An Overview of the Connecticut HUSKY Health Program

Executive Summary

The Connecticut Department of Social Services (DSS) is the single state agency for the administration of Medicaid and the Children's Health Insurance Program (CHIP) in Connecticut. Medicaid and CHIP are collectively described as the HUSKY Health program.

HUSKY Health is a major health plan that covers over 800,000 Connecticut citizens (22% of the state population). This involves providing comprehensive medical, dental and behavioral health services to financially and functionally eligible children, their caregivers, older adults, individuals with disabilities and single adults. HUSKY also helps keep older adults and people with disabilities independent at home and covers nursing home care.

DSS' vision for HUSKY Health is an effective health care delivery system for eligible people in Connecticut that promotes:

- well-being with minimal illness and effectively managed health conditions;
- maximal independence; and
- full integration and participation in their communities.

Medicaid and CHIP represent cost sharing partnerships under which the federal government currently covers 59% of Medicaid costs and 88% of CHIP costs. The state share of the Medicaid budget represents 22.7% of the General Fund, and totals approximately $3 billion annually. The program has administrative costs (including all eligibility-related costs) of only 3.2%.

Unique Self-Insured Model

By contrast to almost all other Medicaid programs throughout the nation, Connecticut HUSKY Health is not using any capitated managed care arrangements. Like most employers, HUSKY Health is a self-insured, managed fee-for-service program. DSS partners with three Administrative Services Organizations (ASOs; medical, dental, behavioral health) to administer services and to achieve improved health and satisfaction outcomes for members. The ASOs also work hard to support health care providers.

The ASOs are responsible for member and provider support, data analytics, Intensive Care Management, technical assistance for Person Centered Medical Home practices, and targeted care delivery initiatives for members.

Key Strategies:

The Department of Social Services is employing diverse strategies to achieve improved health outcomes and cost efficiencies in the Medicaid program, including:

- use of self-insured, managed fee-for-service platform to promote efficient, cost-effective and consumer/provider responsive Medicaid medical, behavioral health, dental and non-emergency medical transportation (NEMT) services
- use of data analytics to improve care
- activities designed to improve access to and use of preventative care
- efforts to integrate health, long-term services and supports (LTSS), and social services
- initiatives designed to "re-balance" spending on LTSS (shifting from institutional to community-based care)
- efforts to promote the use of health information technology (HIT)

