State of Connecticut
Regulation of
Department of Social Services
Concerning
Person-Centered Medical Home Plus (PCMH+) Program

Section 1. The Regulations of the Connecticut State Agencies are amended by adding sections 17b-262-1095 to 17b-262-1108, inclusive, as follows:

(NEW) Sec. 17b-262-1095. Scope and Program Overview

(a) Pursuant to the authority of sections 17b-3, 17b-11, 17b-260 and 17b-263c of the Connecticut General Statutes, the department is implementing the PCMH+ program. Sections 17b-262-1095 to 17b-262-1108, inclusive, of the Regulations of Connecticut State Agencies set forth the department's requirements for the PCMH+ program.

(b) The goals of PCMH+ are to improve health outcomes and care experience for PCMH+ members, while building upon and preserving both the PCMH program and overall efforts to improve quality, access and contain the growth of health care costs in Medicaid.

(c) Participating entities that the department determines generate savings for Medicaid and meet identified benchmarks on quality performance standards will be eligible to receive individual shared savings payments in accordance with the applicable methodology, so long as they comply with measures of under-service. Challenge pool payments may also be available for participating entities that meet specified quality benchmarks. Participating entities that are FQHCs will receive care coordination add-on PMPM payments for providing additional specified care coordination activities.

(d) PCMH+ is an upside-only shared savings program. Accordingly, if the department finds that one or more participating entities generated increased costs for Medicaid, each such participating entity shall not be required to pay the department for any portion of increased costs.

(NEW) Sec. 17b-262-1096. Definitions

As used in sections 17b-262-1095 to 17b-262-1108, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Advanced network" means a provider organization or group of provider organizations that shall include primary care providers within one or more practices with PCMH status or PCMH accreditation, as applicable, but not including a glide path practice, and that complies with the composition specified in section 17b-262-1098 of the Regulations of Connecticut State Agencies;

(2) "Advanced network lead entity" means a provider or provider organization that contracts with the department on behalf of an advanced network. The department may require that an advanced network lead entity shall be a participating provider in the advanced network;

(3) "Advanced practice registered nurse" or "APRN" means an individual licensed pursuant to section 20-94a of the Connecticut General Statutes and practicing within the APRN's scope of practice under state law;

(4) "Care coordination" means the deliberate organization of patient care activities between two or more participants (including a member) involved in a member's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out required patient care activities and is often managed by the exchange of

information among participants responsible for different aspects of care. Care coordination does not mean that any individual has a legal right to any particular level or amount of services;

(5) "Care coordination add-on payment" means a PMPM payment paid prospectively on a monthly basis to participating entities that are FQHCs for providing care coordination add-on payment activities for PCMH+ members;

(6) "Care coordination add-on payment activities" means care coordination activities specified in writing by the department that participating entities that are FQHCs are required to provide to PCMH+ members in order to receive care coordination add-on payments for any given performance year;

(7) "Challenge pool shared savings payment" or "challenge pool payment" means a payment made by the department to a participating entity in accordance with subsection (c) of section 17b-262-1104;

(8) "CMMI" means the U.S. Center for Medicare and Medicaid Innovation;

(9) "CMS" means the U.S. Centers for Medicare and Medicaid Services;

(10) "Comparison group" means the group of health providers that the department has determined will be used to analyze the expected cost trends in connection with calculating each participating entity's quality of performance and savings for Medicaid, if any, in a given performance year;

(11) "Department" or "DSS" means the Department of Social Services or one or more of the department's agents;

(12) "Enhanced care coordination activities" means the care coordination activities specified in writing by the department that all participating entities shall provide to PCMH+ members assigned to them in any given performance year;

(13) "Federally qualified health center" or "FQHC" has the same meaning as provided in 42 USC 1396d(l) and which also includes an FQHC look-alike;

(14) "Federal financial participation" or "FFP" means the payments that CMS makes to the department to reimburse the department for payments made under Medicaid pursuant to 42 USC 1396b in accordance with the applicable FMAP;

(15) "Federal medical assistance percentage" or "FMAP" means the applicable percentage of department payments made under Medicaid, which is calculated in accordance with 42 USC 1396b and is the basis for calculation of FFP;

(16) "Glide Path" means the process by which a practice or an FQHC, as applicable, which does not yet meet the requirements for PCMH status or PCMH accreditation, as applicable, may receive initial financial and technical support from the department to assist the practice or FQHC in meeting the requirements to obtain PCMH status or PCMH accreditation, as applicable;

(17) "Hospital" means a short-term general hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions, including injuries or a short-term general hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions among children, including injuries;

(18) "HRSA" means the U.S. Health Resources and Services Administration;

(19) "Intermediate care facility for individuals with intellectual disabilities" or "ICF/IID" means a residential facility for individuals with intellectual disabilities licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified and enrolled to participate in Medicaid as an intermediate care facility for individuals with intellectual disabilities pursuant to 42 CFR 442.101, as amended from time to time;

(20) "Individual pool shared savings payment" or "individual shared savings payment" means a payment made by the department to a participating entity in accordance with subsection (b) of section 17b-262-1104 of the Regulations of Connecticut State Agencies;

(21) “Medicaid” means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(22) “Medicaid State Plan” means the plan describing Medicaid eligibility, coverage, benefits and reimbursement, including amendments thereto, which is established by the department and reviewed and approved by CMS pursuant to 42 CFR 430, Subpart B;

(23) “Medical necessity” or “medically necessary” has the same meaning as provided in section 17b-259b of the Connecticut General Statutes;

(24) “Medicare” means the program operated by CMS in accordance with Title XVIII of the Social Security Act;

(25) “Medicare Accountable Care Organization” or “Medicare ACO” means a group of Medicare providers who participate in one or more CMS programs focused on improving the quality, efficiency and coordination of care provided to individuals served by such Medicare providers;

(26) “Medicare Advantage plan” means a Medicare plan governed pursuant to Part C of Title XVIII of the Social Security Act;

(27) “Member” means an individual eligible for goods and services under Medicaid;

(28) “Minimum savings rate” or “MSR” means the threshold set forth in the Medicaid State Plan or other applicable PCMH+ FFP authority, as applicable, that a participating entity’s savings or losses for Medicaid, as calculated by the department for PCMH+, needs to exceed before such savings or losses can affect the availability of shared savings payments;

(29) “Money Follows the Person” means the demonstration project established by the department pursuant to section 17b-369 of the Connecticut General Statutes;

