

Proposed Elements of Medicaid Participation in the State Innovation Model (SIM) Initiative: Summary, Background and Questions & Answers

Summary of the Proposal

DSS is proposing to implement two strategies:

- under **Strategy 1**, to build on the DSS Person-Centered Medical Home (PCMH) approach, as well as the model design developed for the Demonstration to Integrate Care for Medicare-Medicaid Enrollees (the “duals demonstration”), to enter into contracts, commencing in 2016, associated with explicit desired health outcomes (e.g. improved maintenance of chronic conditions) and performance measure-driven upside-only shared savings arrangements, focusing upon areas of the state in which there is high incidence of Medicaid and those with complex, unmet needs or high costs, with the goal of improving health and care experience outcomes for Medicaid beneficiaries; and
- under **Strategy 2**, in partnership with the Department of Public Health (DPH), to develop and implement a pilot care delivery model that is explicitly attentive to the social determinants of health (e.g. housing, food security, personal safety, environment) through the flexibility afforded by a narrowly tailored, geographically limited Medicaid 1115 waiver and taking cues on service delivery design and use of an expanded care team (e.g. including community health workers) from states that have already implemented such strategies (e.g. Oregonⁱ).

Important Definitions

Dual eligible: An individual who is eligible for both Medicare and Medicaid.

Single eligible: An individual who is eligible only for Medicaid, and not Medicare.

Advanced network: This term includes large medical groups, physician Independent Practice Associations (IPAs), physician hospital organizations, and clinically integrated networks that have entered in value based payment arrangements with one or more payers (e.g., as an ACO under the Medicare SSP) .

Social determinants of health: The CDC defines **social determinants** as, “the circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.” Many sources recognize the following as key elements of the determinants of health:

- biology and genetics (examples: sex and age);
- individual behavior (examples: alcohol use, injection drug use (needles), unprotected sex, and smoking);
- social environment (examples: discrimination, income, and gender);

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- physical environment (examples: where a person lives and crowding conditions); and
- health services (examples: access to quality health care and having or not having health insurance).

Adverse Childhood Events (ACEs): ACEs are stressful or traumatic experiences, including abuse, neglect and a range of household dysfunction such as witnessing domestic violence, or growing up with substance abuse, mental illness, parental discord, or crime in the home. ACEs are strongly related to development and prevalence of a wide range of health problems, including substance abuse, throughout the lifespan.ⁱⁱ

1115 waiver: Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. The purpose of these demonstrations, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as:

- Expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible
- Providing services not typically covered by Medicaid
- Using innovative service delivery systems that improve care, increase efficiency, and reduce costs.

In general, section 1115 demonstrations are approved for a five-year period and can be renewed, typically for an additional three years. Demonstrations must be "budget neutral" to the Federal government, which means that during the course of the project Federal Medicaid expenditures will not be more than Federal spending without the waiver.ⁱⁱⁱ See this link for a Kaiser Foundation issue brief that includes additional detail about 1115 waivers:

<http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8196.pdf>

Background

The overall goal of SIM is to:

Establish a whole-person-centered health care system that improves community health and eliminates health inequities; ensures superior access, quality, and care experience; empowers individuals to actively participate in their health and healthcare; and improves affordability by reducing healthcare costs.

The first stage of the SIM project was funded through a planning grant from the federal Center for Medicare and Medicaid Innovation (CMMI). Over a year long process, the Connecticut Healthcare Innovation Plan was developed. The Plan, completed in 2013, aims to align providers, consumers, employers, payers, and state leaders around reforms that will improve the health and health care of 80% of the state's residents over the course of five years. The Plan can be accessed at this link:

http://www.healthreform.ct.gov/ohri/lib/ohri/sim/plan_documents/ct_ship_2013_12262013_v82.pdf

The next important stage for the state with SIM is to apply for a model testing grant, somewhere in the magnitude of \$50 to \$80 m. This application will focus on:

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- care delivery reform through promotion of an Advanced Medical Home (AMH) standard for primary care practices that have not yet become medical homes;
- payment reform through use of shared savings models; and
- use of Health Information Technology (HIT) tools such as DIRECT messaging – a secure, HIPAA-compliant means through which health care information can be conveyed, with patient consent, among providers and community-based members of the care team.