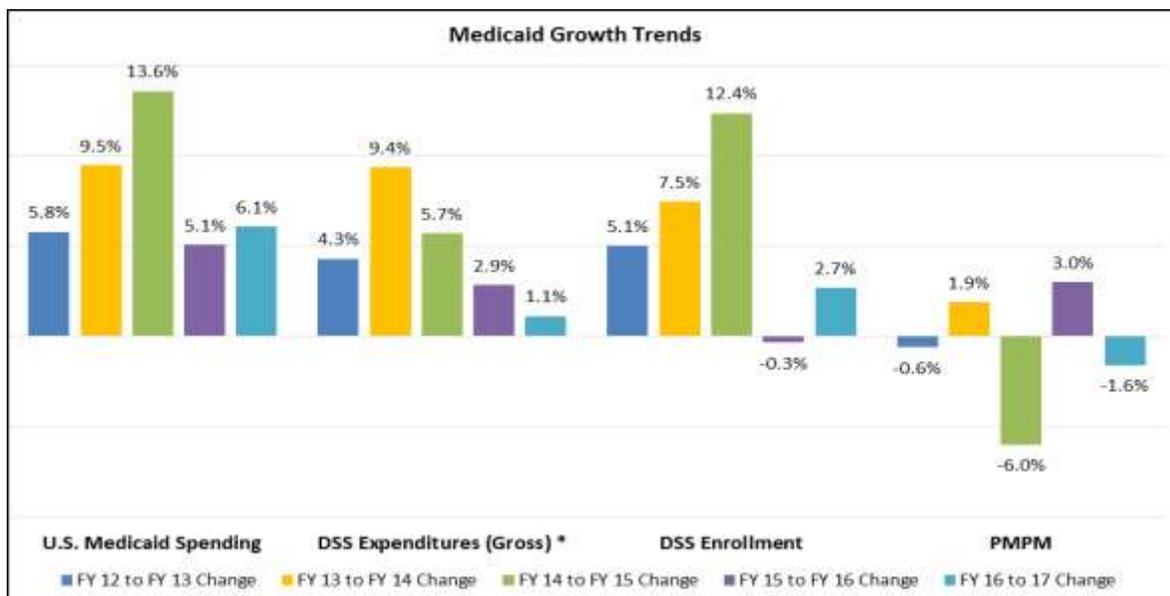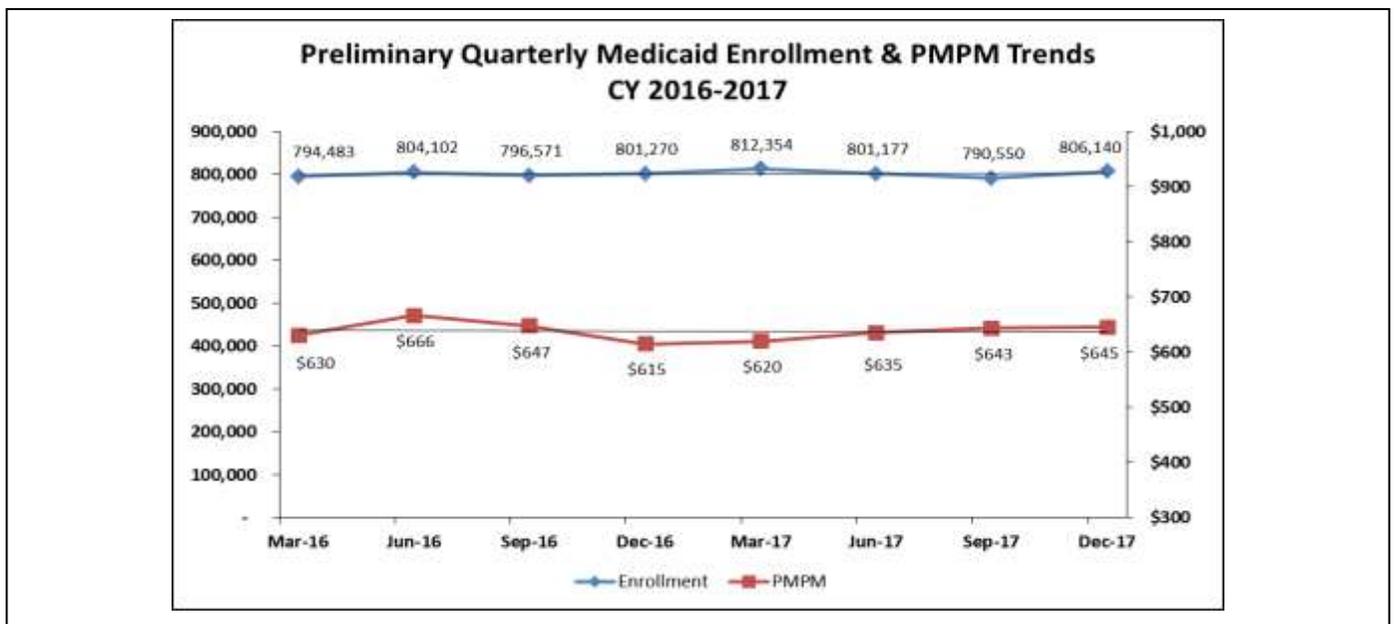*Where is HUSKY Health heading?*

1. Enhanced use of data to identify and assist people in need.

2. Integration of medical, dental and behavioral health services in support of well-being.

2. Linking health services with social services to create housing stability and food security.

HUSKY Health enrollment is growing modestly, health care and satisfaction outcomes continue to improve, and costs are remarkably stable.

