

State Demonstrations to Fully Integrate Care for Dual Eligible Individuals
State of Connecticut Response to CMS Solicitation RFP-CMS-2011-0009

High-Level Description of Connecticut's Proposed Approach to Integrating Care (L.1.2.)

In 2007, dual eligible individuals represented 19% of Connecticut's Medicaid beneficiaries (compared to 15% in the US) and 19% of its Medicare population (21% in the US). However, they accounted for 58% of Connecticut's Medicaid expenditures, fully 50% higher than the national rate of 39% in the US and about 25% of Medicare's expenditures. Approximately 60% are over 65, and 40% are disabled or chronically ill. Medicaid spending per dual eligible in Connecticut is nearly twice the national average (\$27,619 compared to \$15,900 nationally, and Medicaid spending per disabled dual eligible was \$25,902 compared to \$14,755 nationally).

As is the case nationally, Medicare and Medicaid services provided to Connecticut's approximately 100,000 dual eligibles (full and partial benefit dual eligibles) are highly fragmented, duplicative or unnecessary and often delivered in inappropriate settings. Most dual eligibles in Connecticut are enrolled in uncoordinated fee-for-service (FFS) for both Medicaid and Medicare benefits. Coordination of medical care, behavioral health care, long-term care and social supports is critical and lacking. Providers often do not have complete information on an individual, leading to service gaps and duplication in treatment and confusion on the part of dually eligible individuals, their families and caregivers.

To begin addressing these challenges, Connecticut has in recent years undertaken a number of initiatives with advocates, providers, state agency partners, researchers, consultants and stakeholders. Although important steps, these isolated initiatives cannot overcome the fragmentation inherent in the way that services are organized and delivered. No system of providers in any part of the State can measure the value that they provide to dual eligible beneficiaries. Connecticut's goal is to create innovative local systems of care and support that are rewarded for providing better value over time. *Care for dual eligibles is part of a national problem; Connecticut intends to be part of a local and national solution.*

If awarded, Connecticut's demonstration proposal will establish local Integrated Care Organizations ("ICOs") to create a single point of accountability for the delivery, coordination and management of primary, preventive, acute and behavioral health, integrated with long-term supports and services and medication management for dual eligibles. The ICO model features partnerships among multiple provider types and is facilitated by health information technology and electronic data gathering. This new integrated care program will offer dual eligibles a health home where they may access a seamless continuum of enhanced medical, pharmacy, behavioral and long-term services and supports under one program. In addition, because Connecticut's primary care system is predominantly comprised of small group practices, this application will demonstrate how these practices can affiliate with larger, fully-resourced primary care centers to enhance primary care while maintaining maximum freedom of choice for dual eligibles, a model that can be applied to other states with similar systems.

Most importantly, the State will align financial incentives to promote value – the enhancement of quality of care, the care experience and health outcomes at lower overall cost to the Medicare and Medicaid programs. Quality and outcome measures will focus both on medical service outcomes, as well as the effectiveness of home- and community-based services (HCBS) and supports, emphasizing individual satisfaction with the person-centered and disability competent care process. The State will establish risk-adjusted global budgets for the purpose of assessing the ICO's effectiveness in managing overall cost, while retaining existing Medicare and Medicaid benefits and FFS reimbursement.

Connecticut considered a capitated model to integrate care, similar to the Medicare Advantage Special Needs Plans (SNPs) for Dual Eligibles; however, such a model was felt not to be in the best interest of either dual eligibles or the Medicare and Medicaid providers serving them at this time. Thus far, Connecticut's two participating SNPs do not have significant dual eligible participation (3,908 dually eligible enrollees as of January 1, 2011). Instead, attribution of duals to local systems in a FFS model that supports person-centered planning and reliable measurement of value are the most significant structural innovations of this proposal. These elements will provide the accountability and transparency to drive improvements in performance over time.

Recent Initiatives

Connecticut is well-positioned to develop a demonstration proposal for implementation in 2012, with a solid foundation of activities upon which to build the demonstration design. In formulating the demonstration design, Connecticut is drawing from experience on multiple fronts including, but not limited to:

- **Stakeholder Consultation** through the Connecticut Medicaid Care Management Oversight Council, which was established in legislation (CGS 17b-28) as a collaborative body consisting of legislators, Medicaid consumers, advocates, health care providers, insurers and state agencies to advise and oversee the design and implementation of Medicaid care management initiatives. The Oversight Council consulted on the preparation of this proposal and is planning a comprehensive subcommittee structure comprised of people who are dually eligible, providers, advocates and state agencies to oversee the preparation and roll-out of the demonstration application.
- **State Unit on Aging initiatives for chronic care** using the Eric Coleman model of transitional coordination with Aging and Disability Resource Centers, coupled with Stanford University Chronic Disease Self-Management Program.
- **Primary care/behavioral health pilot integration initiatives**, funded by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and by the Department of Mental Health and Addiction Services (DMHAS), seeking to integrate medical, psychiatric and substance abuse treatment services, including co-location of services in local mental health agencies.
- **Behavioral Health Partnership**, administrative service organization (ASO) care management initiative expansion to include dual eligibles under the joint direction of the Department of Social Services (DSS), DMHAS and the Department of Children and Families.
- **University of Connecticut initiatives** focused on dementia care and medication management in a medical home model.
- **Data analysis** of the Medicaid expenditures, top diagnoses and service utilization of dual eligibles.
- **Money Follows the Person** evaluation of the Unmet Needs in the Connecticut Home Care Program for Elders (CHCPE) waiver to identify service gaps in service for elders who are vulnerable for transition from community to nursing home.
- **Centers of care focused on geriatrics**
- **PCMH accreditation** that is gaining momentum in the primary care provider community and is critical to supporting the core primary care “hub” concept that will be central to the demonstration design.
- **Engagement of experts** to understand best practices for care coordination in other states and how they may be applied specifically to this demonstration model.
- **Partnership with other state agencies** as programs that serve dual eligibles do not rest with any one state component.
- **Connecticut Multi-Payer Advanced Primary Care Demonstration Application** as the foundation to design primary and long-term care (LTC) enhancements in the demonstration to address breakpoints in care around transitions, avoidable hospital readmissions, care coordination for high-risk patients and behavioral health needs of dual eligibles.
- **Evaluation of Connecticut HCBS Waiver Programs Report conducted by Mercer** to streamline, integrate and simplify current HCBS waiver processes so that staff can better focus on the consumers to be served and provide the infrastructure necessary to administer the duals demonstration.
- **New, flexible MMIS and data warehouse** to support the benefit design and enhanced data and analytical requirements of the proposed demonstration.

Connecticut recognizes the opportunity this demonstration program offers to coordinate and combine the elements of past lessons and introduce new approaches, as well as national best practices to provide a cohesive system of care that drives improved quality and outcomes, lowers health care costs and enhances the experience for providers, dual eligibles and their families.

Targeted Population

Connecticut is proposing a phased-in approach that will offer participation initially to all (full and partial benefit) dual eligibles ages 65 and over receiving care in nursing facilities and the community. Dual eligibles enrolled in a HCBS waiver other than the Home Care Program for Elders HCBS waiver will not be included in the initial implementation. Providing this opportunity first to elderly dual eligibles will compliment the many current

initiatives in Connecticut focused on the geriatric population, while providing time to develop the model further for participation by younger and disabled dual eligibles. Connecticut estimates approximately 13,000 to 20,000 individuals will participate in the initial implementation of the demonstration, representing approximately 20% to 30% of dual eligibles ages 65 and over. (Note: dual eligibles currently enrolled in Medicare Advantage plans would remain enrolled in those plans, unless an individual chooses otherwise.)

Beginning in the third year of implementation, Connecticut will expand eligibility to dual eligibles under 65 and older dual eligibles with disabilities and incorporate features into the ICO model necessary to meet the unique needs of those populations. Earlier implementation will be an option, if supported by dual eligible recipients and the stakeholder community and determined to be feasible. Concurrently, additional ICOs will be accepted into the demonstration with the goal that all dual eligibles will have at least one ICO available to them by the end of the third year.

Beginning with dual eligibles ages 65 and over, Connecticut will provide outreach and education about the ICO option. Individuals under the care of primary care providers associated with a participating ICO will be attributed to that ICO. ICO attribution procedures will be designed to ensure that a large enough number of individuals participate to ensure the feasibility of the project. Such attribution methodologies as "Opt Out" and "Opt In" will be part of the design discussion. Attribution will be accomplished on the basis of an educational process about the value of the ICO, with documentation that each individual has been fully informed of the initiative, and his or her rights, with respect to participation. Once participating in the demonstration and with an ICO, dual eligibles will have the freedom of choice to switch to another available ICO or to dis-enroll from the demonstration at any time. Participants will be permitted to seek care through their choice of provider whether or not the provider is affiliated with his or her ICO.

The State estimates that 13,000 to 20,000 of the 100,000 dual eligibles will participate in the demonstration initially, depending on which ICOs are selected to participate and the number of duals that receive care from the associated primary care providers.