(30) “Non-standard practice” means a practice setting that is: (A) Staffed by one or more primary care providers; (B) licensed as a separate health care facility by the Department of Public Health; (C) (i) for a practice seeking or that has obtained PCMH status, not eligible for PCMH Level 2 or PCMH Level 3 recognition or (ii) for an FQHC, not eligible, as applicable, for PCMH certification from the PCMH accreditation standard-setting authority or PCMH Level 2 or PCMH Level 3 recognition; and (D) determined by the department to provide primary care services consistent with the goals and purposes of the PCMH program;

(31) “Nursing facility” has the same meaning as provided in 42 USC 1396r(a), as amended from time to time, is licensed pursuant to section 19-13-D8t of the Regulations of Connecticut State Agencies as a chronic and convalescent home or rest home with nursing supervision and is enrolled with the department as a nursing facility;

(32) “Participating entity” means an advanced network or FQHC that is participating in PCMH+ in accordance with section 17b-262-1098 of the Regulations of Connecticut State Agencies;

(33) “Performance year” or “performance period” means a calendar year of the operation of the PCMH+ program by the department, which is the time period that the department will evaluate the clinical and financial performance of participating entities for purposes of determining and calculating shared savings payments, if any;

(34) “PCMH practice” means a practice other than an FQHC that the department has determined meets the requirements for PCMH status, but not including a glide path practice;

(35) “PCMH accreditation” means the department’s process for approving an FQHC to participate in PCMH that meets a high standard of person-centered primary care pursuant to the department’s criteria, including PCMH Level 2 or PCMH Level 3 approval or PCMH certification from the PCMH accreditation standard-setting authority, as well as other requirements set forth by the department for PCMH accreditation;

(36) “PCMH accreditation standard-setting authority” means one or more nationally recognized PCMH standard-setting organizations selected by the department as an authority whose standards apply to an FQHC, such as The Joint Commission (TJC), which sets standards for TJC’s Primary

Care Medical Home program as part of TJC's Ambulatory Health Care accreditation program;

(37) "PCMH Level 2" means the second level of PCMH primary care quality standards or an equivalent to such level, each as established by the PCMH status standard-setting authority;

(38) "PCMH Level 3" means the third level of PCMH primary care quality standards or an equivalent to such level, each as established by the PCMH status standard-setting authority;

(39) "PCMH status" means the department's approval of a practice that meets a high standard of person-centered primary care pursuant to the department's criteria, including, but not limited to, PCMH Level 2 or PCMH Level 3 approval;

(40) "PCMH status standard-setting authority" means one or more nationally recognized PCMH standard-setting organizations selected by the department as an authority whose standards apply to practices seeking or maintaining PCMH status, such as the National Committee for Quality Assurance (NCQA), which sets standards for NCQA's Patient Centered Medical Home Program;

(41) "PCMH+ FFP authority" means applicable portions of the Medicaid State Plan, one or more waivers, demonstrations, other applicable federal legal authority or any combination thereof, as applicable, each as amended from time to time, and that the department determines are sufficient to receive FFP from CMS for operating PCMH+;

(42) "PCMH+ member" means a member assigned by the department to a participating entity for purposes of PCMH+ for a performance year;

(43) "Person-Centered Medical Home" or "PCMH" means the program operated by the department pursuant to section 17b-263c of the Connecticut General Statutes and which provides technical assistance and, when applicable, additional payments to eligible primary care practices and providers that meet the written criteria for PCMH set forth by the department;

(44) "Person-Centered Medical Home Plus" or "PCMH+" means the program operated by the department pursuant to section 17b-263c of the Connecticut General Statutes and sections 17b-262-1095 to 17b-262-1108, inclusive, of the Regulations of Connecticut State Agencies;

(45) "Physician" means an individual licensed pursuant to section 20-13 of the Connecticut General Statutes and operating within such individual's scope of practice under state law;

(46) "Physician assistant" means an individual licensed pursuant to section 20-12b of the Connecticut General Statutes and operating within such individual's scope of practice under state law;

(47) "PMPM" means per-member per-month;

(48) "Practice" means an individual practice site other than an FQHC that provides predominantly primary care services and: (A) Is (i) an independent physician group, (ii) a solo physician, (iii) an APRN group, (iv) an individual APRN or (v) a non-standard practice that is a satellite entity of one or more of the other practice settings set forth in this subparagraph; (B) is enrolled in Medicaid with a valid provider enrollment agreement on file with the department; (C) maintains all required licenses from the Department of Public Health; and (D) provides primary care services by or under the direction of one or more primary care providers;

(49) "Primary care provider" means a physician, APRN or physician assistant who: (A) Provides general pediatric, internal medicine, family practice or geriatric primary care services to a patient at the point of first contact; (B) takes continuing responsibility for providing the patient's care; and (C) has an active, unrestricted license from the Department of Public Health;

(50) "Prior year" means the calendar year immediately prior to the performance year;

(51) "Provider" means a health care provider enrolled in Medicaid with the department in good standing and with a signed provider agreement on file with the department;

(52) "Provider agreement" means the signed written agreement between the department and the provider;

(53) "Quality measures" means written quality performance standards for participating entities

established by the department to calculate shared savings payments, if any, which may include separate sets of measures for pediatric and adult patient populations and separate sets of measures for individual pool shared savings payments and challenge pool shared savings payments and may also include measures used by the department for evaluation of PCMH+, participating entities or both, but which are not directly connected to calculation of shared savings payments;

(54) "Social determinants of health" means the various conditions in which individuals are born, grow, work, live and age and the wider set of forces and systems shaping the conditions of daily life for individuals, including, but not limited to, environmental factors, housing, nutrition, education, social services, medical care and other such conditions;

(55) "Shared savings payments" means individual pool shared savings payments, challenge pool shared savings payments or both types of payments, as applicable to a participating entity for a performance year;

(56) "State innovation model" or "SIM" means the initiative created by CMMI to provide financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery models that is designed to improve health system performance, increase quality of care and decrease costs for various health care payers, including Medicaid;

(57) "Solo physician" means a practice comprised of only one physician;

(58) "Specialist" means a physician other than a primary care provider; and

(59) "Under-service" means actions taken by or on behalf of a participating entity that have the result of limiting, excluding or discouraging one or more members from seeking or receiving medically necessary Medicaid covered services, including actions taken with the express or implicit goal of increasing savings generated by the participating entity, reducing the number of high-risk members assigned to the participating entity or both.