HUSKY Health Group	Provides comprehensive medical, dental, and behavioral health services to . . .	Representing . . .
A	Over 450,000 parents and children	**69%** of members and **29%** of total Medicaid program costs
C	Almost 94,000 older adults and people with disabilities	**11%** of members and **46%** of total Medicaid program costs
D	Almost 240,000 expansion adults	**29%** of members and **25%** of total Medicaid program costs

Preliminary Quarterly Medicaid Enrollment & PMPM Trends CY 2016-2017

Enrollment values: 794,483 (Mar-16), 804,102 (Jun-16), 796,571 (Sep-16), 801,270 (Dec-16), 812,354 (Mar-17), 801,177 (Jun-17), 790,550 (Sep-17), 806,140 (Dec-17)

PMPM values: $630, $666, $647, $615, $620, $635, $643, $645

Legend: Enrollment, PMPM

Medicaid Growth Trends

	FY 12 to FY 13 Change	FY 13 to FY 14 Change	FY 14 to FY 15 Change	FY 15 to FY 16 Change	FY 16 to FY 17 Change
U.S. Medicaid Spending	5.8%	9.5%	13.6%	5.1%	6.1%
DSS Expenditures (Gross) *	4.3%	9.4%	5.7%	2.9%	1.1%
DSS Enrollment	5.1%	7.5%	12.4%	-0.3%	2.7%
PMPM	-0.6%	1.9%	-6.0%	3.0%	-1.6%

Connecticut HUSKY Health: Self-Insured Model

Connecticut Department of Social Services

Self-Insured, Managed Fee-for-Service Program

By contrast to almost all other Medicaid programs throughout the nation, Connecticut HUSKY Health no longer utilizes capitated managed care arrangements, under which companies receive monthly payments for serving members. Instead, like many employers, Connecticut has adopted a self-insured, managed fee-for-service approach. In support of achieving better heath and care experience outcomes for members, and improved processes for Medicaid providers, the Department of Social Services (DSS) has streamlined and centralized member and provider supports and standardized coverage guidelines and utilization management. This has been managed through contracts with three Administrative Services Organizations (ASOs) – **CHN for medical services, Beacon for behavioral health services, and BeneCare for dental services** – and self-management of pharmacy by DSS.   Each ASO operates under a performance-based contract with DSS that requires achievement of identified benchmarks on health outcomes, healthcare quality, and both member and provider satisfaction measures. All savings that are achieved through coordination of care and administrative efficiencies go back into the program, instead of contributing to the profit of a managed care organization.

Key Strategies:

The Department of Social Services is employing diverse strategies to achieve improved health outcomes and cost efficiencies in HUSKY Health, including:

- **use of a self-insured, managed fee-for-service platform to promote efficient, cost-effective and consumer/provider responsive Medicaid medical, behavioral health, dental and non-emergency medical transportation (NEMT) services**
- use of data analytics to improve care
- activities designed to improve access to and use of preventative care
- efforts to integrate health, long-term services and supports (LTSS), and social services
- initiatives designed to "re-balance" spending on LTSS (shifting from institutional to community-based care)
- efforts to promote the use of health information technology (HIT)

Why Did Connecticut Move to this Model?

Historically, Connecticut Medicaid used a mix of capitated managed care and fee-for-service arrangements to provide services to members. Important features, such as rules concerning prior authorization of services, provider networks, and reimbursement rates for services, were not uniform across the managed care entities. This caused confusion and uncertainty for members. Further, lack of consistency posed challenges for providers who participated in more than one managed care network, and providers often reported that it was difficult to engage with the managed care companies and to get paid on a timely basis. Finally, the Department received only incomplete encounter data from the managed care companies, which did not give a complete or accurate view of the use of Medicaid services.

The Hypothesis

Centralizing management of services for all Medicaid members in self-insured, managed fee-for-service arrangements with ASOs, as well as use of predictive modeling tools and data to inform and to target members in greatest need of assistance, will yield improved health outcomes and member experience, and will help to control the rate of increase in Medicaid spending.

Key Strategies

ASOs have centralized and streamlined the care experience for members, and improved support for providers.

- **Member Supports:** The ASOs are responsible for more traditional services including member support, referrals to providers, utilization management (e.g. prior authorization of services when required), and grievances and appeals.

- **Data Analytics:** The ASOs use predictive modeling tools and a fully integrated, statwide set of Medicaid claims data to identify both those currently in greatest need of assistance and those at risk of needing assistance. This data is also shared with primary care providers to help them better serve their patient panels.

- **Intensive Care Management (ICM):** The ASOs serve members with complex needs through ICM. ICM is designed to support the full range of members' needs - from basic needs such as housing stability and food security, to complex medical profiles including chronic disease, behavioral health and oral health conditions. ICM takes different forms across the ASOs:
  - CHN use geographically grouped teams of nurse care managers and community health workers;
  - Beacon has placed ICM staff at high volume hospitals to meet the needs of those members who are admitted to the emergency department at higher rates than their peers; and
  - BeneCare employs a team of dental health specialists who are placed in various communities and are responsible for promoting oral health and reducing barriers to obtaining care.

