



# STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

25 SIGOURNEY STREET • HARTFORD, CONNECTICUT 06106-5033

March 30, 2011

Richard McGreal, Associate Regional Administrator  
Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
JFK Federal Building, Suite 2275  
Boston, MA 02203-0003

Re: Technical Assistance – Connecticut Medicaid Restructuring

Dear Mr. McGreal:

The State of Connecticut is in the process of undertaking the most significant change in Medicaid health care purchasing since it began its HUSKY Medicaid managed care program for children and parents in 1995. The Department of Social Services (“department”) intends to terminate its current 1915(b) managed care waiver effective December 31, 2011 and replace it with an administrative services organization format extended to encompass the entire Medicaid program. The purpose of this letter is to seek specific permissions from the Centers for Medicare and Medicaid Services (CMS) with regard to the phase out of the waiver and to begin a technical assistance process with respect to the design and implementation of our new health care purchasing strategy.

## **Summary of the Proposed Initiative**

The department is procuring an Administrative Services Organization (ASO) to administer the medical benefits for all of its health care programs. The department’s behavioral health and dental benefits will continue to be administered by other contractors. The department’s primary objective in contracting with a medical ASO is to improve quality of care and the care experience for our clients, while reducing cost. Secondary goals include fostering change in local service delivery through the provision of performance data and technical assistance to support the emergence of person-centered medical homes, health homes, and integrated care organizations. Although this letter refers to a single medical ASO, the department may consider contracting with two ASOs, each assigned to a distinct geographic region.

## **Description of Current Program**

The department currently manages medical benefits under two arrangements. The benefits of individuals who qualify for Medicaid on the basis of age or disability status, as well as low-income adults, are managed under a fee-for-service program. The benefits for individuals who qualify for Medicaid family coverage groups (HUSKY A), Connecticut’s CHIP program (HUSKY B), and Connecticut’s Charter Oak Health Plan are all managed under fully capitated risk arrangements with three managed care organizations. Behavioral

health and dental benefits are administered under administrative services organization arrangements. Pharmacy benefits are administered directly by the department and HP Enterprise Solutions, the department's MMIS claims vendor. A single statewide ASO for non-emergency medical transportation services is expected to be in place by January 1, 2012.

Under Conn. Gen. Stat. Section 17b-261m, the department is authorized to procure an ASO to manage medical services provided to all of the above medical assistance clients. Effective January 1, 2012, the ASO will provide a range of management services including centralized customer call center services, utilization management, care coordination, intensive care management, quality management, reporting, predictive modeling, health risk assessment, provider profiling and other administrative services. The ASO will provide assistance with referrals and appointment scheduling, including accessing EPSDT services, facilitate access to services administered by the department's other ASOs and help individuals to better navigate the health care system. The medical ASO contract will contain financial incentives to encourage the ASO to meet performance targets set by the department. However, the ASO will not contain risk sharing or gainshare provisions.

Clients will use the Connecticut Medical Assistance Program (CMAP) network, which is the department's existing fee-for-service provider network. Claims will be processed through the department's MMIS claims processing system. The ASO will be expected to facilitate monitoring and expansion of the provider network in order to ensure access to necessary medical services. This year, the department will aggressively pursue approaches to health care purchasing that promote improvements in person-centered service delivery and organization, accountability among local health care systems, and better efficiencies and outcomes. The department will begin by supporting the emergence of medical homes for all Medicaid, HUSKY A, HUSKY B, and Charter Oak individuals.

