A Brief Primer on the Medicaid Quality Improvement and Shared Savings Program (MQISSP)

The Department of Social Services is launching a planning process to develop a new, upside-only shared savings initiative entitled the Medicaid Quality Improvement and Shared Savings Program (MQISSP). The Department's goal with MQISSP, which is a component of the State Innovation Model (SIM) Model Test Grant initiative, is to improve health and satisfaction outcomes for Medicaid beneficiaries currently being served by Federally Qualified Health Centers (FQHCs) and "advanced networks" (e.g. Accountable Care Organizations, ACOs), which will be competitively selected by the Department via a Request for Proposals. Both FQHCs and certain ACOs are currently providing a significant amount of primary care to Medicaid beneficiaries.

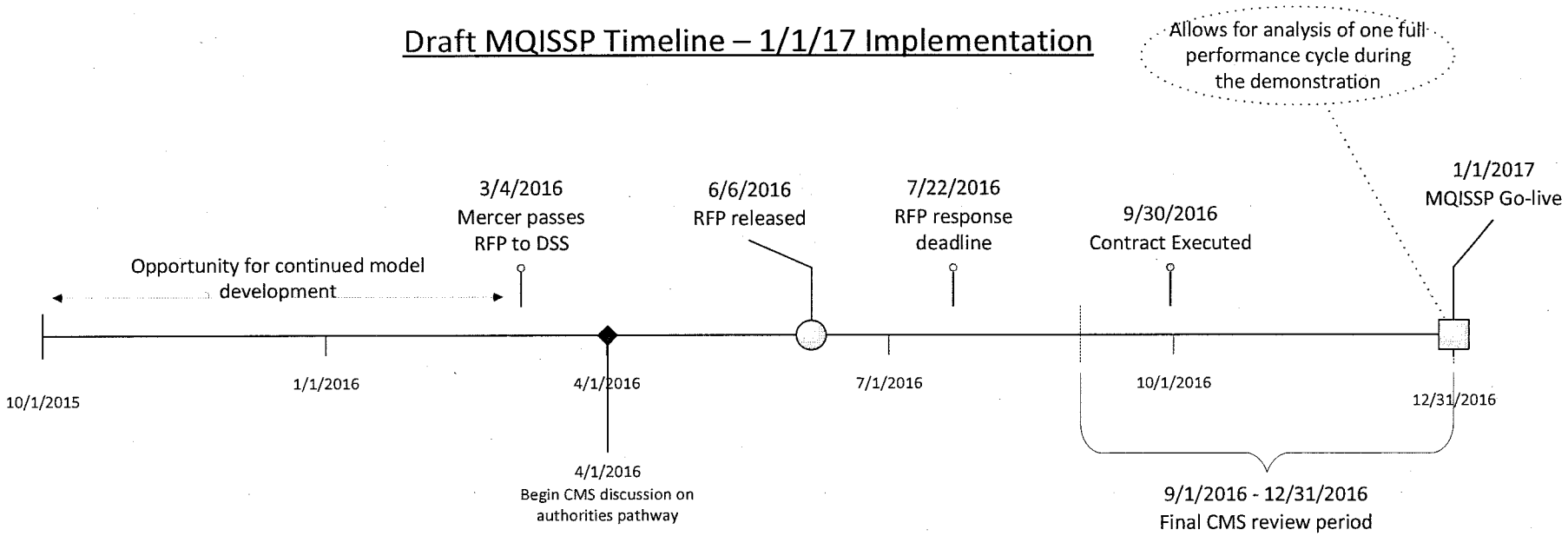
MQISSP represents an opportunity for Connecticut Medicaid to build on, but not supplant, its existing and successful Person-Centered Medical Home initiative, through which over one-third of beneficiaries are being served. While PCMH will remain the foundation of care delivery transformation, MQISSP will build on PCMH by incorporating new requirements related to integration of primary care and behavioral health care, as well as linkages to the types of community supports that can assist beneficiaries in utilizing their Medicaid benefits. Typical barriers that inhibit the use of Medicaid benefits include housing instability, food insecurity, lack of personal safety, limited office hours at medical practices, chronic conditions, and lack of literacy. Enabling connections to organizations that can support beneficiaries in resolving these access barriers will further the Department's interests in preventative health. Further, partnering with providers on this will begin to re-shape the paradigm for care coordination in a direction that will support population health goals for individuals who face the challenges of substance abuse and behavioral health, limited educational attainment, poverty, homelessness, and exposure to neighborhood violence.