Covered Benefits

Dual eligibles participating in the demonstration will have access to the full range of primary, acute, specialty, behavioral health, pharmacy, HCBS and institutional services as currently covered and provided by Medicare and Medicaid. Connecticut currently provides HCBS services to dual eligibles over the age 65 through the Medicaid State Plan and through a broad menu of services covered under a Section 1915(c) elder waiver. In addition, through general revenue, Connecticut funds a HCBS program for elders who do not meet the financial and level of care eligibility criteria of the elder waiver. Together, HCBS provided through the Medicaid State Plan, the elder waiver and the elder HCBS program funded through general revenue provide a comprehensive, flexible service and support package supporting elders in the community and helping avoid unnecessary institutionalization and hospitalization.

Medicaid State Plan Covered Benefits: This package of services provides benefits to participants regardless of level of care. Connecticut's covered benefits include home health services such as home health aides, nursing, occupational therapy, physical therapy, and speech therapy. Connecticut also offers a rehabilitation option as well as addiction and substance abuse services through clinics.

Elder HCBS Program Funded through General Revenue: This state funded 'wrap around' program offers HCBS benefits to those who do not meet the level of care eligibility requirements for the elder waiver. Benefits under this program are available to persons with as few as one 'critical need' Critical needs include assistance in bathing, dressing, toileting, transferring, eating, medication administration and/or meal preparation. The comprehensive benefit package includes: homemaker, companion, personal care, chore, adult day care, personal emergency response system, mental health counseling, transportation, minor home modifications, skilled nursing, home health aide services and assistive technology. In addition, Connecticut extends the benefit of HCBS to those who meet level of care requirements for the elder waiver but do not meet financial eligibility for Medicaid under any coverage group, including the elder waiver.

Elder waiver: Connecticut provides the same benefit package to those participants eligible for the elder waiver as it does under the elder program funded through general revenue.

As Connecticut expands the demonstration to include all dual eligibles, individuals will have access to HCBS offered through the Personal Care Assistance Waiver, the Acquired Brain Injury Waiver, the Individual Family and Support Waiver, the Comprehensive Waiver and the Mental Health Waiver. All waiver covered benefits will

be discussed in more detail during the planning phase of the demonstration. The State will consider the ability to create customized benefit packages not currently available under Medicare or Medicaid to serve the needs of demonstration participants provided sufficient savings are generated in the initial year(s) of the program. At least initially, the Medicare Part D pharmacy benefit will continue to be provided through the Part D benefit plans. However, the demonstration will immediately expand upon the work begun by the University of Connecticut, School of Pharmacy, and funded by the Centers for Medicare & Medicaid Services (CMS) Transformation Grants, to provide medication management services in a medical home model. All demonstration participants will have access to a pharmacist, as a member of the team-based approach, to optimize medication management and patient safety focused on chronic disease and care transitions.

Delivery System

The State intends to redesign the current Medicare and Medicaid delivery system for dual eligibles through contracts between DSS (or the “Department”) and new ICO provider consortia that feature attribution of dual eligibles to these local partnerships in care and reliable measurement of quality and value. The demonstration will test a model that will combine the use of these new ICOs together with support from the State and outsourced administrative functions. Connecticut anticipates requesting technical assistance from the CMS Innovations Center and the Federal Coordinated Health Care Office on the potential impact that forthcoming rules from CMS on standards for accountable care organizations (ACOs) may have on the model design and whether Connecticut might successfully build upon those standards to build a dual eligible ACO model in this demonstration.

The ICO will provide a single point of accountability for the delivery, coordination and management of primary, preventive, acute, specialty, and behavioral health services; long-term supports and services; and medication management. ICOs will feature local primary care centers or “hubs”. Through these primary care centers, ICOs will make available a broad array of healthcare professionals and services to support, integrate and coordinate care for dual eligibles. The centers will be particularly well-suited to serve individuals who have multiple serious, chronic or disabling medical conditions, whose conditions may be unstable and who require, or will likely require, long term care supports. For all individuals, the goal of the model is to continue the successful relationships that so many dual eligibles have with their existing array of providers, while strengthening the collaboration among these providers and aligning incentives.