(NEW) Sec. 17b-262-1097. Program Parameters

(a) The PCMH+ program shall not restrict members' free choice of provider pursuant to 42 USC 1396a(a)(23) and 42 CFR 431.51.

(b) In accordance with 42 USC 1396d(t)(3)(D), participating entities shall not engage in any activities designed to result in selective recruitment, attribution, or assignment of individuals with more favorable health status or any combination thereof.

(c) Any advanced network or FQHC may participate in PCMH+ if it: (1) meets all qualifications established by the department for a PCMH+ participating entity, including, but not limited to, the requirements set forth in section 17b-262-1098 of the Regulations of Connecticut State Agencies, (2) submits a successful response to the request for proposals in accordance with the department's procurement process for PCMH+ and (3) enters into a contract for PCMH+ with the department.

(d) All payments made by the department to participating entities pursuant to PCMH+ are subject to available appropriations.

(e) For one or more of the initial performance years of PCMH+, the department has been receiving funds from a SIM model test grant from CMMI to assist with design and administration of PCMH+. All PCMH+ payments, if any, are expressly conditioned on continued receipt of CMMI model test grant funds in the amounts as determined by the department to be necessary for design and administration of PCMH+.

(f) The department may, within available appropriations, provide technical assistance to participating entities in connection with their participation in PCMH+ and compliance with applicable requirements.

(g) Notwithstanding any provision to the contrary in any contract between the department and a participating entity regarding PCMH+ and notwithstanding any other provision to the contrary in

sections 17b-262-1095 to 17b-262-1108, inclusive, of the Regulations of Connecticut State Agencies, there is no entitlement for any PCMH+ member or any other individual to receive any particular level or amount of services, nor does any such contract create any legal rights for any PCMH+ members or any other third-party beneficiaries.

(1) PCMH+ members do not have a right to receive any particular level or amount of enhanced care coordination activities (and, for FQHCs, also care coordination add-on payment activities).

(2) Participating entities are not required to provide any specific level or amount of enhanced care coordination activities (and, for FQHCs, also care coordination add-on payment activities) to each PCMH+ member.

(3) Each participating entity is required to provide enhanced care coordination activities (and, for 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.

(NEW) Sec. 17b-262-1098. Participating Entity Qualifications and Requirements

(a) Participating entities include both FQHCs and advanced networks that comply with all applicable requirements for participation in PCMH+, including, but not limited to, sections 17b-262-1095 to 17b-262-1108, inclusive, of the Regulations of Connecticut State Agencies.

(b) Participating entities shall include primary care providers who provide primary care case management services in accordance with 42 USC 1396d(t), which includes location, coordination and monitoring of health care services. Pursuant to 42 USC 1396d(t)(2)(A)-(B), a participating entity shall be, employ or contract with one or more physicians, physician groups, APRNs, APRN groups, physician assistants or an entity employing or having other arrangements with physicians to provide such services. The participating entity shall provide services in one or more of the following specialty areas: internal medicine, general medicine, geriatric medicine, family medicine and pediatrics. Accordingly, each participating entity shall comply with 42 USC 1396d(t) and 42 CFR 440.168, each as amended from time to time, regarding the provision of primary care case management services in connection with its participation in the PCMH+ program.

(c) Participating entities shall comply with all provisions of applicable PCMH+ FFP authority as ultimately approved by CMS and for the effective dates specified therein. All PCMH+ payments, if any, are expressly conditioned on CMS approval of the applicable PCMH+ FFP authority, as determined by the department to be sufficient to enable the department to implement PCMH+ and receive FFP for payments made under PCMH+.

(d) Requirements Specific to FQHCs. An FQHC shall:

(1) Comply with all requirements of an FQHC under 42 USC 1396d(l)(2)(B);

(2) Operate in Connecticut and meet all federal and state requirements applicable to FQHCs;

(3) Comply with all PCMH accreditation requirements, as determined by the department; and

(4) Receive shared savings payments, if any, and distribute those payments within the FQHC according to its written distribution plan. No FQHC may receive any shared savings payments, if applicable, prior to the department reviewing and approving its shared savings payments distribution plan.

(e) Requirements Specific to Advanced Networks. Each advanced network shall:

(1) Be composed of one of the following:

(A) One or more PCMH practices;

(B) One or more PCMH practices plus specialists, which could include any combination of physical health, behavioral health and oral health providers;

(C) One or more PCMH practices plus specialists, which could include any combination of physical health, behavioral health and oral health providers, plus one or more hospitals; or

(D) A Medicare Accountable Care Organization that includes one or more DSS PCMH practices.

(2) Designate an advanced network lead entity, which the department may require shall be a provider or provider organization participating in the advanced network.

(3) The advanced network lead entity shall:

(A) Ensure that the required enhanced care coordination activities are implemented as intended, including, but not limited to: ensuring required staff are hired and appropriately trained, monitoring of day-to-day practice, establishment of linkages with community partners and any required reporting to the department; and

(B) Receive any shared savings payments, if applicable, and distribute such payments to advanced network participating providers according to its plan. No advanced network lead entity may receive any shared savings payments, if applicable, prior to the department reviewing and approving its shared savings distribution plan.

(4) If the advanced network is comprised of more than one provider organization, the advanced network lead entity shall have a contractual relationship with all other advanced network participating providers that meet requirements established by the department. Each such contract shall include, at a minimum:

(A) An explicit requirement that each advanced network participating provider agrees to participate in and comply with the applicable requirements of PCMH+;

(B) A description of the advanced network participating provider's rights and obligations in, and representation by, the advanced network lead entity, including language giving the advanced network lead entity the authority to terminate a provider's participation in the advanced network for its non-compliance with the advanced network participation agreement or any applicable requirements of PCMH+ in particular or Medicaid in general;

(C) Language that advanced network participating providers shall allow PCMH+ members freedom of choice of provider and may not require that members be referred to providers within the advanced network; and

(D) A description of the methodology for distributing any shared savings between the advanced network lead entity and advanced network participating providers. The shared savings distribution methodology shall not include any factors that would reward a provider for specific contributions to the overall savings of the network. Primary care practices within the advanced network that do not have PCMH status or PCMH accreditation, as applicable (such as glide path practices) shall not receive a portion of any shared savings payments, if any, that are paid to the advanced network lead entity. The advanced network's shared savings methodology is subject to review and approval by the department.

(5) Be eligible to receive a shared savings payment, if applicable and if all other requirements are met, only for members assigned to the advanced network based on attribution to one or more PCMH practices within the participating entity, each of which shall maintain all applicable PCMH and PCMH+ requirements for the entire performance year.