In developing MQISSP, the Department will seek review and comment on all aspects of model design from the Care Management Committee of the Medical Assistance Program Oversight Council (MAPOC). The Department has memorialized a protocol that governs coordination of this work with activities of the SIM Quality Measures and Equity& Access Councils. This protocol emphasizes that Department is the single state Medicaid agency for Connecticut, and that consistent with federal law, DSS' primary obligation is to promote and safeguard the interests of Medicaid beneficiaries.

Item	Description
Overall statement of purpose	The Connecticut Medicaid Quality Improvement and Shared Savings Program (MQISSP) aims to improve health outcomes and care experience of single-eligible Medicaid beneficiaries through arrangements with competitively selected, participating providers (FQHCs and "advanced networks") that will receive care coordination payments (FQHCs only) and a portion of any savings that are achieved (FQHCs and advanced networks), on the condition that they meet benchmarks on identified quality measures.
Timing and participation	The "first wave" of MQISSP was originally intended to be implemented effective January 1, 2016, but Connecticut is considering an extension of this date to allow for engagement with stakeholders as well as to permit time to gain approval of Medicaid authority by CMS for the care

	coordination and shared savings payments that are proposed to be made under MQISSP. The first wave is slated to include 200,000 to 215,000 Medicaid beneficiaries. DSS must issue a Request for Proposals (RFP) in 2015 to select participating entities. A "second wave" of MQISSP must be implemented effective January 1, 2017.
Target population and method of affiliating beneficiaries with the initiative	DSS will be attributing single-eligible Medicaid beneficiaries to MQISSP participating entities using our current PCMH attribution method (to be refined, if necessary). MQISSP will not include any full or partial dually-eligible (Medicare and Medicaid eligible) individuals. DSS will seek feedback from the Care Management Committee about both the target population and the attribution method.
Overview of financial model	Under MQISSP, DSS will select a number of FQHCs and advanced networks by RFP. DSS will then enter into upside-only shared savings contracts with the providers (FQHCs and advanced networks) that are selected. There will be no downside risk on providers. Additionally, DSS will be making add-on care coordination payments ONLY to the FQHCs that are selected (not to the advanced networks).
Process steps	To implement MQISSP, the Department must take actions including, but not limited to the following, on each matter seeking review and comment by the Care Management Committee: • establish a timeline for development and implementation of the project; • frame provider qualifications and program parameters; • select relevant quality measures (including measures of under-service) on which shared savings will be based; • select additional means of evaluating quality including, but not limited to, assessment of participants' care experience; • develop and implement the means of making care coordination payments to the FQHCs; • develop and implement the shared savings methodology (including, but not limited to, eligibility for and means of distribution) for FQHCs and advanced networks; • investigate, review, decide upon and pursue relevant Medicaid authority to make care coordination payments to the FQHCs that are selected to participate, and shared savings payments to all entities that are selected to participate; and • develop, issue and select participating entities through an RFP.
For more information	Please see the full SIM application at this link: http://www.healthreform.ct.gov/ohri/lib/ohri/sim/test_grant_documents/application/ct_sim_test_program_narrative_final.pdf

Draft MQISSP Timeline – 1/1/17 Implementation



Opportunities for continued development of model design – In Focus

Stakeholder opportunities for continued input

- Inform the Under-service Utilization Monitoring Strategy
  - Secret shopper
  - Member survey
  - Shared savings design elements
  - Member education and grievances
- Inform program and provider monitoring efforts prior to the release of the RFP

Department opportunities for refinement of model design

- Properly align MQISSP care coordination activities with CCIP
- Modify system to accommodate three levels of quality review in the MQISSP design
- Develop and stakeholder program and provider monitoring efforts prior to the release of the RFP
- Validate and proof data for use in the quality score and cost calculations

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STATE OF CONNECTICUT MQISSP ELEMENTS OVERVIEW

September 15, 2015 - Draft and Subject to Revision

The Connecticut Department of Social Services (Department) is launching a planning process to develop a new, upside-only shared savings initiative entitled the Medicaid Quality Improvement and Shared Savings Program (MQISSP). The goal of MQISSP, which is a component of the State Innovation Model, is to improve quality and experience of care for Medicaid beneficiaries currently being served by Federally Qualified Health Centers (FQHCs) and Advanced Networks. The Department will select FQHCs and Advanced Networks to become MQISSP Participating Entities via a Request for Proposals process.

The following are component pieces that have been settled in negotiations during the creation of the MQISSP (e.g., Memorandum of Agreement, Primer, etc.). It is assumed that no input from the committee is necessary on these elements.

