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State/Territory Name: Connecticut

State Plan Amendment (SPA) #: 20-0009

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Suite 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

December 10, 2020

Ms. Deidre Gifford
Commissioner, Department of Social Services
55 Farmington Ave. – 9th Floor,
Hartford, CT 06105-3730

Dear Ms. Gifford,

On March 31, 2020, the Centers for Medicare and Medicaid Services (CMS) received Connecticut State Plan Amendment (SPA) CT-20-0009 amending Attachment 3.1A/B and 4.19B of the Medicaid State Plan in order to implement various program changes in Wave 3 of the PCMH+ program. This SPA also sets forth the total amount available for care coordination add-on payments to Federally Qualified Health Centers (FQHCs) participants for 2020 and 2021.

We approve Connecticut State Plan Amendment (SPA) CT-20-0009 on December 9, 2020 with an effective date of January 1, 2020 as requested by the State.

Enclosed is a copy of the following approved State plan page:

- Addendum page 17-23 to Attachment 3.1-A
- Addendum page 17-23 to Attachment 3.1-B
- Attachment 4.19-B, Page 32-39

If you have any questions regarding this matter you may contact Marie DiMartino at (978) 330-8063 or by e-mail at Marie.DiMartino@cms.hhs.gov.

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 20-0009

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, 2020

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 2020 $2.6 million
b. FFY 2021 $3.2 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Addendum Pages 17-23 to Attachments 3.1-A and 3.1-B
Attachment 4.19-B, Pages 32-38
Attachment 4.19-B, Page 39

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If applicable)
Addendum Pages 17-23 to Attachments 3.1-A and 3.1-B
Attachment 4.19-B, Pages 32-38
NEW

10. SUBJECT OF AMENDMENT: Effective January 1, 2020, this SPA amends Attachments 3.1-A, 3.1-B, and 4.19-B of the Medicaid State Plan: (1) to implement the various program changes in Wave 3 of the PCMH+ program as detailed in the SPA pages, including the program updates and improvements summarized in the cover letter for this SPA and (2) to set forth the total amount available for care coordination add-on payments to Federally Qualified Health Centers (FQHCs) that are Participating Entities (PEs) in the PCMH+ program for calendar years 2020 and 2021.

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:
[redacted]

13. TYPED NAME: Kathleen M. Brennan

14. TITLE: Deputy Commissioner

15. DATE SUBMITTED:
March 31, 2020

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: March 31, 2020

18. DATE APPROVED: December 9, 2020

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2020

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
James G. Scott

22. TITLE: Director
Division of Program Operations

23. REMARKS:

FORM CMS-179 (07-92)

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

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.

An Advanced Network that includes one or more FQHCs is not required to perform Care Coordination Add-On Payment Activities and is not eligible to receive Care Coordination Add-On Payments.

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)) and/or one or more FQHCs (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

The Advanced Network must demonstrate the same standards across the entire network to coordinate member care. The Advanced Network must perform as a complete system of care coordination, providing both clinical and social care coordination to members. Advanced Networks must be able to share and access all necessary electronic health record information needed to support the health, wellness, and care coordination of all of its assigned PCMH+ members.

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.

Each PCMH practice may participate in only one Advanced Network and cannot change during a Performance Year except that, upon request from an Advanced Network Lead Entity, the Department may approve changes for PCMH+ purposes to reflect changes that occurred in the composition and structure of the Advanced Network, such as due to mergers, acquisitions, dissolutions, sale, and other changes in the formal affiliation of components of and within the Advanced Network.

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:

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

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. Must develop fully integrated, dynamic, interdisciplinary care teams that work in collaboration across the organization and at each service location where members are seen. All members of the care team are to have access to the member records to support seamless care coordination.
8. Must have either a unified system using one single EHR among practice sites or an established system that fully integrates multiple EHRs into one unified system, so that care coordinators in any part of the Participating Entity have access to relevant information for members for whom they are providing care coordination services.
9. Will support the integration of behavioral health services and supports into existing operations.
10. 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.
11. 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.
12. Will participate in quality measurement activities as required by DSS.
13. Will participate in program oversight activities conducted by DSS or its designee to ensure compliance with program requirements.
14. Comply with all requirements of DSS's procurement process for PCMH+.
15. Will not limit a beneficiary's ability to receive services from a provider that is not affiliated with the Participating Entity.

16. Will require all primary care practices within the Participating Entity to have full PCMH status at the time of attribution and assignment for each Performance Year.
17. Must not engage in any activities designed to result in selective recruitment and attribution of members for the purposes of improving the probability of achieving savings and/or demonstrating compliance with under-service prevention requirements.
18. 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.

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 are required to 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, 2020 and apply to Performance Years beginning on or after that date and a description of those activities is 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.