(f) Requirements for All Participating Entities. In addition to complying with the requirements specific to an FQHC in subsection (e) of this section or the requirements specific to an advanced network in subsection (f) of this section, as applicable, each participating entity shall comply, on an ongoing basis throughout its participation in PCMH+, with the following requirements:

(1) Have not fewer than 2,500 members eligible for PCMH+ who are attributed to primary care providers within the participating entity who have PCMH status or PCMH accreditation, as applicable, at the time that DSS assigns members to the participating entity in accordance with section 17b-262-1099 of the Regulations of Connecticut State Agencies;

(2) Identify a clinical director and senior leader to represent the participating entity in its participation in PCMH+ and champion PCMH+ goals;

(3) Use reasonable efforts within its control to ensure that only providers enrolled in Medicaid are providing Medicaid services to PCMH+ members;

(4) Comply with the requirements for an oversight body as detailed in subsection (i) of this section;

(5) Have appropriate organizational capacity, including governance and oversight, for implementing PCMH+;

(6) Ensure and promote transparency, community participation and PCMH+ member participation in the operation of PCMH+;

(7) Have a planned and documented approach for providing enhanced care coordination activities and, for FQHCs, also care coordination add-on payment activities, each as described in section 17b-262-1100 of the Regulations of Connecticut State Agencies;

(8) Support the integration of behavioral health services and supports into existing operations;

(9) 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 members in utilizing their Medicaid benefits, as detailed in subsection (k) of this section;

(10) 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;

(11) Participate in quality measurement activities as required by DSS;

(12) Participate in program oversight activities conducted by DSS to ensure compliance with PCMH+ program requirements;

(13) Comply with all requirements of DSS's procurement process for PCMH+ participating entities;

(14) Not limit a member's ability to receive services from a provider that is not affiliated with the participating entity;

(15) Require any primary care practices or FQHC sites that do not yet have PCMH status or PCMH accreditation, as applicable, within the participating entity to achieve PCMH status or PCMH accreditation, as applicable, not less than eighteen months after the start of the first PCMH+ performance year during which the participating entity is participating in PCMH+ and includes such practice as part of the participating entity. DSS may extend this timeframe for PCMH recognition based on good cause outside of the participating entity's control, including, but not limited to, accreditation or certification approval delays, electronic health records system vendor delays, resignation of staff members who are key to the applicable accreditation processes or such other reasons determined by the department to be sufficient good cause. If one or more practices or FQHC sites within a participating entity does not meet the requirements of this subdivision, the department shall issue a corrective action plan to the participating entity. The corrective action plan shall establish timeframes for the practice or practices or FQHC site or sites to address gaps in order to achieve PCMH status or PCMH accreditation, as applicable. DSS shall monitor compliance with the corrective action plan. Non-compliance with corrective action plan will result in termination of the participating entity's PCMH+ contract with the department and ineligibility to receive any PCMH+ shared savings payments for each applicable performance year;

(16) Not distribute shared savings payments, if any, to any individual physician, APRN or physician assistant within the participating entity using any factors that would reward such individual for that individual's specific contributions to the overall savings generated by the participating entity; and

(17) Not engage in any activities designed to result in selective recruitment and attribution of individuals with more favorable health status.

(g) Response to Department's Procurement Process. In its response to the department's procurement process for PCMH+, each participating entity shall demonstrate compliance with applicable PCMH+ requirements, including the requirements set forth in this section. The department may enforce each participating entity's compliance with its response to the applicable request for proposals to participate in PCMH+.

(h) Oversight Body. Each participating entity shall have an oversight body that may, but is not required to, overlap with a governing board or advisory body for the participating entity that existed prior to the performance year. The oversight body shall include substantial representation by PCMH+ members assigned to the participating entity and at least one physician, APRN or physician assistant who is participating in the participating entity. The type and number of providers on the oversight body need not be proportional to participating entity providers, but shall be generally representative of the variety of providers participating in the participating entity, such as primary care providers, other physical health providers, behavioral health providers, oral health providers and other relevant types of providers.

(1) The participating entity shall provide assistance such as transportation and childcare to PCMH+ members to enable them to attend oversight body meetings. Making such payments, rendering such services or both is permissible to the extent of applicable statutes and regulations, provided that: (1) the department shall not reimburse the participating entity for such expenditures or services, (2) the participating entity is responsible for ensuring compliance with all statutes, regulations and other requirements that apply to such expenditures and (3) the participating entity shall use reasonable diligence in preventing any potential negative consequences to individuals that may result from such expenditures, such as any potential impact on those individuals' eligibility for Medicaid, other public benefit programs or any combination of such programs.

(2) The participating entity shall circulate relevant written reports and materials in advance to the members of the oversight body for its review and comment.

(3) The participating entity shall have formal procedures through which to receive feedback from the oversight body and documentation of this communication. The participating entity shall maintain detailed documentation regarding the existence, governance and activities of the oversight body. Upon request, the participating entity shall provide the department with documentation regarding all aspects of the governance, activities and communications of the oversight body.

(4) The oversight body shall:

(A) Meet at least once each calendar quarter and provide meaningful feedback to the participating entity on a variety of topics, including quality improvement, member experience, prevention of under-service, implementation of PCMH+ and distribution of shared savings payments, if any;

(B) Have a transparent governing process;

(C) Have bylaws that reflect the oversight body's structure as well as define its ability to support the department's PCMH+ objectives; and

(D) Have a conflict of interest policy calling for disclosure of relevant financial interests and a procedure to determine whether conflicts exist and an appropriate process to resolve conflicts.

(i) Group Communications to Members. Not less than fifteen business days before planning to send any group communication to Medicaid members regarding PCMH+, each participating entity shall send the department a copy of the intended communication for review and approval by the department. No participating entity may send any such communication to members before receiving written approval from the department.

(j) Linkages with Community Partners to Address Social Determinants of Health. In an effort to meaningfully impact the social determinants of health, promote physical and behavioral health

integrated care and assist members in utilizing their Medicaid benefits, each participating entity shall implement and maintain contractual relationships or informal partnerships with local community partners, as specified in this subsection. The purpose of such partnerships is to develop and implement initiatives to identify and actively refer members with behavioral health conditions that require specialized behavioral health treatment to appropriate sources of care, address social determinants of health and facilitate rapid access to care and needed resources. It is not expected that these partnerships will solve or fully address any individual PCMH+ member's social determinants of health, but rather, to help foster broader collaboration and broader perspectives that are collectively designed to result in overall long-term improvements in health. As part of these relationships, the participating entity, if applicable, one or more providers within the participating entity or both shall meet with various community partners to improve collaboration.