MQISSP Element	Working Assumptions	Date Shared with MAPOC
Upside or Downside Model Design	• Upside-only model for each performance year.	• April 15, 2015[1]; May 13, 2015[2] June 12, 2015[3]; August 26, 2015[4]
Participating Entities	• MQISSP Participating Entities will include FQHCs and Advanced Networks that include at least one Person-Centered Medical Home (PCMH).	• April 15, 2015[1]; May 13, 2015[2] June 12, 2015[3]; August 26, 2015[4,5]
Attribution and Assignment	• Beneficiaries will be prospectively assigned based on the PCMH retrospective attribution process as detailed on the DSS and MAPOC September 8, 2015 conference call.	• April 15, 2015[1]; May 13, 2015[2] June 12, 2015[3]; August 26, 2015[4]

The following are component pieces that have already received input from the Council on Medical Assistance Program Oversight (MAPOC):

MQISSP Element	Working Assumptions	Date Shared with MAPOC
Target Population	• All single-eligible Medicaid beneficiaries with the exception of full/partial dual-eligible beneficiaries, nursing facility residents, 1915(c) waiver members, 1915(i) State Plan Amendment members, Money Follows the Person members, limited benefit Medicaid beneficiaries, and the Department of Mental Health & Addiction Services Health Home participants.	• April 15, 2015[1]; May 13, 2015[2] June 10, 2015[6]; June 12, 2015[3] August 26, 2015[4]
Benefits Included in Shared Savings Calculation	• All Medicaid claims except hospice, long-term supports and services, non-emergent medical transportation, and 1915(c) waiver services.	• July 8, 2015[7,8]; August 26, 2015[4]
Quality Measures	• Quality measure set derived from Department webinars 1–3. Quality measure weighting and underservice utilization monitoring strategy will be reviewed via committee work session on September, 22, 2015.	• August 26, 2015[4,9]

MQISSP Element	Working Assumptions	Date Shared with MAPOC
Care Coodination	• Care Coordination activities specific to FQHCs and applicable to all Participating Entities were reviewed via webinar with MAPOC.	• September 15, 2015 (to be posted on the MAPOC website)

The following elements are technical aspects of the shared savings model. These elements will be vetted with MAPOC during the development of the shared savings model:

MQISSP Element	Working Assumptions	Date Shared with MAPOC
Minimum Number of Members	• MQISSP Participating Entities must have a minimum of 2,500 MQISSP beneficiaries.	• August 26, 2015[4]
Historical Baseline	• MQISSP Participating Entities will be benchmarked for quality against a comparison group or other national benchmarks.	• August 26, 2015[4,10]
Shared Savings Calculation	• Includes a hybrid savings pool incentivizing absolute quality and quality improvement. Realizable savings will capped at 10% of expected costs. There will be no minimum savings rate.	• August 26, 2015[4,10]
Trend Development	• Due to the comparison group approach, trend assumptions will likely be unnecessary because the comparison group will be used to establish actual realized trends.	• August 26, 2015[4,10]
Risk Adjustment Methodology	• Includes a concurrent risk adjustment approach for each MQISSP Participating Entity, for all providers in aggregate, and for the comparison group.	• August 26, 2015[4]
Truncation of High-Cost Claims	• High-cost claims are to be truncated at the ninety-ninth percentile (subject to review of data).	• August 26, 2015[4]

Sources:

The list of sources below does not include hyperlinks for DSS Quality Measure webinars. It is anticipated that these will be posted to MAPOC's website in the near future. In addition, materials to be presented at the September 22, 2015 MAPOC work session are not included in this list.