Connecticut envisions each ICO as having one or more primary care centers for the provision of comprehensive primary care services and supports. At least one such primary care center within each ICO must be designated Tier 1, which means it includes the full complement of core service team members and associated service enhancements as follows:

Core Team Members:

- Primary care physicians (PCPs)
- Registered nurses or advanced practice registered nurses for ongoing patient support during and between regular visits, as well as in hospital or rehab facilities to facilitate communication and discharge planning
- Care coordinators
- HCBS case managers
- Pharmacist to provide consultation for persons with multiple chronic medications
- Behavioral health practitioners with geriatric expertise

Service Enhancements:

- Comprehensive initial and annual assessments of medical, behavioral, social, transportation, medical equipment, homemaker, meal prep and delivery, fall assessment, adult day care and language interpretation needs for all participants
- Home visit upon enrollment and during subsequent annual comprehensive assessments
- Preferred specialty care networks, including streamlined access to at least three specialties that meet the chronic illness needs of the elderly and disabled population
- Assistance with linking to services, such as transportation, specialty medical services and needed social services and supports

- Person-centered care plans developed with and by dual eligibles and family caregivers, guardians or circles of support that provide for the maximum amount of self-direction desired
- Medication management services through an onsite consultation with the PCP and pharmacist, as required by the individual's needs
- Hospital, rehabilitation and nursing home transition coordination, including medication reconciliation by the pharmacist
- Dementia assessment, with family education and support curriculum
- Nutrition counseling
- Intensive care management services, in addition to care coordination, to effectively manage transitions and communicate across the various provider types
- Onsite level of care assessments with linkage to state funded or waiver HCBS
- Enhanced communication through use of electronic health records and an electronic person-centered care plan
- Warm line access to a designated team lead to address questions about health, treatment, housing, family, transportation, safety or other issues and to long term services and supports
- Access to a Dual Eligibles Ombudsman to be established by the State

A variety of entities may be qualified to serve as Tier 1 primary care centers for the provision of enhanced services. In the initial phase, it is anticipated that these centers may be established by federally qualified health centers (FQHCs), large physician groups, hospitals, nursing facilities, adult day care centers and local mental health or substance abuse treatment agencies.

In addition to the Tier 1 primary care centers, ICOs will be encouraged to include small group primary care practices that provide less than the full complement of team members and associated service enhancements. These Tier 2 primary care sites will receive support from a Tier 1 center.

In addition to the primary care centers and small group practices, the ICO will include extended service team members comprised of hospital providers, nursing homes, other primary, acute and specialty providers, rehabilitation, behavioral health, HCBS services and pharmacy providers connected as a virtual team through electronic communications or in-person, as needed. The ICO will also be expected to enter into agreements with existing Area Agencies on Aging, Aging and Disability Resource Centers and Independent Living Centers.

Connecticut will establish provider partner composition requirements, quality and other standards for ICO certification (such as assessment protocols, data collection and integration, information sharing, quality assurance and staff education and training) and seek qualified applicants through a Request for Application (RFA). The process for developing ICO provider requirements and selecting ICO contractors will be fully transparent and available to all interested parties, including the public. Based on discussions to date, the State anticipates that a broad range of providers, including geriatric centers, nursing homes, hospital systems, physicians groups, FQHCs, local mental health and substance abuse treatment agencies, home- and community-based service providers and adult day health centers will be interested in participating in ICOs. Dual eligibles receiving services from selected ICO primary care providers will determine the initial number of duals to be served, but the State estimates that approximately 13,000 to 20,000 duals, age 65 and over, will participate initially in three to six ICOs statewide.

At a minimum, ICO qualifications will include:

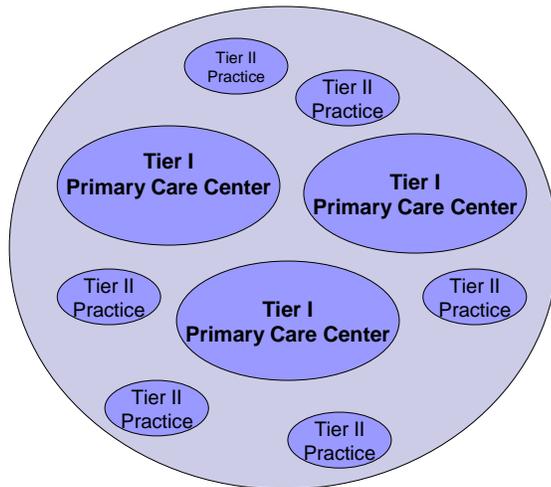
- Comprehensive array of ICO provider partners that utilize cultural and disability-competent, person-centered multi-disciplinary teams, with input from family caregivers, guardians or circles of support
- One or more primary care centers (Tier 1) that are certified as patient-centered primary care medical homes by NCQA (at least Level 1 upon entry, with eventual progression to Level 3), or another model accepted by the State, such as the Joint Commission
- Shared information technology and electronic health record (EHR) interoperability for PCPs and associated specialty providers, Web-based EMRs, encrypted e-mail for all providers and ability to access an electronic person-centered care plan maintained by an ASO or other entity
- An advisory board with representation that includes dual eligibles, family caregivers and advocates

- Mechanisms to promote disability and cultural competence among ICO participating entities, their staff and participating provider partners

The State will continue to provide such functions as claims payment, oversight, audit functions and administrative hearings. The State will contract with an ASO for functions, such as attribution, customer call-center, satisfaction surveys and data aggregation and analytics.