(1) Upon request, the participating entity shall provide the department with documentation of contractual relationships, informal partnerships or both as described in this subsection, as applicable, including the role of such relationships in enabling the participating entity to impact the social determinants of health, promote physical and behavioral health integrated care and assist members in utilizing their Medicaid benefits. In addition, the department may also request that the participating entity provide documentation, explanation or both regarding how such relationships improves the care experience, quality of care and cost of care for PCMH+ members assigned to the participating entity.

(2) The participating entity shall implement and maintain contractual relationships or informal partnerships with:

(A) Community-based organizations, including organizations that assist the community with housing, clothing, utility bill assistance, nutrition, food assistance, employment assistance, education, child care, transportation, language and literacy training, elder support services and other types of such organizations;

(B) Behavioral health organizations, including those providing substance use services;

(C) Child-serving organizations;

(D) Peer support services and networks;

(E) Social services agencies;

(F) The criminal justice system;

(G) Local public health entities;

(H) Specialists and hospitals (except for an advanced network that already includes such providers as part of its network, which may, but is not required to, develop such relationships beyond its network); and

(I) Other state and local programs, both medical and non-medical.

(NEW) Sec. 17b-262-1099. Eligible Members and Assignment Methodology

(a) Categories of Members Eligible to Participate in PCMH+. All members are eligible to participate in PCMH+, except for:

(1) Participants in a behavioral health home established by the department pursuant to 42 USC 1396w-4;

(2) The following categories of individuals who are eligible for both Medicare and Medicaid:

(A) Individuals who are eligible for Medicare and Medicaid but whose Medicaid benefits are limited to Medicare cost sharing, also known as a partial dually eligible individuals;

(B) Individuals who are participating in a Medicare Accountable Care Organization; and

(C) Individuals who are enrolled in a Medicare Advantage plan;

(3) Individuals receiving home and community-based services from a program operated pursuant to 42 USC 1396n(c), (i), (k) or any combination of such programs;

(4) Participants in the Money Follows the Person program;

(5) Residents of nursing facilities, ICF/IIDs and other long-term care institutions that are required by federal or state statute or regulation to coordinate care for their residents;

(6) Individuals who are enrolled in Medicaid solely to receive a limited benefit package, such as a benefit package for family planning, breast and cervical cancer or tuberculosis; and

(7) Individuals who are receiving hospice services.

(b) Each individual who is eligible for both Medicare and Medicaid but does not fall within any subdivision of subsection (a) of this section shall have access to care coordination services included in PCMH+ if that individual desires such services. Accordingly, the individuals described in the previous sentence are excluded from PCMH+ only for purposes of calculating shared savings payments and care coordination add-on payments. Each participating entity shall provide care coordination services included in PCMH+ to each individual described in this subsection if such individual desires to receive such services.

(c) Member Assignment Methodology. The department assigns eligible PCMH+ members as described in subsection (a) of this section to participating entities in accordance with this subsection.

(1) A member may affirmatively select a PCMH practice or FQHC as the member's primary care provider. In the absence of a member's selection, the department's written PCMH attribution methodology retrospectively attributes members to primary care providers based on claims volume. If a member receives care from multiple providers during a given period, the member is attributed to the practice or FQHC that provided the plurality of care and, if there is no single largest source of care, to the most recent source of care, each as determined by the department in accordance with its written PCMH attribution methodology.

(2) A participating entity's assigned members are the members attributed to its PCMH practices or, for an FQHC with PCMH accreditation, members attributed to such FQHC, by the department in accordance with subdivision (1) of this subsection less members that are not eligible for PCMH+ as described in subsection (a) of this section, as assigned by the department in accordance with subsection (d) of this section. If an advanced network includes primary care providers not within a PCMH practice or an FQHC with PCMH accreditation, only the members attributed to the PCMH practices or FQHCs with PCMH accreditation in the advanced network will be assigned to the PCMH+ participating entity.

(3) In accordance with 42 CFR 431.51, regardless of a member's assignment to a PCMH+ participating entity, each member will continue to have the choice to see any enrolled Medicaid provider.

(d) PCMH+ assignment will occur once annually and will last for an entire performance year (unless during the course of a performance year, a member opts out of PCMH+, loses eligibility for Medicaid or falls into a category of individuals excluded from PCMH+, in accordance with this section). The department shall assign members to participating entities on or before November 30th for each performance year starting the following January 1st. The department shall assign a member only to one participating entity for each performance year. If a member's PCMH attribution to a primary care provider changes during a performance year, that change will take effect for the following performance year's PCMH+ assignment.

(e) Member Notification. Prior to each performance year, DSS shall send each member that has been assigned to a PCMH+ entity written notice about such assignment, including a brief description of the PCMH+ program and an opportunity for the member to opt out from participating in PCMH+. The department will provide a copy of the form of such notice to each participating entity not later than ten days after distribution.

(f) Member Opt-Out from PCMH+. A member may opt out of assignment to a participating entity at any time. If a member opts out, then that member's claims costs will be removed from the

assigned participating entity's shared savings calculation, although this member's quality data and applicable data regarding measures of under-service will not be excluded. If a member opts out of PCMH+, the participating entity is not required to provide enhanced care coordination activities to that member. In addition, if the member's assigned participating entity was an FQHC, then that FQHC will no longer receive the care coordination add-on payment for that member for all months in the performance year beginning with the calendar month after the department processes the member's opt-out request.

(g) If, over the course of a performance year, a PCMH+ member loses eligibility for Medicaid or moves into a population that is not eligible for PCMH+ as detailed in subsection (a) of this section, that change has the same effect as if an individual opts out of PCMH+, as described in subsection (f) of this section.

(NEW) Sec. 17b-262-1100. Care Coordination Services

(a) As part of participating in PCMH+, each participating entity shall provide the services described in this section, as applicable to such participating entity. The care coordination services described in this section are designed to improve the quality, efficiency and effectiveness of care delivered to PCMH+ members, as well as improving such members' care experience.

(b) 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 participating entity is responsible for providing care. Each participating entity is required to provide the care coordination services described in this section 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.

(c) Each participating entity shall provide enhanced care coordination services as detailed in the department's written list of such services and in accordance with the Medicaid State Plan or other applicable PCMH+ FFP authority, as applicable.