1. *A Brief Primer on the Medicaid Quality Improvement and Shared Savings Program (MQISSP)*; April 15, 2015.
   https://www.cga.ct.gov/med/committees/med1/2015/0415/201501415ATTACH_A%20Brief%20Primer%20on%20MQISSP.pdf
2. *A Brief Primer on the Medicaid Quality Improvement and Shared Savings Program (MQISSP)*; May 13, 2015.
   https://www.cga.ct.gov/med/committees/med1/2015/0513/20150513ATTACH_A%20Brief%20Primer%20on%20MQISSP%20revised%205-10-15.pdf
3. *A Brief Primer on the Medicaid Quality Improvement and Shared Savings Program (MQISSP)*; June 12, 2015.
   https://www.cga.ct.gov/med/council/2015/0612/20150612ATTACH_A%20Brief%20Primer%20on%20MQISSP%205-10-15.pdf
4. *State of Connecticut MQISSP Elements Overview*; August 26, 2015.
   https://www.cga.ct.gov/med/committees/med1/2015/0826/20150826ATTACH_MQISSP%20Elements.pdf
5. *MQISSP Participating Entity Qualifications*; August 26, 2015.
   https://www.cga.ct.gov/med/committees/med1/2015/0826/20150826ATTACH_MQISSP%20Participating%20Entity%20Qualifications%20Handout.pdf
6. *Attributed Members for the Medicaid Quality Improvement and Shared Savings Program (MQISSP)*; June 10, 2015.
   https://www.cga.ct.gov/med/committees/med1/2015/0610/20150610ATTACH_MQISSP%20Attributed%20Members%20.pdf
7. *Benefits in the Shared Savings Calculation for the MQISSP*; July 8, 2015.
   https://www.cga.ct.gov/med/committees/med1/2015/0708/20150708ATTACH_MQISSP%20Benefits%20in%20Shared%20Savings%20Calculation%202015%2007%2008.pdf
8. *Benefits in the Shared Savings Calculation for the MQISSP Checklist*; July 8, 2015.
   https://www.cga.ct.gov/med/committees/med1/2015/0708/20150708ATTACH_MQISSP%20Benefits%20in%20Shared%20Savings%20Calculation%20Checklist%202015%2007%2008.pdf
9. *MQISSP Proposed Quality Measure List;* August 26, 2015.
   https://www.cga.ct.gov/med/committees/med1/2015/0826/20150826ATTACH_MQISSP%20Proposed%20Quality%20Measure%20List_DRAFT%20.pdf
10. *State of Connecticut Shared Savings Payment Principles*; August 26, 2015.
    https://www.cga.ct.gov/med/committees/med1/2015/0826/20150826ATTACH_MQISSP%20Shared%20Savings%20Payment%20Principles.pdf

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MQISSP — PROPOSED ENHANCED CARE COORDINATION ACTIVITIES

September 4, 2015
Draft and Subject to Revision

The following table provides a set of working assumptions for the enhanced care coordination activities to implement as part of the Connecticut Medicaid Quality Improvement and Shared Savings Program (MQISSP) quality strategy. These enhanced care coordination activities would build upon the existing standardized requirements for Federally Qualified Health Center's (FQHC's) under the Health Resource and Services Administration (HRSA) standards and the Patient Centered Medical Home (PCMH) requirements recognized by either the National Committee for Quality Assurance (NCQA) or The Joint Commission's (TJC) PCMH standards for ambulatory care entities.

In order to identify enhanced care coordination activities, Mercer Government Human Services Consulting conducted research of national best practices in care coordination. Research included the evaluation of health care delivery redesign efforts that included care coordination models. States such as Alabama, Maine, Ohio, Rhode Island, Wisconsin, and Washington implemented changes to their Medicaid health care delivery systems with models of care coordination in PCMH or health home settings. Additional areas of research included the evaluation of national best practices in behavioral health (BH) and physical health (PH) integration, the provision of culturally competent services, establishing the availability and minimum education requirements for care coordinator staff, caring for children and youth with special healthcare needs (CYSHCN) and competencies in care for individuals with disabilities.

The working assumptions for the MQISSP required enhanced care coordination activities are defined as:

- **All Providers**: Indicates the activity will be required for FQHC and Advance Network participating entities.
- **Only FQHCs**: Indicates the activity will be required for all FQHC participating entities and represent the enhanced care coordination payment activities.

Category	Enhanced Care Coordination Activity Description	All Providers	FQHC Only
Behavioral Health/ Physical Health Integration	1. Employ a care coordinator with BH education, training, and/or experience.	✓	
	2. Employ a care coordinator with BH experience who serves as a member of the interdisciplinary team and has the responsibility for tracking patients, reporting adverse symptoms to the clinical team, providing patient education, supporting treatment adherence, taking action when non-adherence occurs or symptoms worsen, provide psychosocial support and referrals to BH services outside of the clinic when indicated.		✓
	3. Use standardized tools to expand BH screenings beyond depression.	✓	
	4. Promote universal screening for BH conditions across all populations, not just those traditionally identified as high-risk.	✓	