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, 2020 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 from the Program Evaluations for prior years.

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.

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 and participants in any other health home program (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.

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

Meet all requirements of an FQHC under section 1905(l)(2)(B) of the Social Security Act.

1. 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.
2. Operate in Connecticut and meet all federal and state requirements applicable to FQHCs.
3. 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.
4. Identify a clinical director and senior leader to represent the FQHC and champion PCMH+ goals.

An Advanced Network that includes one or more FQHCs is not required to perform Care Coordination Add-On Payment Activities and is not eligible to receive Care Coordination Add-On Payments.

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)) and/or one or more FQHCs (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

The Advanced Network must demonstrate the same standards across the entire network to coordinate member care. The Advanced Network must perform as a complete system of care coordination, providing both clinical and social care coordination to members. Advanced Networks must be able to share and access all necessary electronic health record information needed to support the health, wellness, and care coordination of all of its assigned PCMH+ members.

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.

Each PCMH practice may participate in only one Advanced Network and cannot change during a Performance Year except that, upon request from an Advanced Network Lead Entity, the Department may approve changes for PCMH+ purposes to reflect changes that occurred in the composition and structure of the Advanced Network, such as due to mergers, acquisitions, dissolutions, sale, and other changes in the formal affiliation of components of and within the Advanced Network.

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:

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

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. Must develop fully integrated, dynamic, interdisciplinary care teams that work in collaboration across the organization and at each service location where members are seen. All members of the care team are to have access to the member records to support seamless care coordination.
8. Must have either a unified system using one single EHR among practice sites or an established system that fully integrates multiple EHRs into one unified system, so that care coordinators in any part of the Participating Entity have access to relevant information for members for whom they are providing care coordination services.
9. Will support the integration of behavioral health services and supports into existing operations.
10. 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.
11. 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.
12. Will participate in quality measurement activities as required by DSS.
13. Will participate in program oversight activities conducted by DSS or its designee to ensure compliance with program requirements.
14. Comply with all requirements of DSS's procurement process for PCMH+.
15. Will not limit a beneficiary's ability to receive services from a provider that is not affiliated with the Participating Entity.

16. Will require all primary care practices within the Participating Entity to have full PCMH status at the time of attribution and assignment for each Performance Year.
17. Must not engage in any activities designed to result in selective recruitment and attribution of members for the purposes of improving the probability of achieving savings and/or demonstrating compliance with under-service prevention requirements.
18. 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.

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 are required to 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, 2020 and apply to Performance Years beginning on or after that date and a description of those activities is 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.

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

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.

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 from the Program Evaluations for prior years.

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.

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 and participants in any other health home program (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.

described in more detail below). Assignment will occur on or before December 31st for each entire Performance Year starting on each following January 1st, except for the Calendar Year 2018 Performance Year, in which assignment will occur in or around March 2018. 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 Medicaid eligibility or 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. If a PCMH+ member temporarily loses eligibility for Medicaid but is retroactively reinstated so that there is no gap in continuous eligibility, then each Participating Entity that is an FQHC will receive Care Coordination Add-On Payments for such members for all months of continuous eligibility, including the retroactively reinstated months, but only if the eligibility is restored not later than 60 days after temporarily losing coverage. Otherwise, if a PCMH+ member loses eligibility for Medicaid, that loss of eligibility has the same effect as if an individual opts out of assignment to a PCMH+ Participating Entity.

I. 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 (including such services covered both under the state plan and under waivers); 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.

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II. Shared Savings Payment Methodology: Individual Savings Pool

A. Individual Savings Pool Quality Measures

The quality measures applicable to the payment methodology are described in Attachment 3.1-A. In order to receive Individual Savings Pool or Challenge Pool shared savings payments, the Participating Entity must improve on its Total Quality Score.

B. Individual Savings Pool Total Quality Scoring

The Individual Savings Pool will be determined by the Participating Entity's Total Quality Score. The Total Quality Score will be developed based on the Participating Entity's quality scores (Absolute Quality) and improvement on quality scores (Improve Quality). Each quality measure can generate a maximum of two points - one point for the absolute level of quality achieved and one point for the year-over-year improvement in quality.

1. Absolute Quality: For each quality measure, a PCMH+ PE will earn a maximum of one point in accordance with the table below for its ability to reach Absolute Quality targets in the Performance Year.

The 2020 Absolute Quality targets will be derived from the 75th percentile of all PCMH+ PE quality scores from 2018. The 2021 targets will be derived from the 75th percentile of all PCMH+ PE quality scores from 2019. These targets will be shared with each PE.

