DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 23-0001: Targeted Case Management (TCM) for Integrated Care for Kids (InCK) in New Haven

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, 2023, this SPA will amend Attachments 3.1-A, 3.1-B, and 4.19-B of the Medicaid State Plan in order to establish a new Targeted Case Management (TCM) target group. This TCM target group is children under age twenty-one and individuals who are pregnant or up to twelve months post-partum who reside in zip codes 06510 and 06511. However, in order to facilitate continuity of care, if someone resides in one of those zip codes at the time the person receives a comprehensive assessment or reassessment but later moves to a location outside those zip codes but still within New Haven, Connecticut, that person may continue to receive TCM services for InCK for the remainder of the length of stay specified in the person's care plan and so long as the person continues to reside in New Haven, Connecticut. Eligible individuals in the target group will be assessed to determine the appropriate level of need for each person into one of three tiers of Service Integration Level (SIL), which measures the degree to which each person has been determined to need TCM services. SIL Tier 1 reflects a low intensity of need and those members will not receive TCM services. SIL Tier 2 is reflects a moderate intensity of need and those members will receive moderate intensity of TCM services. SIL Tier 3 reflects a significant intensity of need and those members will receive more intensive TCM services. Based on available data, eligible individuals will be preliminarily attributed to TCM InCK providers and, where possible based on available data, assigned a preliminary SIL level for each calendar year.

All TCM InCK services are voluntary. Each Medicaid member can choose their TCM InCK provider and can opt out of TCM InCK or change TCM InCK providers at any time. TCM InCK will not duplicate or modify existing Medicaid covered services and members will continue to have access to the standard Medicaid benefit. TCM InCK providers must serve the New Haven area and have care coordinators and care coordinator supervisors on staff who meet the applicable qualifications.

The state pays TCM InCK providers $201 per-member per month (PMPM) for each attributed member confirmed at SIL 2 and $443 PMPM for each attributed member confirmed at SIL 3. The state pays the provider the PMPM payments starting on the monthly period that begins on the date that the provider completes the assessment for each eligible individual that confirms the person's SIL. In addition, out of a pool for performance payments equal to 10% of the total monthly service payments made to all

InCK providers for dates of service for each calendar year, the state pays performance-based payments to providers that meet the quality performance measures detailed in the SPA pages.

The purpose of this SPA is to improve care coordination and improve physical and behavioral health outcomes for the target population specified above, consistent with the state's federal InCK grant with the Center for Medicare and Medicaid Innovation (CMMI) within CMS. The City of New Haven was selected as Connecticut's pilot location for the InCK program after a competitive selection process was initiated and completed by DSS. In March 2019, DSS selected Clifford Beers Clinic in New Haven as the Local Lead Organization for Connecticut's application to CMMI for the state's participation in the federal InCK grant program. In December 2019, CMS announced that it approved Connecticut's InCK application. DSS and Clifford Beers Clinic, together with various state agency and non-governmental stakeholders, have been working to develop an InCK proposal to improve the lives of children in New Haven.

Fiscal Impact

DSS estimates that this SPA will increase annual aggregate expenditures by approximately $2,686,063 in State Fiscal Year (SFY) 2023 and $7,091,207 in SFY 2024.

Obtaining SPA Language and Submitting Comments

The proposed SPA is posted on the DSS website at this link: https://portal.ct.gov/DSS/Health-And-Home-Care/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 23-0001: TCM for InCK in New Haven."

Anyone may send DSS written comments about this SPA. Written comments must be received by DSS at the above contact information no later than November 9, 2022.

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Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):
The target group for the Integrated Care for Kids (InCK) Model in New Haven is all children under age 21 and individuals who are pregnant or up to twelve months post-partum.

__X__ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to ____180_____ **[insert a number; not to exceed 180]** consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):

___ Entire State

_X_ Only in the following geographic areas: Zip Codes 06510 and 06511, provided that in order to facilitate continuity of care, if someone resides in one of those Zip Codes at the time the person receives a comprehensive assessment or reassessment but later moves to a location outside those Zip Codes but still within New Haven, Connecticut, that person may continue to receive TCM services for InCK for the remainder of the length of stay specified in the person's care plan and so long as the person continues to reside in New Haven, Connecticut.

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

___ Services are provided in accordance with §1902(a)(10)(B) of the Act.

_X_ Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

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An initial comprehensive assessment of needs is performed, which includes a determination of whether each individual risk-stratifies to Service Integration Level (SIL) 1, in which case further InCK TCM services after the assessment are not provided; SIL 2, which reflects a moderate level of need and corresponds to a moderate intensity of InCK TCM services provided, as tailored to each person's needs in the care plan; or SIL 3, which reflects a high level of need and corresponds to a higher level of InCK TCM services provided, as tailored to each person's needs in the care plan. After the initial assessment, reassessments occur at least annually if the individual continues to receive services but may be performed more frequently based on the individual's needs, including to the extent necessary to capture changes in the person's needs. Individuals assessed at SIL 3 in the most recent assessment must be reassessed at least every six months as long as reassessment determines the person eligible for SIL 3, to the extent that the person continues to receive services. This frequency is appropriate because for individuals whose conditions are not likely to change frequently, annual will be sufficient and for individuals whose conditions are changing more frequently, the assessments will be performed at a shorter interval that is appropriate for that individual.

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
    identifies a course of action to respond to the assessed needs of the eligible individual;

- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- Monitoring and follow-up activities:
  - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals

and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:

- services are being furnished in accordance with the individual's care plan;
- services in the care plan are adequate; and
- changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

  Type of Monitoring and Follow-Up Activities: Monitoring and follow-up activities include making necessary adjustments in the care plan and related changes in the services performed by the provider, which may be performed by staff face-to-face, telehealth, or telephone contact with the individual; by chart review; by case conference; by collateral contact with individuals, family members, providers, legal representatives, or other persons or entities for the benefit of the Medicaid member; or any combination thereof.

