DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 21-I: Person-Centered Medical Home Plus (PCMH+) Program Updates

The State of Connecticut Department of Social Services (DSS) proposes to submit the following Medicaid State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS).

Changes to Medicaid State Plan

Effective on or after January 1, 2021, SPA 21-I will amend Attachment 4.19-B of the Medicaid State Plan to update the Person-Centered Medical Home Plus (PCMH+) Program as detailed below. The PCMH+ program is codified in the Medicaid State Plan as an Integrated Care Model within section 1905(a)(29) of the Social Security Act (Act), which is the Medicaid benefit category for "any other medical care, and any other type of remedial care recognized under State law, specified by the [HHS] Secretary." PCMH+ involves shared savings payments and care coordination add-on payments for primary care case management (PCCM) services, as defined by section 1905(t) of the Act.

First, the quality measures for PCMH+, which are used as part of the calculation methodology for the individual pool and challenge pool shared savings payments, will be updated in order to reflect various changes to the measures by the applicable measure stewards. These changes include removing quality measures that have been retired, incorporating changes to the measures that have been made by the measure stewards, and updating measures to new stewards as appropriate.

Second, in recognition of the disruptions in utilization patterns due to the Coronavirus Disease 2019 (COVID-19) pandemic and associated public health emergency declarations and in recognition of the increased stability in Medicaid eligibility due to the requirements for states established pursuant to section 6008(b)(3) of the Families First Coronavirus Response Act (FFCRA), this proposed SPA will provide that the PCMH+ member assignment for the calendar year 2021 measurement year will remain in place based on the member attribution determined as of late 2019 that is currently being used for the calendar 2020 measurement year. However, the member assignment methodology for measurement years in calendar years 2022 and forward will revert to the standard methodology that is currently in place.

Finally, this proposed SPA will make adjustments as necessary to the methodology for measuring performance on quality measures that is used in the calculation of the individual pool and challenge pool shared savings payments in order to account for disruptions in utilization due to the COVID-19 pandemic and associated public health emergency declarations.

Fiscal Impact

DSS does not anticipate that this SPA will have any significant changes in annual aggregate expenditures.

Obtaining SPA Language and Submitting Comments

The proposed SPA is posted on the DSS website at this link: http://portal.ct.gov/dss. Scroll down to the bottom of the webpage and click on "Publications" and then click on "Updates." Then click on "Medicaid State Plan Amendments". The proposed SPA may also be obtained at any DSS field office, at the Town of Vernon Social Services Department, or upon request from DSS (see below).

To request a copy of the SPA from DSS or to send comments about the SPA, please email: Public.Comment.DSS@ct.gov or write to: Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105. Please reference "SPA 21-I: Person-Centered Medical Home Plus (PCMH+) Program Updates".

Anyone may send DSS written comments about this SPA. Written comments must be received by DSS at the above contact information no later than January 13, 2021.

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

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

I. Quality Measures

In addition to providing the Enhanced Care Coordination Activities (and for Participating Entities that are FQHCs, also the Care Coordination Add-On Payment Activities) in order to be eligible to receive shared savings payments, if applicable, each PCMH+ Participating Entity must also maintain and/or improve the quality of care and care experience for beneficiaries assigned to the Participating Entity, as measured by various quality measures. Specifically, in order to be eligible to receive shared savings payments, each PCMH+ Participating Entity must meet specified standards for quality measures, as described in Attachment 4.19-B. The PCMH+ quality measure set contains process and outcome measures that include measures of beneficiary experience. Of those measures, a specified subset of measures will be used in calculating various payments, as described in Attachment 4.19-B. All of the quality measures have been updated as of January 1, ~~2020~~2021 and apply to Performance Years beginning on or after that date and a description of those measures, including the use of each such measure in calculating shared savings payments, is posted to DSS's website at: http://www.ct.gov/dss/pcmh+.

The quality measure set will be reviewed annually and updated as deemed necessary by DSS. Changes in the measure set will be derived from recommendations generated from the Program Evaluations for prior years.

II. Measures to Prevent Under-Service

Participating Entities will be disqualified from receiving shared savings payments if they demonstrate repeated or systematic failure to offer medically necessary services or manipulate their member panel, whether or not there is evidence of intentionality. DSS uses a multi-pronged approach to identify and prevent under-service of PCMH+ members. The data points that DSS monitors under this approach include, but are not limited to: PCMH+ member grievances, provider performance on quality measures (particularly preventive care service measures),

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

III. Quality Measures

In addition to providing the Enhanced Care Coordination Activities (and for Participating Entities that are FQHCs, also the Care Coordination Add-On Payment Activities) in order to be eligible to receive shared savings payments, if applicable, each PCMH+ Participating Entity must also maintain and/or improve the quality of care and care experience for beneficiaries assigned to the Participating Entity, as measured by various quality measures. Specifically, in order to be eligible to receive shared savings payments, each PCMH+ Participating Entity must meet specified standards for quality measures, as described in Attachment 4.19-B. The PCMH+ quality measure set contains process and outcome measures that include measures of beneficiary experience. Of those measures, a specified subset of measures will be used in calculating various payments, as described in Attachment 4.19-B. All of the quality measures have been updated as of January 1, ~~2020~~2021 and apply to Performance Years beginning on or after that date and a description of those measures, including the use of each such measure in calculating shared savings payments, is posted to DSS's website at: http://www.ct.gov/dss/pcmh+.