Category	Enhanced Care Coordination Activity Description		All Providers	FQHC Only
	5. Maintain a copy of the psychiatric advance directive in the patient's file.		✓	
	6. Develop Wellness Recovery Action Plans WRAPs in collaboration with the patient and family.			✓
	7. Maintain a copy of the WRAP in the patient's file.		✓	
	8. Expand the development and implementation of the care plan for transition age youth (TAY) with BH challenges (e.g., collaborative activities to achieve success in transition and/or referrals to and coordination with programs specializing in the care of TAY with BH challenges.			✓
	9. Require the use of an interdisciplinary team that includes BH specialist(s). The team has the responsibility for driving integrated PH and BH integration, to conduct interdisciplinary team case review meetings at least monthly, promote shared appointments and develop a comprehensive care plan outlining coordination of PH and BH care needs.			✓
Culturally Competent Services	10. Require annual cultural competency training for all practice staff. Cultural competency training will include the needs of individuals with disabilities.		✓	
	11. Expand the individual care plan to assess the impact culture has on health outcomes.		✓	
	12. Expand the CAHPS to include the supplemental Cultural Competency Item Set. [1]		✓	
	13. Require compliance with culturally and linguistically appropriate services standards (CLAS) as defined by the Department of Health and Human Services, Office of Minority Health.		✓	
Care Coordinator Staff Requirements: Availability	Providers select at least one of these options based on model(s) that fit their practice.	14. Employ a full time care coordinator dedicated solely to care coordination activities.	✓	
		15. Assign care coordination activities to multiple staff within a practice. Consider adding language about a "lead care coordinator."	✓	
		16. Contract with an external agency to work with the practice to provide care coordination.	✓	
Care Coordinator Staff Requirements: Education	17. Define minimum care coordinator education and experience requirements within the MQISSP and determine if leveraging non-licensed staff such as Community Health Workers is desired.		✓	
CYSHCN: Age 0–17 years	18. Advance care planning discussions for CYSHCN. Advance care planning is not limited to CYSHCN with terminal diagnoses. It can be occur with CYSHCN with chronic health conditions, including BH conditions, which significantly impact the quality of life of the child/youth and their families.		✓	
	19. Development of advance directives for CYSHCN.		✓	
	20. Include school-related information in the health assessment and health record, such as: – An individualized education program or 504, noting any special accommodations, – Assessing patient/family need for advocacy from the provider to ensure the child's health needs are met in the school environment, – Determine how the child is doing in school and how many days have been missed due to the child's health condition, and – Document the school name and primary contact.		✓	

[1] Research indicates that states such as Texas, Maryland, and Oregon are using the CAHPS Cultural Competency Item Set in their Medicaid systems. In particular, Texas collaborated with the Office of Minority Health to added six items from the item set to the four Texas Medicaid biennial CAHPS surveys: STAR Child, CHIP, STAR Adult, and STAR+PLUS.

Category	Enhanced Care Coordination Activity Description	All Providers	FQHC Only
Competencies in Care for Individuals with Disabilities (inclusive of PH, intellectual, developmental and BH needs)	21. Expand the health assessment to include questions about durable medical equipment (DME) and DME vendor preferences, home health medical supplies, home health vendor preferences, home and vehicle modifications, prevention of wounds for individuals at risk for wounds and special physical and communication accommodations needed during medical visits.	✓	
	22. Adjust appointment times for individuals who require additional time to address physical accommodations, communication needs, and other unique needs for individuals with disabilities. Individuals may be seen by the primary care physician and other members of the interdisciplinary team during these adjusted appointment times.	✓	
	23. Develop and require mandatory disability competency trainings to address the care of individuals with physical and intellectual disabilities.	✓	
	24. Acquire accessible equipment to address physical barriers to care (e.g., wheelchair scales, high/low exam tables and/or transfer equipment and lifts to facilitate exams for individuals with physical disabilities).	✓	
	25. Address communication barriers to care (e.g., offer important medical information and documents in Braille or large print, implement policies to ensure services animals are permitted into an appointment). Providers may coordinate with the Medical Administrative Services Organization to obtain available materials.	✓	
	26. Expand the resource list of community providers to include providers who specialize in or demonstrate competencies in the care of individuals with disabilities (e.g., mammography centers that can accommodate women who use wheelchairs, providers who will take the time to help a patient with cerebral palsy who experiences spasticity or tremors during a physical examination).	✓	
Provider Report Cards	27. Evaluate and utilize provider report cards on a quarterly basis to improve quality of care.	**TBD**	**TBD**

MQISSP PROPOSED MEASURE LIST

August 26, 2015
Draft and Subject to Revision

State of Connecticut Department of Social Services (DSS)
Medicaid Quality Improvement and Shared Savings Program (MQISSP) Measure Selection Criteria and Guiding Principles:

- Leverage current DSS Patient Centered Medical Home reporting.
- Measures that are primarily claims based.
- Nationally recognized measures whenever possible.
- Use common CPT and HCPCS billing codes.
- Do not have extended look-back periods.
- Are relevant to Medicaid population:
  - Advance DSS' emphasis on preventative and primary care.
  - Focus on conditions highly prevalent in Medicaid populations.
- State Innovation Model proposed measures may supplement the MQISSP measure set when aligned with MQISSP goals.
- Target measures that identify and eliminate under-service utilization.