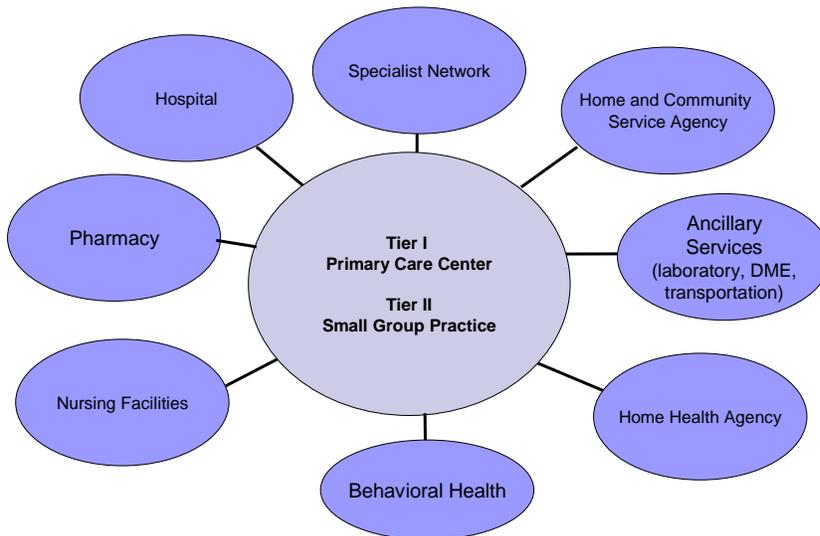
Integrated Care Organization

Small Group Primary Care Practices



Integrated Care Organization

Hub and Spoke



Quality and Performance

Performance measurement is a critical component of the demonstration and will be used to guide continuous improvements in service delivery and program effectiveness. Measurement domains will focus on clinical efficiency, access to care, quality of care and outcomes of care across the continuum of health services and the member population, as well as measures to evaluate the level of implementation of health information technology that is necessary to drive system transformation for the promotion of safe, effective, patient-centered care. Additionally, perception of care and satisfaction among participants are critical components and will be assessed on an annual basis. Measurement processes, data collection and analysis will examine overall program and ICO-specific performance on a quarterly and annual basis. Development of ICO report cards or dashboards will be utilized for public reporting purposes, as well as for use in distributing any shared savings generated from the program.

While the methods, frequency and benchmarks for performance measurement will need to be established through continued stakeholder input, there are a number of publicly available, evidence-based measurement sets that are currently utilized within the Medicare and Medicaid programs that provide the initial building blocks for performance evaluation. These include measures available from HEDIS and CAHPS, as well as measurement sets such as MDS for Nursing Facility, OBQII/OASIS data for home health and ACOVE-3 measures for gaps in care. It is the intent of the demonstration program to continually build upon the base set of measures with the understanding that, as the program matures, as health information systems come “on line” and as additional evidence and stakeholder input is received, measurement sets will be adjusted to ensure continuing alignment with programmatic goals and objectives.

The demonstration program will pull measures from all domains in an effort to monitor ongoing performance, as well as inform the broader programmatic goals of the demonstration.

Demonstration and ICO Financing

The State proposes to use a shared savings model for this demonstration. For the shared savings model, CMS will retain 30% of the total savings realized in each year of the demonstration, while the remaining 70% will flow to the State. The savings will be measured against a projected per-member per-month (PMPM) budget target. The PMPM budget target will be calculated based on the approach used by the CMS Medicare Advantage program for the dual eligible special needs plans, which includes risk-adjusted payments and adjustments for Medicare program changes and fee schedule changes that are outside of the control of the State. Additional adjustments may be needed to reflect any risk characteristics that are not currently reflected in the CMS Medicare Advantage program rate-setting methodology, such as differentiation by nursing home versus community. Furthermore, any savings, up to a maximum of the State’s contribution of the care management fee (described below), will accrue 100% to the State before the shared savings formula is applied.

The State will share any combined Medicare and Medicaid savings with the ICOs using a combined Medicare and Medicaid budget target. The Medicare target will be calculated based on the approach outlined above. The Medicaid target will be calculated using an actuarially sound methodology and risk-adjusted. In addition, the State will initially fund a PMPM care management fee for those dual eligible beneficiaries attributed to an ICO. The ICO will use the care management fee to help fund infrastructure costs, retain additional staff positions, perform assessments and support incentive payments to its provider partners. Any shared savings between the State and the ICO would be reduced by the PMPM fee, so that the ICO is expected to generate savings at least equal to the care management fee paid by Medicaid before any additional savings are paid to the ICO by the State. The amount of shared savings returned to the ICO will depend on the ICO’s ability to meet quality and outcome targets, including measures of beneficiary satisfaction.