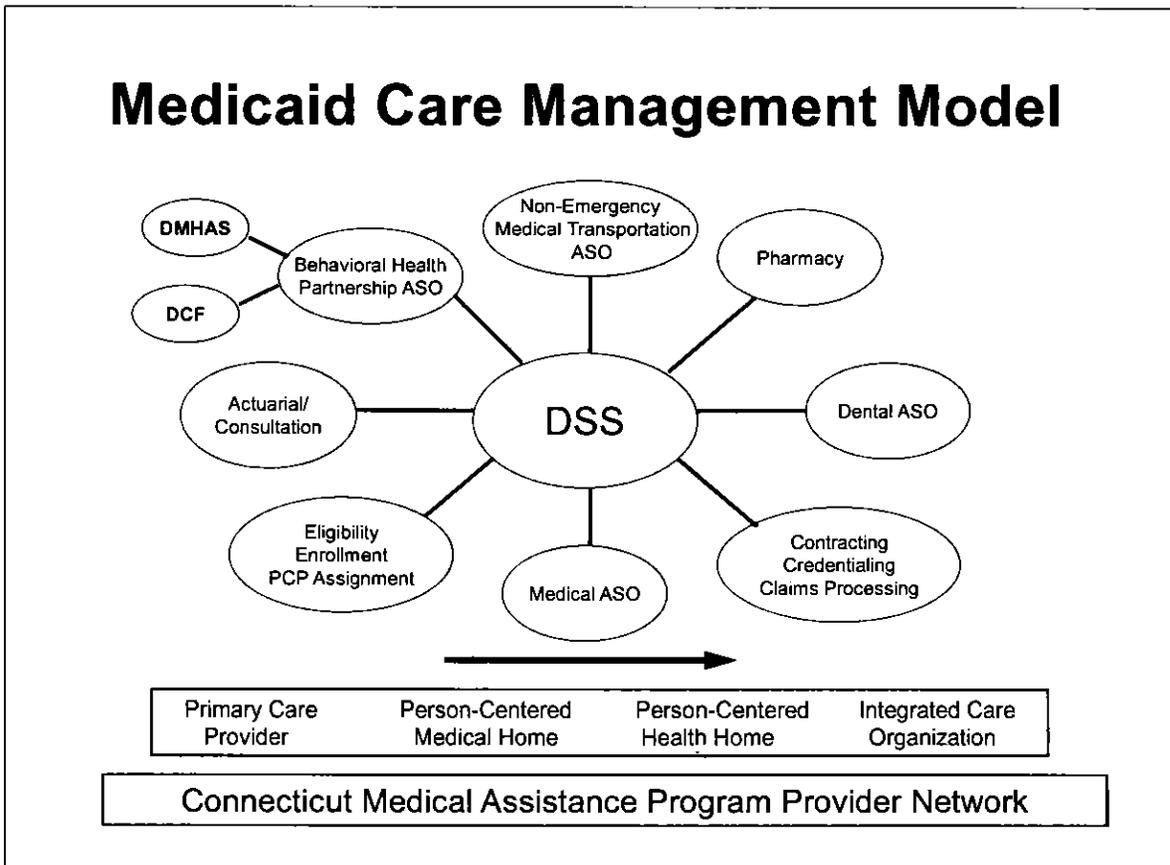
Although there are many definitions of medical home, it is essentially a person-centered approach to providing comprehensive primary care that facilitates partnerships between individuals and their providers and, when appropriate, the individual's family and other supports. The medical home also serves as a focal point for information sharing and referral to specialists and sub-specialists, as well as communication, evaluation and interpretation of specialist recommendations. Medical homes empower individuals to make informed choices regarding their health care and leads to shared decision-making. The medical home typically relies on advanced health information systems to support evidence-based care and includes resources to support the individual's coordination of care. Person-centered medical homes will allow better access to health care, increased satisfaction with the care process, and improved health and health outcomes.

The department will also begin planning for the submission of a state plan amendment to establish health homes, a new opportunity under Section 2703 of the Affordable Care Act to improve care for individuals with multiple chronic conditions. Health homes expand on the medical home concept by placing a greater emphasis on: comprehensive care management; disease education, self-management, and health promotion; care transitions including appropriate follow-up from inpatient to other settings; referral to needed community and social support services; use of health information technology to link

services; and reliance on a team of health care and support professionals. Only a subset of medical homes will qualify as health homes. No date has been set for the implementation of the health home initiative.