A key element of the SIM initiative is multi-payer alignment around the care delivery and payment reform strategies that are chosen. Throughout the project, there has been strong alignment with respect to care delivery reform with the Department's existing, successful Person Centered Medical Home (PCMH) and Glide Path program, which is now serving a third of the over 700,000 Medicaid beneficiaries.

With respect to payment reform, the Department's original position was that we would inaugurate our use of shared savings with the CMS Demonstration to Improve Care for Medicare-Medicaid Enrollees. The Department further committed in the SIM State Health Innovation Plan to align with other payers to the extent of implementing an upside only shared savings program for the general Medicaid population. In support of this, the Department proposed to review the early experience of other payers with this approach, to assess the need for protections for Medicaid beneficiaries and on that basis to determine when during the test grant period to implement an upside only shared savings program.

Following submission of the Innovation Plan, the SIM PMO conducted a comprehensive review of the Innovation Plans submitted by other Model Test and Model Design states. This review revealed that Medicaid was the leading strategy that states used to achieve care delivery and payment reform and the primary means of driving innovations in community integration and social determinants. It also became apparent that Medicaid participation is essential if Connecticut is to make real progress in closing the health equity gaps that predominate in the Medicaid population. As a result, the SIM PMO and its state agency partners prepared Issue Brief #4, which proposed a strategy for engaging advanced networks and FQHCs in care delivery reforms focused on clinical integration, community integration, and expanded care teams as a means to address social determinants.

When the funding opportunity announcement was released for Round 2 of the model test grant funds, for which Connecticut is applying it became clear that:

- Medicaid participation in both care delivery and payment reform is a requirement of the grant application; and
- early participation within the grant period is warranted in support of achieving CMS identified goals related to a federal return on investment.

The Department has affirmed its support for the SIM care delivery strategies relating to primary care practice transformation. We have also spent the last three weeks carefully reevaluating our position with respect to payment reform. In many respects, the Connecticut Medicaid program has unique features. In contrast to most other states:

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- we are using no managed care;
- instead, we are using performance based contracts with ASOs for medical, dental, behavioral health and NEMT;
- we have also incorporated predictive modeling tools to risk stratify our beneficiaries, and an Intensive Care Management program and PCMH effort that have shown great initial promise;
- the ASO approach has also enabled creation of a consolidated set of Medicaid utilization data, as well as unprecedented analytic capability; and
- it has also been the vehicle for practice transformation supports for primary care practices, both for those on the glide path to recognition and those already recognized as PMCH practices.

Moreover, enhancement of access to primary care, and integration of behavioral health and medical care, are two of the three key strands of our current Connecticut Medicaid reform agenda.

We recognize that payment reform is essential to support flexibility in practice and non-visit based methods for engaging and supporting individual health needs. Moreover, Medicaid's participation in payment reform, along with other payers, is the only means by which we can change the focus of our care delivery system from service volume to beneficiary value. In reviewing our position on payment reform, we were guided by a number of important values:

- focus on protecting the interests of our beneficiaries, who face unique challenges associated with poverty, housing instability, food insecurity, and personal safety; and
- interest in building on the platform of our PCMH effort, as well as the strengths of our ASO analytic capability; and
- attention to where our beneficiaries are seeking care, and what factors may be inhibiting the health outcomes and care experience that they desire;

After considered review, we are proposing two strategies. These are depicted on the attached chart. The intention with the chart is to provide a broad schema of what we intend to do. Many details remain to be considered, and we intend to use the same strong stakeholder process that we have used for the duals demonstration to seek comment and advice. These include, but are not limited to, qualifications of providers and means of protecting beneficiary interests.

Strategy 1. Under the first strategy, the Department is proposing to issue an RFP and to enter into performance measure-driven, upside only shared savings arrangements with a number of Federally Qualified Health Centers (FQHCs) and advanced networks. The goal of these contracts will be to improve health and care experience outcomes for Medicaid beneficiaries. FQHCs are currently serving approximately 200,000 Medicaid beneficiaries. In support of achieving better integration, both of clinical care and specialty care (for example, behavioral health, use of community health workers to improve outcomes for those with chronic conditions) and also integration of care with the types of community services (e.g. housing assistance) that can support Medicaid beneficiaries in utilization of health services, we are proposing to make enhanced reimbursement in support of practice transformation (e.g. expanded care teams, person-centered practice, attention to health literacy, access to specialty care through non face-to-face means, and applied efforts to reduce health disparities), and

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also share a portion of any savings that are achieved with entities that have met performance measures, including those that will be developed by the SIM council on under-service. We are proposing to use the Department's PCMH attribution method to identify 200,000 to 215,000 beneficiaries who have received their care through participating FQHCs and advanced networks, and for those individuals to participate in this model effective January 1, 2016. We do not have a predisposition as to geographic focus - the references that we included in the chart are illustrative only. We will not implement this proposal until performance measures, including measures of under-service, are developed and approved by the SIM councils on multi-payer alignment on quality and under-service.