MQISSP Proposed Measures

Measure Title	Measure Description	Measure Steward	NQF #	ACO #
Adolescent Well-Care Visits	The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrics and gynecology practitioner during the measurement year.	NCQA		Pediatric Prevention Composite
Annual Fluoride Treatment Ages Birth to Four Years	Annual fluoride treatment ages 0<4 (in a pediatric setting).	To be created by DSS		

Measure Title	Measure Description	Measure Steward	NQF #	ACO #
Annual Monitoring for Persistent Medications (roll-up)	The percentage of patients 18 years of age and older who received a least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. • Angiotensin converting enzyme inhibitors or angiotensin receptor blockers. • Digoxin. • Diuretics. • **Total Rate will be measured** (the sum of the three numerators divided by the sum of the three denominators).	NCQA	2371	
Appropriate Treatment for Children with Upper Respiratory Infection	Percentage of children three months to eighteen years of age with a diagnosis of upper respiratory infection who were not dispensed an antibiotic medication. A higher rate indicates appropriate care (i.e., the proportion for whom antibiotics were not prescribed).	NCQA	0069	
Asthma Medication Ratio	The percentage of members 5–64 (19–64 breakout can be used for adult practices) years of age with persistent asthma and had a ratio of controller medications to total medications of 0.50 or greater during the measurement year.	NCQA	1800	
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription. A higher rate indicates appropriate care (i.e., the proportion for whom antibiotics were not prescribed).	NCQA	0058	
Behavioral Health Screening Ages 1–17	The percentage of children ages 1–17, who were screened for developmental or behavioral problems using a validated survey instrument, approved by the AAP.	NCQA		
Breast Cancer Screening	The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer in a two year period.	NCQA	2372	20

Measure Title	Measure Description	Measure Steward	NQF #	ACO #
Cervical Cancer Screening	Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: • Women age 21–64 who had cervical cytology performed every three years. • Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every five years.	NCQA	0032	
Chlamydia Screening in Women	The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	NCQA	0033	
Developmental Screening in the First Three Years of Life. Three Age Breakouts (ages 1, 2, and 3)	The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age, and by 36 months of age.	OHSU	1448	Pediatric Prevention Composite
Diabetes Eye Exam	The percentage of patients 18–75 years of age with diabetes (Type I or Type II) who had an eye exam (retinal) performed in a two year period.	NCQA	0055	DM-41
Diabetes HbA1c Screening	Adults age 18–75 with a diagnosis of Type I or Type II diabetes who received at least one HbA1c screening during the measurement year.	NCQA	0057	27
Diabetes: Medical Attention for Nephropathy	The percentage of patients 18–75 years of age with diabetes (Type I or Type II) who received a nephropathy screening test or had evidence of nephropathy during the measurement year.	NCQA	0062	
Emergency Department Usage	Emergency department usage (all ages, but 0–19 can be broken out for pediatric practices). Excludes mental health and chemical dependency services.	NCQA		

Measure Title	Measure Description	Measure Steward	NQF #	ACO #
Follow-up Care for Children Prescribed ADHD Medication	The percentage of children ages 6–12 as of the Index Prescription Start Date newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported: • Initiation Phase: The percentage with an ambulatory prescription dispensed for ADHD medication that had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase. • Continuation and Maintenance Phase: The percentage with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (nine months) after the Initiation Phase ended.	NCQA	0108	
Frequency of Ongoing Prenatal Care	Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following number of expected prenatal visits: • > or = 81% of expected visits.	NCQA	1391	
HPV for Female Adolescents	The percentage of female adolescents 13 years of age who had three doses of the HPV vaccine by their thirteenth birthday.	NCQA	1959	
Medication Management for People with Asthma	Medication Management for people with asthma age 5–64 (age 5–18 breakout can be used for pediatric practices). Percent of patients with **persistent** asthma who were prescribed and remained on asthma "controller medication" for at least 75% of their treatment period.	NCQA	1799	
Metabolic Monitoring for Children and Adolescents on Antipsychotics	Percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.	NCQA		

Measure Title	Measure Description	Measure Steward	NQF #	ACO #
Oral Evaluation, Dental Services	Percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year.	American Dental Association	2517	
PCMH CAHPS	Consumer Assessment of Healthcare Providers and Systems ® (CAHPS) — Person-Centered Medical Home (PCMH) version. Supplemental questions can be added.		N/A	
Plan All-Cause Readmission	The number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days; for members 18 years of age or older.	NCQA	1768	
Post-Hospital Admission Follow-Up	Percentage of adults age 21–75 with an inpatient "medical" or psych admission with a claim for post-admission follow-up with a physician, Physician Assistant, or advanced practice registered nurse within seven days of the inpatient discharge. Medical admissions are defined as all admissions that are not maternity or surgery related.	DSS		
Prenatal Care and Postpartum Care	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care: • Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a patient of the organization in the first trimester or within 42 days of enrollment in the organization. • Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	NCQA	1517	
Use of Imaging Studies for Low Back Pain	The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of the diagnosis. The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).	NCQA	0052	