Finally, DSS has applied for federal funding to support full integration of care for individuals who are eligible for both Medicare and Medicaid (i.e., dual eligibles). The federal Centers for Medicare and Medicaid Services will be awarding funds to 15 states. If awarded, Connecticut's demonstration will establish local Integrated Care Organizations (ICOs) with accountability for the delivery and coordination 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 the measurement of quality, outcomes and cost. In order to promote value, the state will align financial incentives to performance – the enhancement of quality person-centered care, the care experience and health outcomes at a lower overall cost. Regardless of whether Connecticut is selected as one of the states to receive this additional federal support, transitioning individuals to an ASO will provide needed care management and improved patient care.

It is anticipated that the ASO will provide technical assistance in the field and data to support the emergence and ongoing operations of medical homes, health homes, and other person-centered service delivery innovations, such as Integrated Care Organizations. Medical homes will be established as early as January 1, 2012. The figure below depicts the department's new health care purchasing model.



## **Populations Covered**

The intended populations to be served by the ASO include individuals who qualify for Medicaid as Aged, Blind and Disabled, individuals who qualify as Low Income Adults, and adults and children who qualify for family coverage under HUSKY A; CHIP (HUSKY B); and the Charter Oak Health Plan. Individuals who qualify for both Medicare and Medicaid (“dual eligible”) are also included in the new program. In total the new ASO will be responsible for administration of the care for nearly 600,000 individuals.

## **The Role of the Administrative Services Organization**

### Overview

The ASO will be the primary vehicle for organizing and integrating clinical management processes across medical assistance populations. The ASO’s main function is to support individuals’ access to primary, preventive, and specialty care on both an inpatient and outpatient basis, maintain the delivery of high quality and high value services to individuals and prevent unnecessary utilization of care in inappropriate settings. The ASO is expected to enhance communication and collaboration within the health care delivery system, assess provider network adequacy on an ongoing basis, ensure delivery of person-centered services, and improve the overall delivery system by working with the department to recruit and retain healthcare providers. The ASO is also expected to support and assist the department in its efforts to ensure that all individuals have access to a person-centered medical home or health home (PCMH/HH) appropriate to their health care needs.

### Primary Care Provider Assignment and PCMH/HH Attribution

The ASO will be responsible for establishing a usual source of primary care for all individuals. Initially, every individual will be asked to choose a primary care provider (PCP). Those who do not choose a PCP will be assigned one based on where the individual has received care in the past and existing provider capacity. As a network of PCMH/HH providers emerge, the ASO will also be responsible for administering individual attribution to a PCMH/HH. This attribution may be in addition to specific assignment to a PCP within the PCMH/HH. It is anticipated that individuals will have the opportunity to opt out of PCMH/HH attribution. This remains a point of discussion between the department and Connecticut’s advocacy community.

### Utilization Management

The ASO will be required to provide prospective, concurrent and retrospective utilization management (UM) services for eligible individuals. Either registration or prior authorization may be used. Registration is reserved primarily for less complex or costly procedures or service areas. Prior authorization and continued care review are reserved for services with higher risk of adverse health outcome, less likelihood of clinical benefit, or greater potential for inappropriate use. The quality of services provided is monitored and managed and frequent users or potential frequent users of services are identified through prospective, concurrent and retrospective review processes. The UM program will support

providers in delivering clinically necessary and effective care with minimal administrative barriers. The ASO may purchase, license or develop other guidelines or criteria to assist in utilization decisions, but the department's legal definition of "medical necessity" must always be determinative in service authorization decisions.