Strategy 2. Under the second strategy, we propose to expand on that same theme of clinical and community integration by developing with sister department DPH and diverse stakeholders a demonstration project specifically related to population health, better supporting the needs of whole family systems, and particularly addressing childhood trauma. Medicaid has keen interest in this not only to support the current day needs of children and families, but also to prevent the likely effects of failing to intervene in Adverse Childhood Events - failure which is associated in those children growing up to become adults challenged by chronic conditions, obesity and tobacco dependence.

In support of this, we propose to use an authority available under federal law, the 1115 waiver, for research and demonstration projects. Use of an 1115 waiver will require careful and extensive planning, as it includes as a condition accepting a global cap over a five year period on the federal share of Medicaid expenses. In return, however, the 1115 offers considerable flexibility to cover services and supports that are not coverable under the Medicaid state plan - non-exclusive examples of which include:

- community health workers; and
- equipment such as air conditioners for individuals with asthma or multiple sclerosis, or adaptive equipment or home modifications to support an individual in management of a chronic condition in his or her home.

We are proposing to use a narrowly tailored, geographically limited approach under the 1115.

We reference another state, Oregon, that has done exciting work in this area not to propose wholesale adoption of their approach, but simply to illustrate a model from which we can see this approach applied in practice. Similarly, we reference proposed elements, including use of Health Savings Accounts, that will require discussion and comment through the same type of stakeholder process described above. We will not implement this proposal until performance measures, including measures of under-service, are developed and approved.

Overall, our goals with both of these strategies are to:

- better address whole person needs of beneficiaries;

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- continue to enable practice transformation, and to extend the reach of transformation to encompass community integration; and
- overcome some of the rigidity of services approvable under our Medicaid State Plan by enabling coverage of additional supports.

Questions and Answers

Following an initial presentation of the attached to the Steering Committee of the State Innovation Model (SIM) initiative, we received the questions noted below. This list will be updated as additional questions are received.

Strategy 1

1. What are the benefits of this proposal to Medicaid participants?

As noted above, FQHCs are currently serving approximately 200,000 Medicaid beneficiaries. Additionally, advanced networks are serving a number of Medicaid beneficiaries. This proposal aims to build on the existing strengths of the PCMH approach to build in incentives for FQHCs and advanced networks to provide the type of care coordination and facilitation of use of health care services (e.g. through community health workers) that will overcome some of the current barriers to successful outcomes that Medicaid beneficiaries regularly experience. These barriers include, but are not limited to, lack of integration of primary and specialty care (e.g. behavioral health care), lack of systematic community connections designed to address social determinants of health, and need for next generation practice transformation that will focus upon the applied practice of person-centeredness as well as consciously identifying and addressing health disparities. Additionally, this strategy is designed to help improve the care experience of Medicaid beneficiaries, who reported via SIM focus groups a range of concerns about using health care (e.g. not feeling welcomed, respected or listened to).

2. What are the benefits of this proposal to the Medicaid program?

This strategy will enable the program to build upon two key strands of its current Medicaid reform agenda (enhancement of access to primary care, and integration of primary medical and behavioral health care), as well as the analytic capabilities and PCMH practice expertise of our Medicaid medical Administrative Services Organization, CHN. It is our hypothesis that establishing a means of supporting practice transformation (e.g. expanded care teams, integration of medical and community services, person-centered practice, attention to health literacy, access to specialty care through non face-to-face means, and applied efforts to reduce health disparities) in FQHCs and advanced networks will enable the interventions necessary to

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achieve improved health and beneficiary experience outcomes. We also posit that such activity will help, as it has already been demonstrated to do through Medicaid Intensive Care Management (ICM), to control costs related to non-acute use of the emergency room and potentially avoidable complications such as hospital re-admission.

3. How does this affect the dual eligible Integrated Care Demonstration Project?

This strategy will not affect the duals demonstration. DSS is currently negotiating a Memorandum of Understanding with CMS to implement the duals demonstration effective on or about January 1, 2015.