(d) Each participating entity that is an FQHC shall provide care coordination add-on payment activities as detailed in the department's written list of such services and in accordance with the Medicaid State Plan or other applicable PCMH+ FFP authority, as applicable, which the department may update from time to time. Care coordination add-on payment activities are in addition to the enhanced care coordination activities.

(NEW) Sec. 17b-262-1101. Measuring Quality of Performance

(a) Purpose of Measuring Quality. In addition to providing the care coordination services required pursuant to section 17b-262-1100 of the Regulations of Connecticut State Agencies, in order to be eligible to receive shared savings payments, if applicable, each participating entity shall also maintain, improve or both maintain and improve the quality of care and care experience for members assigned to the participating entity, as measured by quality measures specified by the department in accordance with this section.

(b) The PCMH+ quality measure set contains process and outcome measures that include measures of member experience. Of those measures, a specified subset of measures will be used in calculating various payments, as described in section 17b-262-1104 of the Regulations of

Connecticut State Agencies. The department shall post such list on the department's website or otherwise distribute such measures in writing to participating entities.

(c) The department shall review and update the quality measures on a periodic basis as determined by the department. The department will provide participating entities not less than thirty days advanced written notice of any proposed update or revision of the quality measures.

(d) Quality Scoring. For purposes of calculating a participating entity's individual pool shared savings payment, a participating entity's total quality score will be based on three components of quality measurement (maintain quality, improve quality and absolute quality) for each of the quality measures that apply to the individual savings pool in any given performance year. To calculate each participating entity's total quality score, its points will be summed and then divided by a maximum score of the total number of points (three possible points per quality measure multiplied by the total number of quality measures for the individual savings pool in a performance year). The total quality score, expressed as a percent of the total potential quality score, will be used in calculating the individual pool shared savings payment, if any, as described in subsection (d) of section 17b-262-1103 of the Regulations of Connecticut State Agencies. A maximum of one point is available for each component of quality measurement for each measure, determined as follows:

(1) Maintain Quality. One point is awarded in this category for each quality measure in the individual savings pool if a participating entity's performance year quality score is greater than or equal to its prior year score. The department may establish a statistically significant threshold based on historical quality measure data to account for annual variation, which results in lower scores.

(2) Improve Quality. A participating entity will earn up to one full point for each quality measure in the individual savings pool in accordance with the department's written sliding scale for the performance year as specified in the Medicaid State Plan or other applicable PCMH+ FFP authority, as applicable, based on the participating entity's year-over-year performance (quality improvement trend) against the comparison group's quality improvement trend.

(3) Absolute Quality. A participating entity will earn up to one full point for each quality measure in the individual savings pool in accordance with the department's written sliding scale for the performance year as specified in the Medicaid State Plan or other applicable PCMH+ FFP authority, as applicable, based on the participating entity's ability to reach absolute quality targets, derived from the comparison group's quality scores.

(NEW) Sec. 17b-262-1102. Preventing, Monitoring and Remedying Under-Service

(a) 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, from and within participating entities. DSS will also conduct a PCMH+ member survey to evaluate the first performance year.

(b) Subject to subsections (e) and (f) of this section, participating entities will be disqualified from receiving shared savings payments if the department determines that they demonstrate repeated or systematic failure to offer medically necessary services or manipulate their member panel in a manner that results in under-service, whether or not there is evidence of intentionality.

(c) If the department detects that any potential under-service has occurred regarding a participating entity, the department shall use best efforts to notify the participating entity in writing as soon as possible. The department shall give the participating entity an opportunity to respond to such notification and to take corrective action to prevent any future under-service or potential under-service.

(d) If the department determines that one or more individual providers within the participating

entity, the participating entity overall or both may have engaged in repeated or systematic under-service, regardless of intentionality, the department shall send the participating entity such findings in writing. The department shall give the participating entity an opportunity to respond to such findings and to take corrective action.

(e) As appropriate based on the nature, extent and severity of under-service detected by the department, the department shall take appropriate sanctions against the participating entity to enforce the requirement to prevent under-service, including, but not limited to, issuing a corrective action plan with defined steps and timeframes to correct and prevent under-service, denial of all or a reasonable portion of shared savings payments (if applicable), denial of all or a reasonable portion of care coordination add-on payments for FQHCs, denial of all or a reasonable portion of a combination of both types of payments, such other actions as the department reasonably determines are necessary to protect members from under-service or any combination of the actions described in this subsection, as determined by the department.

(f) To the extent the participating entity objects to any determination of the department regarding under-service as specified in this section, the participating entity may use the desk review process described in section 17b-262-1105 of the Regulations of Connecticut State Agencies.

(NEW) Sec. 17b-262-1103. Shared Savings Calculation

(a) Overall Description. As described in more detail in this section and in section 17b-262-1104 of the Regulations of Connecticut State Agencies, participating entities that the department determines generate savings for Medicaid and that meet identified benchmarks on quality performance standards will be eligible to receive individual pool shared savings payments in accordance with this section, so long as they comply with measures of under-service.

(b) Comparison Group. For the performance year from January 1, 2017, through December 31, 2017, the comparison group consists of all FQHCs that have and maintain PCMH accreditation and non-FQHC practices with PCMH status, each of which is not a PCMH+ participating entity in a given performance year and each of which must have at least 2,500 members, except that the department may exclude one or more FQHCs or non-FQHC practices from the comparison group in order to ensure the statistical validity of the comparison group. Based on the number of eligible FQHCs and PCMHs that participate in PCMH+ in performance years occurring after calendar year 2017, the department may adjust the comparison group to include additional categories of FQHCs and non-FQHC practices beyond those described in this subsection as necessary to remain statistically valid.

(c) Benefits Included in Calculations. DSS will include all Medicaid claim costs for covered services provided by any provider to a PCMH+ member in the shared savings calculation described in subsection (a) of this section, except for: hospice; long-term services and supports, including institutional and home and community-based services; and non-emergency medical transportation services. Participating entities do not need to deliver all of the benefits received by PCMH+ members.

(d) Calculation of Individual Pool Shared Savings. For each participating entity, in each performance year of the PCMH+ program, the department shall calculate whether and to what extent the participating entity achieved a lower cost trend than the comparison group for the costs as detailed in subsection (c) of this section and in accordance with this subsection.

(1) Assigned Members. The expenditures for each participating entity will be measured only for a participating entity's assigned PCMH+ members who remain assigned for not fewer than eleven months of the performance year. Cost data of members who opt out of PCMH+ at any time before or during the performance year will also be excluded from the calculation of shared savings.