Savings are expected to be achieved through reduced hospitalizations and institutionalizations, reduced emergency room visits and reductions in unnecessary or duplicative services. When savings are achieved and disbursed to the ICOs from the State, part of the savings will be expected to be directed to the practices and network partners in the form of performance incentives to promote safe, effective, patient-centered care. The State will be responsible for defining the overall target and expectations for the ICOs.

The ICOs will be responsible for tracking and disbursing the appropriate allocation of funds to ICO provider partners based on the pre-defined performance incentive metrics. The metrics are to be based on quality and outcome measures, as well as measures of beneficiary satisfaction and targets for infrastructure improvements. We are aware of the potential issues this model may encounter regarding federal trade and anti-trust regulations. We are optimistic that these issues can be addressed and will work to structure the model in accordance with forthcoming federal guidance.

The State will be accountable for the payment of additional benefits and services made available through the demonstration. Additional benefits will be decided based on the amount of savings accumulated throughout the demonstration period.

Initially, the State will pay providers at the prevailing Medicaid fee schedules. CMS will continue to process claims for Medicare. During the demonstration planning process, the State, the Care Management Oversight Council, ICOs and providers will work together to examine alternative reimbursement models, including but not limited to, global capitation, partial capitation and episode-based bundled payments to be phased-in during the demonstration.

Overview of State Capacity and Infrastructure (L.2.2)

Connecticut has undertaken major investments in State and contractor resources to support improvements in care and service delivery for Medicaid aged, blind and disabled (ABD) and the Low Income Adult (LIA) populations, including dual eligibles. The investments are of a scope and magnitude that far exceed any previous initiatives for this population. They are intended to support the transformation of the service delivery system and the data available to participants in that system to continuously drive better performance, in the manner envisioned in this proposal. Connecticut is uniquely situated to deploy resources immediately, as needed, to begin the work necessary to prepare a comprehensive demonstration proposal and implement in 2012.

Contractor Resources:

The above investments began in 2010 with a joint procurement with the Department of Mental Health and Addiction Services of an ASO to manage behavioral health services for all of Medicaid, including dual eligibles, with implementation expected to be completed by Spring, 2011. In March, the Department will also procure an additional ASO to manage all medical services for Medicaid ABD, including dual eligibles, for implementation by the end of 2011. Each ASO will provide centralized customer service, utilization management, intensive care management and health informatics necessary to support population health management and to implement provider and ICO performance profiling. In addition, these ASOs will provide technical assistance in the field to support the emergence of medical homes, health homes and ICOs. The behavioral health ASO will focus on provider initiatives to integrate behavioral health and medical in both medical and behavioral health settings. ASO-based care management resources will be reduced over time as provider-based care management capacity increases with the gradual expansion of medical homes, health homes and ICOs. Establishing these specialized ASOs by 2011 builds the foundation for the proposed dual initiative. State staff will be able to leverage and learn from the experiences gained from the ASO model for the Medicaid ABD and LIA non-dual eligibles populations and further tailor the program management activities of the ASOs and ICOs to support the unique needs of the dual eligibles. The Department has specific statutory authority and funds appropriated to support these initiatives.

State and Consultant Resources:

DSS administers the Medicaid program and will take lead responsibility for the design of the demonstration, in consultation with the Department of Developmental Services (DDS) and DMHAS. Within the department, the dual eligibles demonstration will be overseen by the Medical Care Administration (MCA) division, which is also responsible for program management, policy, rate setting and operations related to all of the department's medical assistance programs. Medical Care Administration is reorganizing to devote 12-18 medical professional, program management and data analytic staff to support the duals initiative and related efforts for other Medicaid eligible populations. The department intends to add four to five staff to the Medical Operations division to support the enrollment of ICOs and to administer the administrative payments through the MMIS.

The Department's Division of Financial Management and Analysis (DFMA) is responsible for budget, federal claiming and actuarial services. DFMA has staff responsible for performing actuarial services and for overseeing actuarial contracts. The department also intends to use its contract with Mercer to perform many of the planning activities necessary to support this proposal. Mercer has performed actuarial and EQRO services under the department's direction for its capitated Medicaid managed care program for more than ten years.