- **Provider Supports:** ASO arrangements have substantially improved engagement with providers. There is a single set of coverage guidelines for each service, and a uniform fee schedule from which to be paid. Providers can bill every two weeks, and clean claims are paid completely and promptly through a single fiscal intermediary (DXC). This promotes participation and retention of providers, and enables monitoring of the adequacy of the provider network.

The Results

- **Health outcomes and care experience for members are continuing to improve** through use of data to identify and support those in greatest need, care delivery reforms and use of community-based, as opposed to institutional, long-term services and supports.
- **Provider participation has increased** as a result of targeted investments in prevention, practice transformation, and timely payment for services provided.
- **Connecticut's expenditure trends**, when measured by per member, per month costs across the entire program and by the level of State share of program costs, **have remained exceptionally steady for the past five years.**

Connecticut HUSKY Health: Use of Data to Improve Care

Data Analytic Capacity

Connecticut HUSKY Health is uniquely situated in its data analytic strength. Since 2012, HUSKY Health has had the benefit of a fully integrated, statewide set of claims data across all categories of Medicaid services. The Department's medical ASO, CHN, maintains this data within the CareAnalyzer system, an analytical and data discovery tool, and performs predictive modeling in support of identifying HUSKY Health members in need of support with complex health conditions. CareAnalyzer utilizes QlikView software and is uploaded monthly with claims, member eligibility, and provider data. The tool provides a simple, rapid, and comprehensive means of assessing medical cost and utilization trends in various cuts of the claims, member eligibility and provider data with multiple layers of drillable investigative analysis, down to the claim, member and provider level. CHN also pushes a range of information, including claims data; admissions discharge and transfer (ADT) data; and some clinical information to primary care providers who participate in the Person Centered Medical Home (PCMH) and PCMH+ initiatives. This enables them to more intelligently respond to the needs of the members whom they serve.

Why Are We Focusing Here?

A key motivation for transitioning from capitated managed care arrangements to the current self-insured, managed fee-for-service model was to improve the completeness and integrity of the data that was available to DSS and providers, and to utilize that data to improve quality. The United States Department of Health and Human Services Agency for Healthcare Research and Quality has stated that, "the rationale for measuring quality improvement is the belief that good performance reflects good-quality practice, and that comparing performance among providers and organizations will encourage better performance."

Key Strategies:

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- use of a self-insured, managed fee-for-service platform to promote efficient, cost-effective and consumer/provider responsive Medicaid medical, behavioral health, dental and non-emergency medical transportation (NEMT) services
- **use of data analytics to improve care**
- activities designed to improve access to and use of primary care
- efforts to integrate health, long-term services & supports (LTSS), and social services
- initiatives designed to "re-balance" spending on LTSS (shifting from institutional to community-based care)
- efforts to promote the use of health information technology (HIT)

Key Strategies:

- **Predictive Modeling.** CHN has extensive predictive modeling and data analytic capabilities through use of DSTHS CareAnalyzer®, a web-based tool that combines elements of patient risk, care opportunities and provider performance. The tool is updated on a monthly basis with Medicaid claims, member eligibility, provider data and lab results. CareAnalyzer® includes two main components: quality measures including NCQA HEDIS® certified measures and the Johns Hopkins ACG® (Adjusted Clinical Group) system. In addition, CareAnalyzer® contains a series of reports designed to provide information on provider effectiveness (quality of care) and provider efficiency (cost of care).

- **Tracking of Health Measures.** CHN uses the HEDIS® measures within CareAnalyzer® to monitor provider performance throughout the year on key measures. Performance is monitored at the population level, by setting (e.g., Person-Centered Medical Home, hospital clinic, and non-PCMH community practice) and at the individual practice level. The HEDIS® measures also allow CHN to identify individual members who have gaps in care. The Johns Hopkins ACG® system provides risk-adjusted member information and is used by CHN in identifying members who may benefit from care management or other interventions. CHN also uses the ACG® system to evaluate the disease prevalence of member populations, assess pharmacy adherence and determine current and predicted risk for the Medicaid population.