The quality measure set will be reviewed annually and updated as deemed necessary by DSS. Changes in the measure set will be derived from recommendations generated from the Program Evaluations for prior years.

IV. Measures to Prevent Under-Service

Participating Entities will be disqualified from receiving shared savings payments if they demonstrate repeated or systematic failure to offer medically necessary services or manipulate their member panel, whether or not there is evidence of intentionality. DSS uses a multi-pronged approach to identify and prevent under-service of PCMH+ members. The data points that DSS monitors under this approach include, but are not limited to: PCMH+ member grievances, provider performance on quality measures (particularly preventive care service measures),

described in more detail below). Assignment will occur on or before December 31st for each entire Performance Year starting on each following January 1st, except for: (1) the Calendar Year 2018 Performance Year, in which assignment will occur in or around March 2018 and (2) the Calendar Year 2021 Performance Year, in which the assignment will continue to use the assignment determined for the Calendar Year 2020 Performance Year. Beneficiaries will be assigned to only one Participating Entity for each Performance Year. Any change in the beneficiary's PCMH attribution will be reflected in the following year's PCMH+ assignment.

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

If, over the course of a Performance Year, a PCMH+ member Medicaid eligibility or moves into a population that is not eligible for PCMH+ (see Attachment 3.1-A), that change has the same effect as if an individual opts out of assignment to a PCMH+ Participating Entity, as described immediately above. If a PCMH+ member temporarily loses eligibility for Medicaid but is retroactively reinstated so that there is no gap in continuous eligibility, then each Participating Entity that is an FQHC will receive Care Coordination Add-On Payments for such members for all months of continuous eligibility, including the retroactively reinstated months, but only if the eligibility is restored not later than 60 days after temporarily losing coverage. Otherwise, if a PCMH+ member loses eligibility for Medicaid, that loss of eligibility has the same effect as if an individual opts out of assignment to a PCMH+ Participating Entity.

I. Benefits Included in the Shared Savings Calculation

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

PCMH+ QUALITY MEASURE SET - UPDATED FOR PERFORMANCE YEAR CALENDAR YEAR 2021

Scoring Measures	**Measure Steward**	**National Quality Foundation #**
Avoidable Emergency Department (ED) visits	3M	NA
Avoidable hospitalizations	3M	NA
Child and Adolescent Well-Care Visits (Combined Rate of 12-17 and 18-21) (WCV)	NCQA	1516
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	NCQA	0058
Developmental screening in the first three years of life	CMS	NA
Comprehensive Diabetes Care - Hemoglobin A1c (HbA1c) testing (CDC)	NCQA	0057
Ambulatory Care - ED Visits (AMB)	NCQA	NA
Asthma Patients with One or More Asthma-Related Emergency Room Visit(s) (Ages 2-20)	DSS	NA
PCMH CAHPS	NCQA	NA
Challenge Measures	**Measure Steward**	**National Quality Foundation #**
Behavioral Health Screening 1–18	DSS	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	NCQA	2800
Readmissions within 30 Days - Physical health and behavioral health	DSS	NA
Antidepressant Medication Management (AMM)	NCQA	0105
Prenatal and Postpartum Care (PPC)	NCQA	1517
Follow-up After Hospitalization For Mental Illness (FUH)	NCQA	0576
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	NCQA	3489
Reporting Only Measures	**Measure Steward**	**National Quality Foundation #**
Annual fluoride treatment ages 1-4	DSS	NA
Appropriate Treatment for Upper Respiratory Infection (URI)	NCQA	0069
Asthma Medication Ratio (AMR)	NCQA	1800
Breast Cancer Screening (BCS)	NCQA	2372
Cervical Cancer Screening (CCS)	NCQA	0032
Chlamydia Screening in Women (CHL)	NCQA	0033
Comprehensive Diabetes Care - Eye Exam (Retinal) Performed	NCQA	0055
Follow-Up Care For Children Prescribed ADHD Medication (ADD)	NCQA	0108
Immunizations for Adolescents - HPV	NCQA	1407
Oral Evaluation, Dental Services	ADA	2517
Use of Imaging Studies for Low Back Pain (LBP)	NCQA	0052
Well-Child Visits in the First 30 Months of Life (Well-Child Visits in the First 15 Months rate)	NCQA	1392