### Intensive Care Management

Individuals whose needs meet criteria established by the ASO and the department will have access to intensive care management (ICM). ICM refers to specialized care management techniques when an individual has significant health care needs that are not adequately or effectively addressed. Criteria for ICM may include, but are not limited to, individuals with an unstable chronic condition or behavioral health condition, more than one chronic condition with or without co-occurring behavioral health conditions; developmental delays; acute conditions at risk of resulting in adverse long term outcomes, such as some pregnancies or severe trauma; or chaotic social or living circumstances. The ASO will convene a multi-disciplinary team review when necessary. For those individuals who require ICM services, a written ICM plan will be required. The process for development of the ICM plan will begin with identification of key clinical persons as well as the individual or the individual's designee. Together, these persons comprise the ICM planning team. Existing care plans will be reviewed by the planning team to ensure that the plan reflects the individual's needs and adequately addresses his or her complex medical issues.

Only a small percentage of individuals will qualify for ASO-directed ICM services. Identification of individuals who would benefit from ICM due to their chronic condition is key to achieving successful outcomes. Equally important is the timely identification of individuals whose clinical conditions or social circumstances place them at risk of eventually requiring multiple, intensive, high cost services. Early intervention for individuals at risk may avoid or minimize their eventual need for intensive services.

The ASO will provide ICM at the ASO's Connecticut service center, however, regional deployment of Intensive Care Managers in the field may help build local collaborative relationships and improve effectiveness. As the ASO and the department recruit and certify PCMH practices, the ASO will have less of a role in coordinating care for individuals assigned to these practices. In many cases, it is expected that the ASO will identify high risk individuals and provide linkage to the PCMH. PCMH practices that meet the special requirements for serving as a health home will be expected to provide all necessary ICM (or the equivalent) for individuals attributed to them. Here as well, the ASO will be expected to identify high risk individuals and link these individuals to their ICM counterparts employed by the health home.

Although the department envisions a migration of care coordination and ICM functions to local PCMH/HH practices and clinics, there may be an ongoing role for the ASO with respect to these functions. ASO-directed ICM will continue to be necessary for individuals who are not assigned to a PCMH/HH. In addition, it is possible that the ASO could establish local ICM service hubs that support individuals by linking them to small group practices too small to establish dedicated resources on site.

By providing UM services and ICM services, the ASO will have a significant impact on the quality of clinical care and clinical care decisions. In doing so, it must make every effort to support collaborative clinical care decision-making at the local level, inform and support care-planning processes, support the meaningful participation of families and consumers in directing their own care, and enhance, rather than impede, an individual's ability to access medically necessary, high quality and high value health services.

The ASO's UM and ICM processes must support effective system management, easy access to appropriate services, and the development and maintenance of high quality services. In order to achieve improvements in care, the management techniques and principles utilized by the ASO must support the following "Key Aspects" of quality care:

- **Coordination and Continuity of Care:** Care must be provided in a fashion that is both well coordinated and easy for consumers to utilize with better access to information and services through a one-stop source for assistance.
- **Emphasis on Preventive Care and Early Intervention:** The most efficacious and cost-effective care of any illness is to prevent it from ever occurring. If illness does develop, early detection and intervention early in the course of the disease is essential to prevent development of chronic illness or the complications of chronic disease.
- **Value-added Services:** Services must maximize the quality of service and outcomes, emphasizing informed individual choice and the ability of the system to meet the needs of the individuals. Creative person-centered planning approaches should be promoted and supported and should result in shared decision making.
- **Greater Accountability:** The service system must keep individuals and families engaged to seek the input necessary to improve its performance as measured by consumer satisfaction, quality of life, and positive health outcomes.
- **Cultural Competency:** The unique linguistic and cultural needs of the individual and family need to be recognized and respected as individual services are identified and coordinated. The unique cultural diversity within the state must be recognized and respected as the system increases its service and system scope.

#### Quality Management

Quality Management (QM) refers to a comprehensive program of quality and cost measurement, quality improvement and quality assurance activities responsive to the department's objectives. The ASO will be expected to conduct ongoing quality management activities and performance improvement initiatives.