Within the department, Dr. Robert Zavoski will lead the project with support from key staff in MCA and DFMA, including Mark Schaefer from MCA and Lee Voghel from DFMA. The Department will use demonstration planning funds to retain an external consultant to provide project management for the development of the demonstration application. This consultant will be responsible for analyzing current state agency staff resources and will be required to make recommendations for staffing, organizational changes and consultative support necessary to provide full support for the duals initiative.

Description of Current Analytic Capacity (L.2.3)

The State has access to the Medicare 5% sample data files but does not currently have access to the full Medicare data files. The State is currently pursuing the attainment of the full Medicare data files through a data use agreement with CMS. The State is also prepared to use the data that CMS anticipates providing shortly to link the Medicare with the Medicaid data and conduct more detailed analyses. Connecticut has a data warehouse that allows for easy and timely access to all eligibility, Medicaid FFS and encounter claims data. Connecticut has an in-house actuarial unit, as well as an ongoing contractual relationship with Mercer to provide additional analytical capacity to link the data and perform actuarial and data analyses. The State plans to build on the studies previously undertaken to better understand the unique characteristics of the dual populations, identify potential areas to target for performance improvement, review the adequacy of the Medicare Advantage financing payments and assess various risk adjustment approaches for Medicaid.

Summary of Stakeholder Involvement (L.2.4)

Connecticut has engaged a wide variety of stakeholders in the design of the duals demonstration model, including dual eligibles, advocacy groups, provider associations, DDS and DMHAS, legislative staff and researchers. This is a continuation of Connecticut's successful past effort to work collaboratively with stakeholders, such as in the design of the State's MAPCP proposal, consultation with stakeholders, as part of the Mercer review of HCBS waivers and ongoing monthly meetings with consumers, and advocates as part of the MFP demonstration. The demonstration model described here is a direct reflection of the input received from a stakeholder community with diverse needs and interests working collaboratively together for the end goal of high-quality, cost-effective care for Connecticut's dual eligibles. Support for this proposal, particularly from advocates directly representing the needs of dual eligibles and their families is evidenced by the letters of support the State has received from groups including the Medicaid Care Management Oversight Council, Center for Medicare Advocacy, AARP Connecticut, Connecticut Legal Services, Inc., New Haven Legal Assistance Association, Inc., Greater Hartford Legal Aid, Inc., the National Alliance on Mental Illness-CT, the Connecticut Commission on Aging, the University of Connecticut School of Pharmacy, University of Connecticut Health Center's Center on Aging, The Connecticut Association of Adult Day Centers, the Connecticut Association of Not-for-Profit Providers For the Aging (CANPFA), the Area Agency of South Central CT, Connecticut Coalition on Aging, the Brain Injury Association, the Connecticut AIDS Resource Coalition, Keep the Promise Coalition, AIDS LIFE Campaign, Connecticut State Independent Living Council, Arthritis Foundation, National Association of Social Workers of Connecticut, CT Oral Health Initiative, Felician Sisters Adult Day Care Center, VNA Community Healthcare, Grasmere by the Sea Adult Day, Community Health Center, Inc., the Connecticut Hospital Association (CHA), the Community Health Center Association of Connecticut (CHCACT), the State Unit on Aging, the Office of the Long Term Care Ombudsman, Connecticut Disability Advocacy Collaborative, Allied Community Resources, Inc., Alzheimer's Association, the Connecticut Department of Mental Health & Addiction Services, several Area Agencies on Aging, and a number of home and community based care and support providers. (These letters will be posted online at www.ct.gov/dss/duals and are available upon request but were not provided due to the page limit of the application.) The State will continue seeking meaningful consumer and stakeholder input in program planning, implementation and evaluation of this program and is committed to transparency in the development of the final demonstration proposal. Most importantly, the State is invigorated by the energy and collaboration that stakeholders representing different interests have brought to the model design in support of the goal that all must "pull for the same team" to effectively improve care and the care experience for dual eligibles and their families/caregivers.

Timeframe (L.2.5)

The State estimates being ready to implement in the last quarter of calendar year 2012. The State currently has legislative authority to implement a care management initiative for duals. Connecticut anticipates seeking and receiving any additional legislative authority needed with the ability to implement, via draft regulation in 2011, in advance of the demonstration proposal submission. Additionally, the State will need to issue the RFA in May/June 2011 and select ICOs by early 2012, as well as contract with the outsourced administrative entity. Implementation in Fall 2012 will allow time for these activities, as well as Medicare data analysis, continued stakeholder consultation, provider and enrollee education, establishment of the Dual Eligible Ombudsman, MMIS updates, any necessary State Plan Amendment or waiver activity and other activities to be detailed in the demonstration proposal, as necessary.

