings following the calculation steps above, these savings will be multiplied by a Sharing Factor of 50%. The resulting amount will form the Entity's Individual Savings Pool.

*Individual Savings Pool = Capped MSR Adj. Savings * 0.50*

D. Individual Pool Shared Savings Calculation

For each Participating Entity, the Individual Savings Pool Shared Savings payment, if any, is equal to the Individual Savings Pool times the Total Individual Pool Quality Score defined above.

*Individual Savings Pool Shared Savings = Individual Savings Pool * Total Quality Score*

VI. Shared Savings Payment Methodology: Challenge Pool

A. Challenge Pool Eligibility

To be eligible for a Challenge Pool payment, a Participating Entity must improve its overall performance year-over-year on the measures that apply to the Individual Savings Pool.

B. Challenge Pool Funding

It is expected that one or more Participating Entities may not receive 100% of their Individual Savings Pool as shared savings payments because of less than perfect scores on the applicable quality measures or because DSS determined that the Participating Entity systematically engaged in under-service for Medicaid members. The amounts not

returned will be aggregated to form a target amount for the Challenge Pool. The Challenge Pool funding is limited so as to ensure that the Challenge Pool payments will not exceed the Aggregate Savings of the PCMH+ program less the Aggregate Individual Shared Savings payments. For this test, the Aggregate Savings of the PCMH+ program is defined as all credible savings and losses for all Participating Entities (*i.e.*, subject to the MSR requirement and subject to all other requirements for calculating available individual savings pool shared savings, as described above).

Aggregate Savings = $\sum$ Savings and losses subject to the MSR for all Participating Entities

Challenge Pool Target = $\sum$ Not Returned Individual Savings Pool Amounts

Challenge Pool Limit = Aggregate Savings – $\sum$ Individual Savings Pool Shared Savings

Challenge Pool Funding = Minimum (Challenge Pool Limit, Challenge Pool Target)

Note: The Challenge Pool Funding cannot be negative.

C. Challenge Pool Quality Measure Scoring

For each of the four Challenge Pool quality measures, Participating Entities that achieve at least the median score (of all Participating Entities) for a Challenge Pool quality measure will pass or get credit for that measure.

D. Challenge Pool Distribution

The amount of the Participating Entity's Challenge Pool payment, if any, will be the product of the number of its assigned PCMH+ members times the number of Challenge Pool quality measures passed, divided by the sum of this statistic across all Participating Entities. As such, it is certain that the full Challenge Pool will be returned. It should be noted that the Challenge Pool payment to any particular Participating Entity is not directly related to its individual savings.

*Challenge Pool Distribution Participating Entity A = (Participating Entity A Number of Challenge measures passed * Number Assigned PCMH+ Members in Participating*

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Connecticut

*Entity A) / (∑ Participating Entity Number of measures passed * Participating Entity Number of Members)*

VI. Care Coordination Add-On Payment Methodology (FQHCs Only)

DSS will make Care Coordination Add-On Payments prospectively to Participating Entities that are FQHCs on a monthly basis using a per-member per-month (PMPM) amount for each beneficiary assigned to the FQHC, using the assignment methodology described above. DSS will factor the Care Coordination Add-On Payments in each FQHC's shared savings calculation. For the Performance Year for dates of service for calendar year 2017, except as otherwise provided below, the PMPM payment amount is $4.50.

For the Performance Year for dates of service for calendar year 2017, the total pool of funds for making Care Coordination Add-On Payments is $5.57 million. Notwithstanding the PMPM payment amount listed above, if DSS determines that this total pool of funds may be reached or exceeded in a calendar month, DSS shall reduce the PMPM amount for that month as necessary in order to remain within the total pool of funds and no PMPM payments will be made for any subsequent months in the performance year.