The ASO is expected to undertake a core set of access and quality initiatives in addition to any initiatives that the ASO may propose to undertake. These initiatives include improving access to EPSDT and adult well visits; improving screening for childhood

developmental delays, behavioral health conditions including adult and perinatal depression, and breast, cervical and colon cancers; appropriate use of preventive services such as controller medications for asthma; monitoring for eye, heart, kidney and foot disease among individuals with diabetes; utilization of care in appropriate settings; improving satisfaction with the service delivery system; and working with hospitals to minimize unnecessary emergency department and inpatient care.

The ASO will systematically and objectively measure access to care, demand for services, quality of care, outcomes, care experience surveys, complaints, and other sources of quality information. This information will support the development of continuous quality improvement strategies by the ASO and by providers that are consistent with the vision and mission of the department.

#### Data Analytics, Reporting and Performance Measurement

Perhaps the most important ongoing role that will be played by the ASO is the use of data to inform policy, direct resources, and monitor statewide and local system performance. Profiling and analysis will be of three types:

- Provider profiling to support quality improvement and pay for performance initiatives.
- Performance measurement of PCMH/HH providers, and regional provider consortia such as integrated care organizations with respect to access, quality and cost.
- Statewide performance measurement with respect to access, quality and cost to enable comparison of Connecticut's performance with state, regional, and national benchmarks.

One essential component of quality service in a person-centered system is satisfaction with the care experience; therefore, performance profiling activities will include opportunities for individuals to evaluate providers, their experience of care and the service delivery system. Performance measurement will support the payment of bonus or other financial incentive payments to providers.

#### **Request for 1915(b) waiver extension**

The department's 1915(b) waiver is due to expire on June 30, 2011. We are requesting CMS's authorization to extend the term of the current waiver to December 31, 2011. If authorized, it would be our intent to submit for CMS approval an extension of the current actuarially certified rate range adjusted to reflect medical trend through the six month extension.

In addition, we are requesting authorization to suspend immediately all External Quality Review Organization (EQRO) related activities under the waiver. Our current EQRO is Mercer Government Human Services Consulting (Mercer). We would like to use all or a

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portion of the funds currently budgeted for EQRO monitoring to support planning and implementation activities related to the department's new health purchasing strategy. It is anticipated that the department would engage Mercer to assist with some of these tasks given their extensive national experience in managed care quality oversight. In particular, the department expects to seek assistance in designing the department's ongoing monitoring and accountability functions and to provide training to departmental staff who would be responsible for these functions.

### **Technical Assistance**

The department is currently working with various stakeholders to establish standards for person-centered medical homes and health homes, reimbursement methods, performance measures, and incentive payments. We would like to establish ongoing communication with CMS with regard to our proposed approach as the details emerge. We would also like to discuss further the federal authority under which person-centered medical homes would initially be established. Our expectation is that we would contract for person-centered medical homes under 1915(a) authority and eventually migrate to 1915(b) or other waiver authority. Health homes would of course be administered under a state plan amendment. However, there is much that will need to be worked out with regard to the interweaving of these two service delivery reform initiatives. Our overall strategy will also depend on whether Connecticut receives funding to support its proposed demonstration for dual eligibles, which will require the establishment of Integrated Care Organizations by FFY12.

We look forward to your answers to our questions about the 1915(b) waiver termination. We are also eager to begin technical assistance discussions with respect to our proposed reforms. I will be in contact with your office in the near future to establish regular meeting times. Until then, you and your team are welcome to share your comments and submit any questions that you may have in advance of our first meeting.

Sincerely,



Mark Schaefer  
Director, Medical Care Administration

### **Attachment**

cc: Ben Barnes, Secretary, Office of Policy and Management  
Michael P. Starkowski, Commissioner  
Anne Foley, Undersecretary, Office of Policy and Management  
Marie Montemagno, CMS  
Chris LaVigne, Department of Social Services  
Lee Voghel, Department of Social Services  
Robert Zavoski, Department of Social Services