(2) Claims Truncation. In order to avoid unwanted bias due to outlier cases, for each PCMH+

member, annual claims will be truncated at a level specified in writing by the department for the performance year and in accordance with the Medicaid State Plan or other applicable PCMH+ FFP authority, as applicable, so that expenses above that level will not be included in the calculation.

(3) Risk Adjustment.

(A) The department shall use risk adjustment methods to adjust for both prior year and performance year costs for underlying differences in illness burden for both participating entities and the comparison group.

(B) The comparison group trend is derived as the risk adjusted performance year cost divided by the risk adjusted prior year cost.

(4) Expected Performance Year Costs. A participating entity's risk adjusted expected performance year costs are developed by multiplying the participating entity's risk adjusted prior year costs by the comparison group trend described in subdivision (3) of this subsection.

(5) A participating entity's savings is the difference between its risk adjusted expected performance year costs described in subdivision (4) of this subsection and its actual risk adjusted performance year costs. Participating entities that demonstrate losses (i.e., higher than expected expenditures for PCMH+ members assigned to the participating entity) will not be required to return these losses to the department because PCMH+ is an upside-only shared savings program, as described in section 17b-262-1095 of the Regulations of Connecticut State Agencies.

(6) Minimum Savings Rate. A participating entity's risk-adjusted savings shall meet the MSR requirement, which is greater than or equal to the percentage of the expected performance year costs as specified in writing by the department and in accordance with the Medicaid State Plan or other applicable PCMH+ FFP authority, as applicable. 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 the negative MSR threshold will not be considered credible when deriving the aggregate program savings.

(7) Savings Cap. A participating entity's savings will be capped at the percentage of its risk adjusted expected performance year costs, as specified by the department in writing in accordance with the Medicaid State Plan or other applicable PCMH+ FFP authority, as applicable, so that any savings above the savings cap will not be included in its individual savings pool.

(8) Sharing Factor and Individual Savings Pool. A participating entity's individual savings pool, if any, will be multiplied by a sharing factor of the percent specified in the Medicaid State Plan or other applicable PCMH+ FFP authority, as applicable. The resulting amount from all of the calculations and adjustments specified in subdivisions (1) through (8), inclusive, of this subsection, will form the participating entity's individual savings pool.

(9) Quality Scoring and Individual Pool Shared Savings Calculation. For each participating entity, the individual savings pool shared savings payment, if any, is equal to the individual savings pool as calculated in accordance with subdivision (8) of this subsection multiplied by the total individual pool quality score as specified in subsection (d) of section 17b-262-1101 of the Regulations of Connecticut State Agencies.

(NEW) Sec. 17b-262-1104. Reimbursement Methodology

(a) Care Coordination Add-on Payments. Participating Entities that are FQHCs are eligible to receive monthly PMPM payments for care coordination add on payment activities that the FQHC provides to PCMH+ members in accordance with the PMPM amount and methodology as described in the Medicaid State Plan or other applicable PCMH+ FFP authority, as applicable.

(b) Individual Pool Shared Savings Payments. For any given performance year, if the department determines that a participating entity has achieved savings for members assigned to it in accordance

with subsection (d) of section 17b-262-1103 of the Regulations of Connecticut State Agencies, then the department will make individual pool shared savings payments to the participating entity as specified in said subsection.

(c) Challenge Pool Shared Savings Payments.

(1) Challenge Pool Eligibility. To be eligible for a challenge pool payment, if any, a participating entity shall improve its overall performance year-over-year on the measures that apply to the individual savings pool.

(2) Challenge Pool Funding. The potential challenge pool funding, if any, includes shared savings calculated for one or more participating entity's individual shared savings pool pursuant to subsection (d) of section 17b-262-1104 of the Regulations of Connecticut State Agencies, but which were not paid to one or more participating entities such as because of less than perfect scores on the applicable quality measures or because the department determined that the participating entity systematically engaged in under-service.

(A) The department calculates the aggregate savings of the PCMH+ program for a performance year by adding together all credible savings and losses for all participating entities in accordance with all of the calculations and adjustments for calculating individual savings pool shared savings, as described in subsection (d) of section 17b-262-1104 of the Regulations of Connecticut State Agencies, but excluding the calculation of the individual pool shared savings payment quality score percentage for each participating entity.

(B) Total challenge pool payments to all participating entities for any performance year shall not exceed the aggregate savings of the PCMH+ program as detailed in subparagraph (A) of this subdivision less the total of all individual pool shared savings payments made pursuant to subsection (b) of this section.

(3) Challenge Pool Quality Measure Scoring. In any performance year, for each of the challenge pool quality measures, participating entities that achieve at least the median score (of all participating entities) for a challenge pool quality measure will pass or get credit for that measure.

(4) Challenge Pool Distribution. For any performance year, the amount of a participating entity's challenge pool payment, if any, for each participating entity that complies with subdivision (1) of this subsection will be the product of the number of its assigned PCMH+ members times the number of challenge pool quality measures passed as detailed in subdivision (3) of this subsection, divided by the sum of this statistic across all participating entities to arrive at the participating entity's portion of the challenge pool. This methodology ensures that the available challenge pool funds are exhausted for a performance year. The challenge pool payment, if any, to a participating entity is not directly related to its individual pool savings.

(NEW) Sec. 17b-262-1105. Monitoring Performance

(a) The department uses a set of internal monitoring and reporting measures that will be collected and analyzed not less than quarterly. DSS shall review the information and follow up with participating entities as needed regarding their performance.

(b) The department will develop and implement methods to monitor delivery of enhanced care coordination activities and, for FQHCs, care coordination add-on payment activities.

(c) Upon request from the department and not later than twenty-one days after receiving such request, each participating entity shall provide the department with information regarding the participating entity's participation in PCMH+, including, but not limited to: (1) policies and procedures regarding participation in PCMH+ and compliance with PCMH+ requirements; (2) explanation and documentation regarding how the participating entity provides the enhanced care coordination activities (and for FQHCs, also the care coordination add-on payment activities) and all other activities required to be performed by participating entities; (3) data requested by the

department regarding the activities related to the participation in PCMH+; and (4) all other documentation and information requested by the department regarding the participating entity's participation in PCMH+.