Measure Title	Measure Description	Measure Steward	NQF #	ACO #
Well-Child Visits in the First Fifteen Months of Life	Percentage of patients who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: • Six or more well-child visits.	NCQA	1392	Pediatric Prevention Composite
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Percentage of patients 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.	NCQA	1516	Pediatric Prevention Composite

A Précis of the Connecticut Medicaid Program

Department of Social Services

Executive Summary

Under the leadership of Governor Dannel Malloy and Commissioner Roderick Bremby, the Connecticut Department of Social Services (DSS) is the single state agency for the administration of Connecticut Medicaid and the Children's Health Insurance Program (CHIP). Medicaid and CHIP are collectively described as the HUSKY Health Program.

The DSS Division of Health Services as well as Eligibility Policy and field staff support access to and utilization of HUSKY Health. These programs provide person-centered health care coverage to over 700,000 individuals (19% of the Connecticut population).

Our vision for Medicaid and CHIP is that they represent an effective health care delivery system for eligible people in Connecticut that promotes:

1) well-being with minimal illness and effectively managed health conditions;

2) maximal independence, and

3) full integration and participation in their communities.

HUSKY Health serves eligible children, their caregivers, older adults, individuals with disabilities and single, childless adults. HUSKY also helps keep older adults and people with disabilities independent at home through Medicaid "waivers".

Key Strategies:

The Department of Social Services Division of Health Services is employing diverse strategies to achieve improved health outcomes and cost efficiencies in the Medicaid program. Strategies include:

1) use of an administrative services organization (ASO) platform to promote efficient, cost-effective and consumer/provider responsive Medicaid medical, behavioral health, dental and non-emergency medical transportation (NEMT) services;
2) use of data analytics to improve care;
3) activities in support of improving access to preventative primary care;
4) efforts to support integration of medical, behavioral health, and long-term services and supports (LTSS);
5) initiatives designed to "re-balance" spending on LTSS; and
6) efforts to promote the use of health information technology.

Unique ASO Model

By contrast to almost all other Medicaid programs throughout the nation, Connecticut Medicaid is not using any managed care arrangements and is structured as a managed, fee-for-service program. Each of the four Administrative Services Organizations (ASOs) are contracted to administer services and to achieve improved health and satisfaction outcomes for beneficiaries, as well as improved experience for providers enrolled in the Medicaid program. The ASOs are responsible for member and provider support, data analytics, Intensive Care Management, technical support for Person Centered Medical Home practices, and a host of targeted initiatives in support of the needs beneficiaries.

HUSKY Health care and satisfaction outcomes are improving, and costs are holding constant.

Where is HUSKY Health heading?

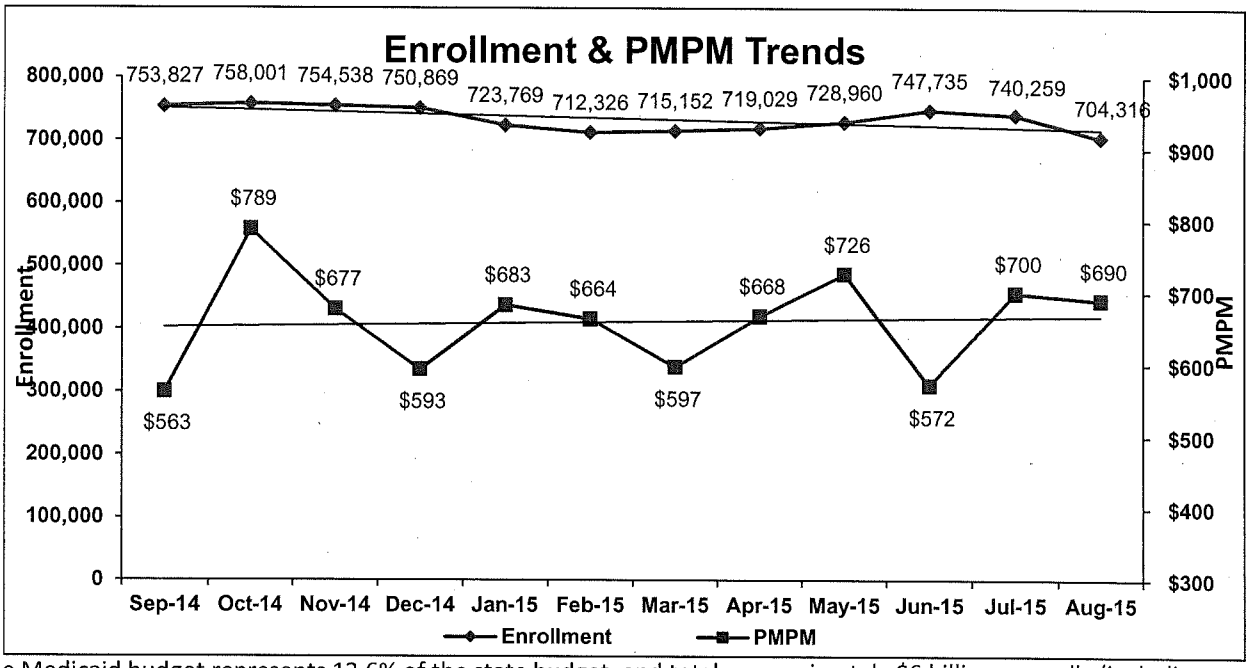
1. Integration of services in support of well-being.