- **Use of Data to Inform Provider Support.** CHN pushes out a broad range of data to primary care practices that participate in the PCMH and PCMH+ initiatives. This information allows both CHN and the primary care practices to monitor measure results on an ongoing basis and identify members with gaps in care. Additionally, CHN produces detailed annual primary care physician (PCP) profile reports that analyze the relative cost efficiency of practices and a PCP cost of care assessment that provides risk-adjusted comparison of total cost of care.

Connecticut is uniquely situated to use data to identify those in greatest need, equip providers with better understanding of their patients, analyze whether interventions have had their desired effect, and assess the impact of Medicaid services on individuals, families and populations.

What is "predictive modeling"?

The Center for Health Care Strategies (CHCS) has defined "predictive modeling" as "data-driven, decision-support tools that estimate an individual's future potential health care costs and/or opportunities for care management." CHCS further comments that predictive modeling has three key elements: 1) the *outcome* being predicted (e.g. the relative future overall costs for an individual or expected inpatient utilization); 2) the mix of *predictor variables* used in predicting the outcome (e.g. basic demographic information as well as diagnosis and prescription claims, functional status, prior utilization data); and 3) the means by which *predictor variables are combined* to create the predicted outcome.

Connecticut HUSKY Health: Improving Access to Primary Care

Connecticut Department of Social Services

Why is Primary Care Important?

Connection with a primary care provider is an important foundation for each individual's overall health status. Primary care represents access to a consistent source of support, a partner with whom to develop health goals, and assistance in diagnosing, treating and preventing a wide variety of health conditions. Routine primary care check-ups help by identifying health issues early, enabling people to avoid more serious problems. This supports education and intervention with a range of conditions that can be addressed and/or effectively self-managed. Primary care also supports school readiness of children through assessment of developmental stages, vaccines and well-child checks. Consistent connection with a primary care provider can also help reduce the need for people to see specialists. Further, timely access to primary care prevents unnecessary and expensive care in emergency rooms and inpatient in hospitals. As a result, adults in the U.S. who have a primary care provider have lower odds of premature death than those who only see specialists for their care.

Key Strategies:

The Department of Social Services is employing diverse strategies to achieve improved health outcomes and cost efficiencies in the Medicaid program, including:

- use of a self-insured, managed fee-for-service platform to promote efficient, cost-effective and consumer/provider responsive Medicaid medical, behavioral health, dental and non-emergency medical transportation (NEMT) services;
- use of data analytics to improve care;
- **activities in support of improving access to preventative primary care;**
- efforts to support integration of health, long-term services and supports (LTSS), and social services;
- initiatives designed to "re-balance" spending on LTSS; and
- efforts to promote the use of health information technology.

Why Are We Focusing Here?

Historically, many Connecticut HUSKY Health members did not have a usual and customary source of primary care. When Connecticut was using capitated managed care arrangements, members served by those plans were often arbitrarily assigned to a primary care provider, no matter where they might have sought care. Also problematic was that members very frequently sought care in emergency rooms that could otherwise have been provided by a primary care provider in the community. Information was not routinely shared with community providers following a visit to the ER, or discharge from inpatient hospital services. This made it very difficult to establish a consistent relationship with a provider, and to develop an overall plan of care.

What is a Person-Centered Medical Home?

In their *Joint Principles* document, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association define a Person-Centered Medical Home as, "an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family." The premise of a PCMH is that it enables primary care practitioners to bring a holistic, person-centered approach to supporting the needs of patients, while reducing barriers to access (e.g. limited office hours) that have inhibited people from effectively using such care.

HUSKY Health Key Strategies

Connecticut's nationally recognized Person-Centered Medical Home (PCMH) program is now serving almost half of Medicaid members, and has enrolled nearly 2,000 providers.

- **Affordable Care Act (ACA) Primary Care Rate Increase.** The ACA required that states increase reimbursement to primary care providers to 100% of the Medicare rate in calendar years 2013 and 2014, and covered the cost of that increase. Connecticut has continued this rate increase at a somewhat reduced level.