Quality Performance Measured Against Quality Target	Points Awarded
Between 0.00% and 74.99%	0.00
75.00% or greater	1.00

2. Improve Quality: For each quality measure, a PCMH+ PE will earn a maximum of one point in accordance with the table below based on its year-over-year improvement compared to the improvement for all of the PCMH+ Performing Entities. The table for each measure will be derived from all Performing Entities for each Performance Year.

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Quality Improvement Measured Against All Participating Entities	Points Awarded
Between 0.00% and 49.99%	0.00
50.00% or greater	1.00

To calculate each PCMH+ PE's Total Quality Score, its points will be summed and then divided by the maximum number of points possible. The Total Quality Score, expressed as a percentage, will be used in calculating the portion of a Participating Entity's Individual Savings Pool.

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 first Performance Year will be January 1, 2017 through December 31, 2017, and the prior year will be January 1, 2016 through December 31, 2016. Each subsequent Performance Year will be January 1st through December 31st of each year and the prior year will be January 1st through December 31st of the previous year. For the 2018 Performance Year, the Performance Year will be measured based on the entire 2018 calendar year for claim cost and quality data. This analysis applies to all Participating Entities, including those who did not participate in PCMH+ for the calendar year 2017 Performance Year and began participating in the program effective on or after April 1, 2018. 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 a comparative trend to be derived from non-participating entities.

Savings will only be calculated based on PCMH+ members who remain eligible for PCMH+ 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.

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The first step in calculating savings is to derive the Prior Year Cost and the Performance Year Cost for each Participating Entity. 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.

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 comparative 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 * comparative 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)*

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)*

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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 Savings 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 Savings Pool Quality Score defined above.

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

III. 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 and improve year-over-year performance on the Avoidable ED Visits and Avoidable Hospitalizations quality measures. To determine eligibility, each Participating Entity's Individual Savings Pool Quality Measures are averaged for the Prior Year and Performance Year, with each measure receiving equal weighting. Each Participating Entity whose Performance Year average is greater than the Prior Year average becomes eligible to participate in the Challenge 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

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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 = ∑ Savings and losses subject to the MSR for all Participating Entities

Challenge Pool Target = ∑ Not Returned Individual Savings Pool Amounts

Challenge Pool Limit = Aggregate Savings – ∑ 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

The Challenge Pool quality score will be determined based on the Participating Entity's Performance Score and Improvement Score on a subset of four Challenge Pool quality measures selected by the Participating Entity from the list of all available Challenge Pool quality measures. The selection of measures will be subject to DSS approval and must be made prior to the start of the Performance Year.

1. Performance Score:
Percentiles will be calculated for each Participating Entity relative to all Participating Entities for each of the Challenge Pool quality measures for the Performance Year. One point will be earned for each Challenge Pool quality measure result above the 75th percentile of all Participating Entities. These points will be summed to create the Performance Score.

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Quality Performance Measured Against All Participating Entities at a Percentile	Points Awarded
Between 0.00% and 74.99%	0.00
75.00% or greater	1.00

2. Improvement Score:
Improvement will be calculated for each Participating Entity relative to their Prior Year score for each of the Challenge Pool quality measures. One point will be earned for improvement on each Challenge Pool quality measure result compared to the Prior Year score.

Quality Improvement Measured Against Prior Year	Points Awarded
No Improvement	0.00
Improvement	1.00

D. Challenge Pool Distribution

To calculate each Participating Entity's Challenge Pool Score, its points will be summed and then divided by the maximum number of points possible. The Challenge Pool Score, expressed as a percentage, will be used in calculating the portion of a PCMH+ PE's Challenge Pool shared savings payment. Each Participating Entity will receive a portion of the Challenge Pool as a shared savings payment calculated using the following equation, which incorporates Challenge Pool Eligibility, the Challenge Pool Score, the Total Quality Score, and Performance Year Member Months (Challenge Pool Payment will be determined by the Total Quality Score from the Individual Savings Pool, the Challenge Pool Score, and the number of member months in the Performance Year):

$$\text{Participating Entity Challenge Pool Allocation} = \frac{\textit{Total Quality Score x Challenge Pool Score x Member Months}}{\Sigma\ \textit{All Participating Entity Total Quality Score x Challenge Pool Score x Member Months}}$$

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

DSS will make Care Coordination Add-On Payments prospectively to Participating Entities that are FQHCs (but not Advanced Networks that include one or more 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 years 2017 and each Performance Year thereafter, 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. For the Performance Year for dates of service for calendar year 2018, the total pool of funds for making Care Coordination Add-On Payments is $6.1 million. For the Performance Year for dates of service for calendar year 2019, the total pool of funds for making Care Coordination Add-On Payments is $6.6 million. For the Performance Year for dates of service for calendar year 2020 and all subsequent calendar years, the total pool of funds for making Care Coordination Add-On Payments is $6.36 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.