4. Will this proposal also affect HUSKY B children?

HUSKY B children will be attributed under this strategy if they receive their primary care from one of the entities selected to participate (e.g. FQHC or advanced network).

5. How does this proposal fit with/build on the PCMH approach in Medicaid?

This builds upon the Medicaid PCMH initiative by extending the scope of practice transformation to include additional clinical integration (e.g. as between medical and behavioral health care) and community integration (e.g. as between medical and social services providers). Please note that we intend to reinstate enhanced fee-for-service (FFS) and performance payments to FQHCs under this proposal.

6. How will the experience of the Integrated Care Demonstration Project be used to shape this proposal?

The Department gratefully acknowledges the extensive participation of a broad and diverse set of stakeholders in advice and comment by the Complex Care Committee (CCC) of the Medical Assistance Program Oversight Council (MAPOC) on all aspects of development of the duals demonstration. We intend to mirror this process for purposes of development and refinement of goals and means of implementing Strategy 1.

7. How does this proposal fit with the FQHC proposal?

We understand this question to refer to a proposal originated by CHC-ACT to enter into total cost of care arrangements. We share many of the aims articulated by CHC-ACT in its document, but are proposing a more narrowly tailored approach that focuses upon performance-measure driven, upside-only shared savings arrangements.

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8. What is the reaction of private physicians who serve Medicaid to this proposal?

The Connecticut Medical Society participates in the CCC and has been asked to solicit comments on these strategies from its membership.

9. Is it your expectation that this proposal will either encourage or discourage provider participation in Medicaid?

We believe that Strategy 1 has the potential to increase providers' interest in serving Medicaid beneficiaries and, importantly, interest in achieving better outcomes and care experience. We are proposing to focus on FQHCs and advanced networks that are already serving a significant number of Medicaid beneficiaries. We do not anticipate changes in the network related to this proposal. Related, however, we appreciate the fact that funding in support of extending the Affordable Care Act (ACA) primary care rate increases, as well as our current enhanced FFS and performance payments to PCMH practices, will continue to enable us to support a high level of provider participation in Medicaid.

10. Is this proposal fully developed? If not, what is the process and timeline for developing the proposal? Who will participate in the development? Is there an option not to implement this proposal or to make substantial changes to the proposal as a result of the planning process?

As noted above, the chart includes a broad schema of our intention with both strategies. We have presented the proposal to the Executive Committee of the CCC, and will in the near future engage the Executive Committee of the MAPOC, as well as the full membership of MAPOC, to solicit comments and to answer questions. We acknowledge the constraints of time associated with this review, but want to reinforce that all details related to this proposal (including, but not limited to qualifications of providers, attribution method, and means of protecting beneficiary interests) will be reviewed by the CCC prior to implementation, and that the CCC will have extensive opportunity during the detailed design and implementation to offer advice and comment.

11. Will this proposal be presented to the Legislature for approval?

DSS plans to utilize the CCC as the key stakeholder body to advise and comment on implementation of the strategy. Correspondingly, the CCC will make recommendations to MAPOC that will enable advice and comment by MAPOC.

12. If the planning and review process will include the Complex Care Committee, can you define the membership of that Committee and who you are considering adding to that Committee?

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The CCC membership includes representation from the ARC, Southwestern and South Central Agencies on Aging, Connecticut Community Care, Connecticut Health Policy Project, New Haven Legal Assistance, Connecticut Legal Rights Project, Connecticut Association of Health Care Facilities, Leading Age, APT Foundation, Hospital for Special Care, Yale-New Haven Hospital, Day-Kimball Hospital, Connecticut Hospital Association, Commission on Aging, Connecticut Community Providers Association, Qualidigm, AARP, Connecticut Association for Home Care and Hospice, Natchaug, Connecticut Medical Society, Center for Medicare Advocacy, and the Departments of Social Services, Mental Health and Addiction Services, and Developmental Services. CCC leadership will no doubt solicit recommendations for augmenting the membership in support of review of this proposal.

13. What will the role of MAPOC be in the planning and reviewing of this process?

As indicated above, DSS will develop all aspects of the proposal in consultation with the CCC, which will in turn offer recommendations to the MAPOC.

14. What is the mechanism for on-going review and adjustment of the proposal after implementation?

We are proposing that the CCC continue to be the lead stakeholder body for reviewing and offering recommendations on any adjustments to the proposal ongoing.