- **Person-Centered Medical Homes (PCMH).** DSS implemented its PCMH initiative on January 1, 2012. Through this effort, the Department invested significant resources to help primary care practices obtain PCMH recognition from the National Committee for Quality Assurance (NCQA). Practices on the "glide path" toward recognition receive technical assistance from CHN. Practices that have received recognition are eligible for financial incentives including enhanced fee-for-service payments and retrospective payments for meeting benchmarks on a targeted list of quality measures. Key features of practice transformation include embedding limited medical care coordination functions within primary care practices, capacity for non-face-to-face and after hours support for patients, and use of electronic health records (EHR).

- **PCMH+.** In January, 2017, DSS built on its PCMH initiative by contracting with selected Federally Qualified Health Centers and Advanced Networks to implement an array of advanced care coordination strategies in support of further improvements in outcomes for HUSKY Health members. PCMH+ providers that are successful in meeting quality benchmarks will share a portion of any savings that are achieved.

Key Results

- Use of primary care has increased, and use of the emergency room has markedly decreased, as have readmissions to the hospital following discharge. On the whole, health outcomes (e.g. use of preventative visits and management of chronic conditions including diabetes) for participants of PCMH practices are better than those for individuals not served by a PCMH.

- The ACA primary care rate increase inspired many primary care providers to enroll in HUSKY Health. There were **3,454** primary care providers enrolled in Medicaid at the end of July, 2018, up from **2,370** in January 2013, when the reimbursement increase became effective. In January 2012, there were only **1,622** primary care providers.

- As of July, 2018, there are **120** practices (associated with **536** sites and **1,966** providers) enrolled in the Department's PCMH program. These practices are serving over **390,000** Medicaid members. Members are attributed to these practices based on their use of them, as opposed to the typical managed care approach of assigning members regardless of where they have chosen to receive care.

Connecticut HUSKY Health: Integration of Health, Long-Term Services & Supports, and Social Services

Connecticut Department of Social Services

Integration of Services

Many Medicaid members, especially those who are dually eligible for Medicare, have very complex health profiles. A high incidence of members have both physical and behavioral health conditions, and need support in developing goal-oriented, person-centered plans of care that are realistic and incorporate chronic disease self-management strategies. A siloed approach to care for a member's medical and behavioral health needs is unlikely to effectively care for either set of needs. For example, a client with depression and a chronic illness such as diabetes is unlikely to be able to manage either diabetes or depression without effectively addressing both conditions at the same time. Further, historically there has been considerable division between medical and long-term services and supports, with little coordination or communication occurring among providers. Finally, there has been little nexus historically between health and social services. DSS believes that overcoming these boundaries is essential to responding in a person-centered manner to member needs, and to achieving better outcomes.

How Is This Changing Medical Practice?

Integration is being achieved through a range of strategies. Initially, HUSKY Health focused on supporting primary care providers in transforming their practices in ways that made them more accessible and person-centered. Through its medical Administrative Services Organization (ASO), CHN, HUSKY Health provided free, multi-disciplinary practice coaching that enabled providers to become Person Centered Medical Homes (PCMH). HUSKY Health has also supported integration by using Medicaid data to identify members with complex health profiles, by providing Intensive Care Management, and through sharing of information among the medical, behavioral health and dental ASOs. The ASOs have used a range of Intensive Care Management approaches that have included hospital discharge support and use of community health workers to address social services needs and to act as peer supports. Not least important, new opportunities under the Affordable Care Act have enabled HUSKY Health to fund care coordination activities by local practices and providers, with specific emphasis on integration of medical, behavioral health and social services supports.

Key Strategies:

The Department of Social Services is employing diverse strategies to achieve improved health outcomes and cost efficiencies in the Medicaid program, including:

- use of a self-insured, managed fee-for-services platform to promote efficient, cost-effective and consumer/provider responsive Medicaid medical, behavioral health, dental and non-emergency medical transportation (NEMT) services
- use of data analytics to improve care
- activities designed to improve access to and use of primary care
- **efforts integrate health, long-term services & supports (LTSS), and social services**
- initiatives designed to "re-balance" spending on LTSS (shifting from institutional to community-based care)
- efforts to promote the use of health information technology (HIT)

What is Integrated Care?