(d) The department will conduct one or more periodic compliance reviews during each performance year to evaluate the participating entity's performance of the activities required as part of participation in PCMH+. Such reviews may include, but are not limited to: a request for information and documentation, a review of PCMH+ members' clinical and care coordination records, an on-site evaluation that includes interviews with the participating entity's PCMH+ staff, clinicians and PCMH+ members and any other evaluation as determined by the department. Each participating entity shall provide the department with access to its facilities and staff to enable the department to perform such reviews, including, but not limited to, ensuring that each participating entity's PCMH+ clinical director and senior leader shall participate and facilitate the participating entity's full cooperation and participation in such reviews.

(e) If the department determines that a participating entity does not provide sufficient evidence of performing required enhanced care coordination activities or care coordination add-on payment activities for FQHCs, the department may: (1) require the participating entity to comply with a corrective action plan; (2) make the participating entity ineligible to receive all or part of shared savings payments for which the participating entity might otherwise be eligible to receive; or (3) a combination of such actions.

(f) Desk Review Process.

(1) Not later than October 31 of the year following each performance year, the department shall provide each participating entity with a written description of the participating entity's results regarding performance on quality measures, applicable Medicaid expenditures for PCMH+ members assigned to the participating entity and calculation of savings or increased expenditures, as applicable for said members. After receiving said description from the department, the participating entity may respond to any calculations, results, or decisions contained therein. Such response shall: be in writing, received by the department not later than thirty days after the participating entity receives the written description from the department and include all supporting documentation. The department shall issue a written decision not later than thirty days after receiving the participating entity's response. There is no further right to review the department's decisions regarding the written description described in this subdivision, other than as described in this subdivision. There is no right to review the final distribution of shared savings payments, if any, among the various participating entities.

(2) If the department makes any decision specific to a participating entity's participation in PCMH+, but not including any of the circumstances described in subdivision (1) of this subsection and not including any department decisions that apply to the entire PCMH+ program or any component thereof, after receiving said written decision, the participating entity may respond in writing to said decision. Such response shall: be in writing, be received by the department not later than fifteen days after the participating entity receives the written decision from the department and include all supporting documentation. The department shall issue a written final decision not later than thirty days after receiving the participating entity's response. There is no further right to review the department's decisions described in this paragraph, other than in accordance with this paragraph.

(NEW) Sec. 17b-262-1106. Documentation and Record Retention

(a) Each participating entity shall maintain documentation sufficient to document that the participating entity performed all activities related to its participation in PCMH+, including, but not limited to: provision of enhanced care coordination activities, care coordination add-on payment activities (for FQHCs) and all other required activities, as well as information documenting the care

experience and quality of care provided, as determined and specified by the department.

(b) Each participating entity shall preserve all required documentation in its original written or electronic form for a period of time not less than five years or the length of time required by statute or regulation, whichever is greater. Such documentation is subject to review by the department. If there is a dispute between the department and a participating entity concerning any aspect of the participating entity's participation in PCMH+, documentation shall be maintained until the end of the dispute, five years or the length of time required by statute or regulation, whichever is greater.

(c) The department may disallow and recover any amounts paid to a participating entity for which required documentation is not maintained and not provided to the department upon request.

(d) The department may audit all relevant records and documentation and take any other appropriate quality assurance measures it deems necessary to assure compliance with applicable regulatory and statutory requirements.

(NEW) Sec. 17b-262-1107. Reserved

(NEW) Sec. 17b-262-1108. Reserved

Statement of Purpose

The purpose of this regulation is to establish rules and parameters to enable the department to implement the PCMH+ program.

(A) The problems, issues or circumstances that the regulation proposes to address: SIM is a multi-payer approach to promote improved health care delivery. The development of the SIM initiative has been led by the SIM Project Management Office, located within the Office of the Healthcare Advocate, which serves under the leadership of the Lieutenant Governor. The development of SIM is supported by consultants and statewide advisory committees composed of payers, providers, consumers and advocates.

In March 2013, the State of Connecticut received a planning grant from CMMI to develop a State Healthcare Innovation Plan. Through the planning process, the SIM Program Management Office brought together a wide array of stakeholders who worked together to design a model for health care delivery supported by value-based payment methodologies with the goal of impacting care delivered to at least 80% of the entire State population within five years. The resultant State Healthcare Innovation Plan outlines the goals and anticipated pathway to promote the Triple Aim for everyone in the State: better health while eliminating health disparities, improved health care quality and experience and reduction of growth in health care costs.

The department is participating in SIM by implementing PCMH+. The goals of PCMH+ are to further improve health outcomes and care experience for Medicaid members who are assigned to PCMH+, through these efforts containing the growth of Medicaid expenditures. Specifically, PCMH+ will build on DSS' existing person-centered medical home (PCMH) model by incorporating new enhanced care coordination activities and care coordination add-on payment activities related to the integration of primary care and behavioral health care, building provider competencies to support Medicaid members with complex medical conditions and disability needs and promoting linkages to community supports that can assist members in utilizing their Medicaid benefits.

PCMH+ is open to two groups of providers (known as participating entities): FQHCs and advanced networks. If the participating entity meets identified benchmarks on quality measures, while also demonstrating shared savings for members assigned to the entity, then it will be eligible to receive individual pool shared savings payments. In addition, if the PCMH+ program demonstrates aggregate savings for the Medicaid program during the performance year and the participating entity meets specified benchmarks on quality measures for the challenge pool, while also maintaining or exceeding its performance on the quality measures for the individual shared savings pool, it may also be eligible to receive shared savings payments from the challenge pool.

(B) The main provisions of the regulation: (1) Describes the provider qualifications necessary for providers to become participating entities in the PCMH+ program, (2) describes the types of care coordination services that providers affiliated with participating entities are required to offer as part of the PCMH+ program, (3) sets forth the framework for measuring the quality of participating entities' performance, (4) describes the approach for preventing, monitoring and remedying under-service of Medicaid members participating in PCMH+, (5) sets forth the categories of Medicaid members who are eligible to participate in PCMH+, (6) describes the methodology for assigning Medicaid members to participating entities, (7) establishes the parameters for monitoring participating entities' adherence to PCMH+ requirements, (8) sets forth the framework for measuring Medicaid expenditures incurred by PCMH+ members, including inventorying the benefits and associated expenditures that are included in the calculation of shared savings payments, if earned by participating entities, (9) describes the reimbursement methodology for the PCMH+ program, including care coordination add-on payments, individual pool shared savings payments, and

challenge pool shared savings payments, and (10) sets forth such additional details as are necessary for the department to implement the PCMH+ program.

(C) The legal effects of the regulation, including all of the ways that the regulation would change existing regulations or other laws: The regulation sets forth the parameters and requirements to enable the department to implement the PCMH+ program.