Budget and Use of Funds (L.2.6)

Connecticut is requesting \$1,000,000, the entire amount of the funding available through this solicitation, recognizing that additional State funds may be needed to support this important initiative. The requested funding will be used to support project management, data linkage and validation, actuarial analyses, systems assessment and development of performance measurements. The funds will be allocated to consultant resources and to support in-house staff needs. A detailed description of the proposed budget and use of funds, along with required subcontractor information, can be found in Appendix A.

Summary

Connecticut is committed to transforming the healthcare delivery system for dual eligibles. By providing a fully integrated system of care through the ICO model, providing enhanced services, aligning financial incentives across payers and providers and focusing on quality and outcomes, the State fully expects to improve the quality, cost-effectiveness and experience of care for dual eligible individuals. The department has staff and other resources continuing to work through the numerous details of the proposed initiative. Connecticut has invested in developing flexible systems, data analytic tools and infrastructure to aid in the ongoing data collection and analysis needed to support the demonstration. Many stakeholders representing a wide variety of interests provided input throughout this application process, communicated their critical issues and have demonstrated their support of this initiative. Through ongoing stakeholder engagement, the State will refine, enhance and improve the proposed ICO model to ensure that this new integrated delivery system, first and foremost, meets the needs of our dual eligible citizens. Connecticut applauds CMS's vision to support innovation through partnerships with states and is ready to begin that partnership to transform the system of care for dual eligibles in 2012.

Appendix A – Budget Narrative

The Department anticipates the need for both in-house and contractual support services in several key areas to support this project. The areas of support include the following activities:

- Linkage of the distinct Medicaid and Medicare data sets into an integrated data set to facilitate the various analyses required. Data will need to be extracted from the Connecticut Medicaid Management Information System (interChange) and linked to the federal Medicare data set. Assessment of existing data availability, cross-program data definition (Medicare/Medicaid) and specific extract requirements will be necessary. The development of an integrated database of all relevant Medicare and Medicaid data will be the anticipated deliverable. Our anticipated resource for this portion of the project would be Mercer Health & Benefits, LLC, given their significant understanding of Connecticut’s data, the data linkage and associated analytical support necessary for this project.
- Data validation and actuarial analyses. Due to the complexities associated with merging datasets, data validation activities will be provided by the contractor responsible for the dataset development described above. Additional activities will include various data analyses, initial risk adjustment reviews, and budget and savings projections related to the prospective implementation of this effort. As noted above, our anticipated resource for this portion of the project would be Mercer Health & Benefits, LLC, given their significant understanding of the linked data, risk adjustment models and associated analytical support necessary for this project.
- Project design and management support to integrate the required contractual service providers, serve as the project liaison for the State oversight of the project and to develop the final demonstration application. This resource is expected to be an external resource working closely with the key State staff under the direction of Dr. Robert Zavoski that can effectively coordinate all State and contractual activities, having a significant understanding of both Connecticut Medicaid services and the integrated care framework anticipated under this project.
- Development of performance measures to evaluate demonstration model performance and programmatic design. This work will leverage the data integration work described above and informed by stakeholder consensus, data availability, consistency and comparability, as well as by population size and final program design. This scope of work would include stakeholder meetings, identification of different domains for performance measurement, specific measures within the domains, development of technical specifications for each measure and establishment of a “baseline”. The baseline results will be critical in evaluating quality and cost outcomes after program implementation and will serve as the basis for continual improvements in quality, access and efficiency. Evaluation of participant satisfaction will not be included in this scope of work as this information will be gathered post-program implementation to ensure no bias is introduced when comparing baseline results with re-measurement. Connecticut has not yet selected a vendor for this work, but has existing contract resources available.

The following summarizes the estimated contractual budgetary needs by area:

Contractual Services	Estimate
Medicare/Medicaid data set integration	\$150,000
Data validation and analyses, risk adjustment review and budget projections	\$325,000
Assessment/recommendations to develop performance measurement tools	\$350,000
Project design and management support	\$175,000
Total Services	\$1,000,000

This requested level of contractual support and expertise will allow the Department to provide associated internal staffing support within existing resources through this assessment and development phase. It should be noted that one of the project management support deliverables resulting from this planning initiative will be the clear identification of both State and external resource needs necessary to support the implementation/operational phase of this effort.

G.19 Subcontract Consent

Connecticut intends to use the following subcontractor to assist in the completion of the deliverable:

Name	Rate*	Hours	Total Cost
Mercer Health & Benefits, LLC	\$297	1,600	\$475,200

**Estimated average hourly rate exclusive of travel, based on the current contract rates that vary by labor category.*

A copy of the State of Connecticut's contract with the proposed subcontractors along with supporting documentation, as required by FAR Clause 52.244-2, can be made available upon request.