2. Meaningful engagement with social determinants of health (e.g. housing stability, food security).

3. Increased use of our rich store of data.

Current Participation in HUSKY Health

Coverage Group	Description	Participation as of August, 2015
HUSKY A	Connecticut children and their parents/relative caregivers as well as pregnant women, all based on income	429,200
HUSKY B (Children's Health Insurance Program or CHIP)	Uninsured children under age 19 in higher-income households	15,057
HUSKY C	Individuals age 65 and older, individuals who are blind, individuals who have disabilities	95,424
HUSKY D	Childless individuals age 19-64 who do not otherwise qualify for Medicaid	179,692



The Medicaid budget represents 13.6% of the state budget, and totals approximately $6 billion annually (including federal and state shares). The program has administrative costs (including all eligibility-related costs) of only 5.2%. Connecticut Medicaid is one of the very few Medicaid programs whose expenditures have remained fairly constant. Per member per month (PMPM) costs have also been held constant.

Connecticut's Medical Expenditure Trends

	FY 12 to FY 13 Change	FY 13 to FY 14 Change
U.S. Total Spending	7.6%	12.2%
DSS Expenditures (Gross) *	4.3%	9.4%
Enrollment (Average)	5.1%	7.5%
PMPM (Average)	-0.7%	1.8%

** Expenditures are net of drug rebates and include DMHAS' behavioral health costs claimable under Medicaid.*

A quick snapshot of Medicaid care coordination and integration initiatives . . .

What links all of these? The desire to improve health outcomes and care experience.

Health Homes

Key goal: integration of behavioral health care, medical care and social services

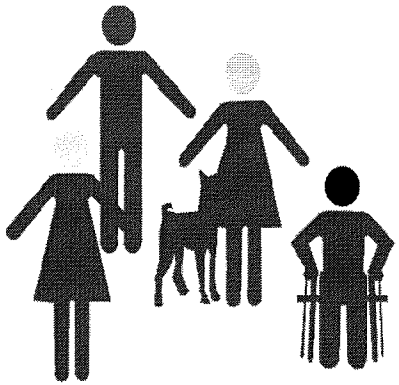
Who: Individuals with Serious and Persistent Mental Illness served by Local Mental Health Authorities who have annual expenses in excess of $10,000

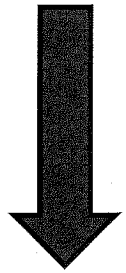
What: multi-disciplinary care coordination team funded by Medicaid care coordination payments

How: enrollment with provider from whom receiving services, with opt-out provision

Shared savings model? No

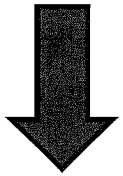
People with behavioral health conditions health conditions





People served by Medicaid who need community-based Long-Term Services and Supports

People served by Medicaid who receive their care at Federally Qualified Health Centers and "advanced networks"



Medicaid Quality Improvement Shared Savings Initiative

Key goal: clinical and community integration

Who: individuals

What: care coordination funded by Medicaid supplemental payments to FQHCs

How: retrospective attribution to provider from whom the individual has received services

Shared savings model? Yes

Home and Community-Based Waivers

Key goal: diversion of individuals from institutional care

Who: individuals who have functional limitations that put them at risk of nursing home placement

What: care coordination and LTSS services funded by Medicaid

How: through assigned care manager

Shared savings model? No

Money Follows the Person

Key goal: community integration

Who: Individuals with need for LTSS who have received in an institution for 3 or more months

What: transition assistance, funded by a federal grant for first year, and state-funded housing vouchers

How: through transition staff

Shared savings model? No