  Frequency of Monitoring and Follow-Up Activities: Monitoring and follow-up activities are performed annually or more frequently in accordance with each individual's care plan, which, in general, will be more frequent for individuals classified at a higher Service Integration Level (SIL). This frequency is appropriate because it will be tailored to each person's needs.

_X_ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Provider Attribution Methodology: Individuals eligible for TCM for InCK in New Haven are attributed to a qualified provider based on the following attribution methodology:

In 2023, the state will use a two-pronged approach to attribute InCK eligible individuals, promoting choice and recognizing that there will be limited or no Medicaid claims history for receiving InCK services in the initial implementation of this benefit.

The state will use community health organizers (CHOs) to outreach to InCK eligible individuals who do not have Medicaid claims history. Claims data sufficient to enable

claims-based attribution (described below) will begin to accumulate upon successful completion of each member's initial appointment with an enrolled TCM for InCK in New Haven provider.

In 2023, the state will work with an initial cohort of qualified Medicaid enrolled TCM for InCK in New Haven providers. For those participating providers, the state will collect patient information for Medicaid members, including data elements necessary to establish the attribution methodology.

The state will use this data to perform a Matching Person Index (MPI) to align patient panels against the CT InCK target population. If individuals have more than one relationship with a CT InCK provider (e.g. are on multiple supplied lists), they will be contacted by the CHO to choose an enrolled CT InCK provider.

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Note that throughout this section, all coursework and degrees are counted only from educational institutions accredited by an organization authorized by the United States Department of Education.

- Location: provider must be able to deliver services in New Haven and comply with timely service requirements
- Entity Type: must be enrolled in good standing in CMAP as a TCM InCK provider
- Additional Entity Qualifications
    - Experience providing community-based care coordination services
    - Must designate one or more dedicated care coordinator supervisors sufficient to supervising TCM for InCK for that provider and that must meet the following specified qualifications:
        - A master's degree in a human service or related field with at least one year's full-time equivalent experience providing care coordination or a bachelor's degree in a human service or related field with at least three years' full-time equivalent experience providing care coordination; and
        - One year of experience providing care coordination in the New Haven, Connecticut area.
    - Regular supervision and oversight of care coordinators

- Individual Staff Qualifications and Requirements
    - Care coordinators must meet all of the following:

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- Have at least a bachelor's degree in a human services or a related field.
- At least one year of full-time equivalent experience providing care coordination services. Related life experience receiving or providing care coordination is also included as part of the experience.

Freedom of choice (42 CFR 441.18(a)(1)):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services: [**Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]**

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

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Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations: Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

[Specify any additional limitations.]

Duration: TCM for InCK in New Haven is provided for no more than six months from the initial needs assessment for each eligible individual, which may be extended with prior authorization based on medical necessity.

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C. Targeted Case Management (TCM) for Integrated Care for Kids (InCK) in New Haven

1. Monthly Service Payments

Effective January 1, 2023, the state pays TCM InCK providers $201 per-member per month (PMPM) for each attributed member confirmed at SIL 2 and $443 PMPM for each attributed member confirmed at SIL 3. The state pays the provider the PMPM payments starting on the monthly period that begins on the date that the provider completes the assessment for each eligible individual that confirms the person's SIL. PMPM payments continue for the duration that the services are provided, subject to the limitations set forth in Attachment 3.1-A.

2. Performance-Based Payments

Effective January 1, 2023, the state pays a performance-based payment to each participating InCK provider that meets the quality performance measures detailed below during the first twelve months of service and each calendar year thereafter. The performance period for these quality payments is January 1, 2023 through December 31, 2023 and each calendar year thereafter. The performance payments will be made not later than 12 months after the end of the performance period.

i. Total Pool Calculation: The total pool for the performance-based payments is equal to 10% of the total monthly service payments made to all InCK providers for dates of service from January 1, 2023 to December 31, 2023 and each calendar year thereafter.

ii. InCK Provider Payment Allocation: InCK providers that meet all quality performance measures (see 2.iii below) are eligible for performance-based payments. Each InCK provider's payment is proportional to its share of attributed beneficiaries. The performance-based payment to each eligible InCK provider is calculated as follows:

1. Identify total pool amount for the performance period (as defined in 2.i.)
2. Identify the ratio of attributed member months during the performance period for each eligible InCK provider to the total number of attributed member months during the performance period for all InCK providers that meet the quality performance measures
3. Multiply the eligible TCM provider's ratio (item 2.ii.2) by the total pool amount (item 2.ii.1)

iii. Quality Performance Measures: Each measure listed below is weighted equally. Each provider that meets the target for each measure will receive the entire performance-based payment for each quality measure.

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1. *Successful Completion of Needs Conversations*: This measure is met if an InCK Provider completes Needs Conversations with 60% or greater of its attributed population. This measure is calculated by dividing the total number of completed Needs Conversations by the total number of attributed members for an InCK Provider.

2. *Comprehensive Collection of Race, Ethnicity, and Language Data*: This measure is met if an InCK Provider collects race, ethnicity, and language data in 75% or greater of its completed Needs Conversations. This measure is calculated by dividing the total number of InCK members with completed race, ethnicity, and preferred language demographic data by the total number of InCK members with completed Needs Conversations by an individual InCK Provider.

3. *Referral Efficacy*: This measure is met if 50% or greater of referrals made by an InCK Provider for attributed patients are closed. This measure is calculated by dividing the total number of closed referrals by the total number of referrals made (in aggregate across all attributed patients).