15. Can someone from these bodies be added to the Steering Committee?

The Steering Committee currently includes representatives from several of these bodies, or individuals recommended by them. A representative from the long term care community may also be added.

16. In light of the increased emphasis on Medicaid in the application, will you examine membership in the various work groups and the Consumer Advisory Board of SIM to ensure adequate representation of Medicaid participants, advocates and providers?

We recognize the important role that this initiative will play in our overall efforts under SIM. However, the CCC and MAPOC have extensive involvement of Medicaid advocates and providers. Given the central role that these advisory and oversight bodies will have in planning, a change in SIM work group and Consumer Advisory Board representation may not be necessary.

1. What are the benefits of this proposal to Medicaid participants?

This strategy will enable the DSS to more comprehensively address the social determinants of health (e.g. housing, food security, personal safety, environment) that often impede Medicaid beneficiaries in successfully utilizing the extensive health benefits that are covered. We propose to employ the flexible authority of an 1115 waiver to achieve this through:

- use of an expanded care team that will include community health workers;
- bundled payments for trauma-informed, wrap-around services to support both children and their families; and
- coverage of services and supports that are otherwise not coverable under the Medicaid State Plan.

We anticipate that this approach will enable us to intervene in situations in which children have experienced Adverse Childhood Events (ACEs), and to address both near term and long-range needs of these children and their families.

2. What are the benefits of this proposal to the Medicaid program?

Addressing social determinants of health and ACEs will enable the Medicaid program to facilitate more optimal utilization of health services and to intercept the likely onset of adult health conditions, obesity and tobacco dependence that is predictable for those who have experienced one or more ACEs and have not had the benefit of intervention. We posit that doing so will advance our agenda of focusing on preventative health, as opposed to the emergency and acute care that is so typically utilized by individuals who have not had these supports.

3. What is the timeline for developing this waiver?

Development of the elements of this waiver will take considerable thought and time, as will negotiation of the waiver with CMS. We plan to launch planning efforts concurrent with the start of the SIM model test grant period, and to invest the time necessary to conscientiously develop the waiver in close partnership with the Department of Public Health.

4. When you anticipate implementing this kind of waiver?

We do not have a specific target date in mind. We will solicit advice from states that have implemented similar approaches, and discuss and reach mutual agreement with the CCC on timelines associated with developing concepts, as well as timelines associated with negotiating the waiver with CMS.

5. Who will be involved in its development?

We are proposing to engage the CCC as DSS' lead stakeholder group for review and comment on the 1115 waiver.

6. Will waiver submission be authorized by the Legislature? Will the waiver be approved by the relevant legislative committees of cognizance prior to submission?

The Department of Social Services (DSS) and DPH, in consultation with the SIM PMO, will jointly develop the Plan, with a multi-stakeholder health systems workgroup previously established under the HCT 2020 planning initiative and enhanced with additional partners such as policy makers, other state agencies, local health departments, community based organizations, payers, hospitals, healthcare providers, and others.

As is required by statute^{iv}, DSS will through the process described above seek advice and comment on the waiver through the Complex Care Committee of MAPOC, and submit the waiver for review of the committees of cognizance.

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CT State Innovation Model Proposed Medicaid Approach – DRAFT 6/28/14

Initiative	Target Date and Estimated Participation	Description	Proposed Requisites for Selection	Proposed Conditions of Participation
Strategy 1: Shared savings initiative with FQHCs and advanced networks serving single-eligible Medicaid beneficiaries, selected by RFP	January, 2016 An estimated 200,000 to 215,000 beneficiaries	DSS will build on its PCMH approach, as well as the model design developed for the Demonstration to Integrate Care for Medicare-Medicaid Enrollees, to enter into contracts associated with explicit desired health outcomes and performance measure-driven upside-only shared savings arrangements, developed in conjunction with diverse stakeholders, prioritizing areas of the state in which there is high incidence of Medicaid beneficiaries and those with complex, unmet needs or high costs. DSS will make enhanced FFS payments to entities selected by RFP, and will agree to share a portion of any savings derived with entities that meet or exceed established benchmarks on quality measures.	<ul style="list-style-type: none"> • demonstrated commitment, experience and capacity to serve Medicaid beneficiaries • minimum participation in each contracting entity of 5,000 single-eligible individuals • preference for FQHCs and advanced networks that exhibit interest, experience and capacity to support Medicaid beneficiaries and desire to meet identified standards for clinical and community integration 	<ul style="list-style-type: none"> • focus on identified, desired health outcomes (e.g. improved maintenance of chronic conditions) and use of performance measures related to access, under-service, quality of care, health equity and care experience • use of either the federated data analytic and ICM supports of the medical ASO or an entity's own such supports • arrangements under which FQHC providers would potentially agree to reduce per beneficiary billable encounters in consideration of receipt of enhanced PPS reimbursement for non-billable services (e.g. care coordination, health coaches), the anticipated higher incidence of non-visit based activities, and the potential for shared savings payments

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Strategy 2: Population health initiative with providers serving single-eligible Medicaid beneficiaries in a targeted geographic area (i.e. Health Enhancement Community)	To be determined through 1115 planning process	DSS will in partnership with the Department of Public Health (DPH) and diverse stakeholders, develop and implement a care delivery and community health improvement demonstration that is explicitly attentive to the social determinants of health (e.g. housing, food security, personal safety, environment) through the flexibility afforded by an 1115 waiver and taking cues on service delivery design and use of an expanded care team (e.g. including community health workers) from initiatives successfully implemented in other states. DSS will make comprehensive payments in support of trauma-informed wrap-around services to support children and their families. DSS will also reimburse for a range of services not covered by the Connecticut Medicaid State Plan.	<ul style="list-style-type: none"> • demonstrated commitment, experience and capacity to serve Medicaid beneficiaries • local governance • broad, cross-disciplinary stakeholder participation (medical and non-medical providers, health departments, social services organizations, schools and businesses) • alignment of reimbursement for health care and other funding sources to reward achievement of community health improvement goals 	<ul style="list-style-type: none"> • focus on identified, desired health outcomes and use of performance measures related to access, under-service, reductions in disease incidence and prevalence, quality of care, and care experience • coverage of services beyond those covered in the Medicaid State Plan, non-exclusive examples of which include flexible services (e.g. air conditioner for individual with asthma) and reimbursement of community health workers (e.g. peer wellness specialists, disease educators) • use of Health Savings Accounts funded through shared savings through which Medicaid beneficiaries could use funds to pay for health and personal care products • extension of DSS' incentive-based Rewards to Quit tobacco cessation initiative • attention to all aspects of streamlining access to primary care, including use of ASO and community-based ICM, developing a Medicaid solution for primary and behavioral health urgent care, optimizing ASO functions around referrals and transportation, and cementing partnerships with the hospitals for real-time sharing of emergency department (ED) data and collaboration in support of the needs of super utilizers

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ⁱ Oregon, which serves approximately 650,000 beneficiaries (16 percent of the population), has implemented a model of "Coordinated Care Organizations" (CCOs). In many aspects of model design, this effort has similarities to our proposed approach for Medicare-Medicaid Eligibles under the Demonstration to Integrate Care for Medicare-Medicaid Enrollees. Coordinated Care Organizations are networks of local, community-based providers. There are 15 across the state and they range in size, with the smallest serving 5,000 members. The model is focused on integrating physical and behavioral health, PCMH, wellness and preventive care. CCOs are permitted to utilize flexible services (e.g. air conditioner for individual with COPD). Their multi-disciplinary teams explicitly include community health workers (peer wellness specialists, doulas, disease educators). The model currently serves about 95 percent of the non-Aged, Blind and Disabled (ABD) population (ABD was carved out by statute) and will expand this year to include dental services. A distinguishing feature of this model is that it is subject to a global budget that will grow at a fixed sustainable rate (no more than 3 percent annually) and providers receive a fixed per member, per month payment (PMPM). Oregon's hypothesis is that the Intensive Care Management (ICM), PCMH and community health interventions will permit the model to operate within these limitations on growth. Another compelling characteristic is that Oregon has implemented a transformation center to help engage beneficiaries and providers in the model. This involves peer to peer learning, innovator agents, and learning collaboratives. We have proposed many of those features in our duals demonstration application. Oregon negotiated authority with CMS for this initiative under an 1115 waiver, including Delivery System Reform Incentive Payments (DSRP).

ⁱⁱ <http://captus.samhsa.gov/prevention-practice/targeted-prevention/adverse-childhood-experiences/1>

ⁱⁱⁱ <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html>

^{iv} Connecticut General Statutes §§ 17b-28 and 17b-8