The American Psychological Association (APA) has stated that what makes, "integrated health care unique is the sharing of information among team members related to patient care and the establishment of a comprehensive treatment plan to address the biological, psychological, and social needs of the patient. The interdisciplinary health care team includes a diverse group of members (e.g., physicians, psychologists, social workers, and occupational and physical therapists), depending on the needs of the patient."

Connecticut HUSKY Health Key Strategies

HUSKY Health integration efforts have focused upon using data to identify members with complex needs, use of Intensive Care Management, expanding care teams to include community health workers, and implementation of new initiatives to support integration of services by local providers.

- **ASO Predictive Modeling.** The Department's medical ASO, CHN, utilizes the CareAnalyzer system, an analytical and data discovery tool that uses Medicaid claims data to perform predictive modeling in support of identifying HUSKY Health members who need support with complex health conditions.
- **Intensive Care Management (ICM).** The Department's medical, behavioral health and dental ASOs perform comprehensive screenings of individuals with complex needs, initially focusing upon social determinant needs (housing, food and safety) as well as partnering with members to identify their health goals. The ASOs then support high need members with a range of ICM strategies, including use of community health workers to connect people with social services supports and as peer supports with lived experience with behavioral health conditions and substance use disorder.
- **Person Centered Medical Home+ (PCMH+).** PCMH+, which was launched in January, 2017, is an initiative that builds on early primary care practice transformation work to require the involved Federally Qualified Health Centers (FQHCs) and Advanced Networks to offer enhanced care coordination supports to members, focusing on integration of medical and behavioral health as well as community-based social services supports. PCMH+ FQHCs receive supplemental per member, per month payments (PMPM) to help finance this work.
- **Health Homes for Individuals with Serious Behavioral Health Conditions.** The Department partnered with the Department of Mental Health and Addiction Services (DMHAS) to implement integrated behavioral health and medical hubs called health homes for individuals who are diagnosed with an identified Serious and Persistent Mental Illness (SPMI), have high expenditures, and are served by Local Mental Health Authorities (LMHAs). This model makes PMPM payments to LMHAs that have enabled them to incorporate nurse care managers and connections to social services within their existing models of behavioral health support.
- **Behavioral Health Screening for Children.** The Department reimburses providers for conducting annual behavioral health screens for children ages 1 through 17 years, as part of an early childhood evaluation. Providers must indicate on claims for screenings whether the result was positive or negative. This indicator enables HUSKY Health to track whether children who have screened positive for a behavioral health condition receive appropriate referrals and aftercare.

Connecticut HUSKY Health: Rebalancing of Long-Term Services & Supports

What is Rebalancing?

Rebalancing refers to reducing reliance on institutional care and expanding access to community-based Long-Term Services and Supports (LTSS). A rebalanced LTSS system gives Medicaid members greater choice in where they live and from whom they receive services. It also delivers LTSS that are integrated, effective, efficient, and person-centered. Achieving a rebalanced LTSS system requires that states examine current policies, services, access, and other systemic elements that may present challenges to rebalancing goals. In January, 2013, the Governor, the Office of Policy and Management and the Department of Social Services released the State's Strategic Plan to Rebalance LTSS. Updated in 2016, this plan details diverse elements of a broad agenda that is designed to support older adults, people with disabilities and caregivers in choice of their preferred means, mode and place in which to receive LTSS. Key aspects of the plan include 1) continued support for the Money Follows the Person program; 2) activities in support of enhancing community-based services; 3) nursing home diversification; 4) housing; and 5) workforce development. The Strategic Plan also identifies "hot spots" for development of services, including medical services, by projecting demand attributed to the aging population at a town level. Consistent with the Supreme Court's decision in *Olmstead,* the Strategic Plan supports provision of services in the most integrated setting that is appropriate for each individual.

Why Are We Focusing Here?

Consumers overwhelmingly wish to have meaningful choice in how they receive needed long-term services and supports. Connecticut's Medicaid spending remains weighted towards institutional settings, but re-balancing is shifting this. Continuing to build on these efforts is essential given that community supports cost half as much on average as do institutional supports, and the growth in future demand for long-term services and supports is estimated to grow as much as 25% over the next seven years.

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:

- use of a self-insured, managed fee-for-service platform to promote efficient, cost-effective and consumer/provider responsive Medicaid medical, behavioral health, dental and non-emergency medical transportation (NEMT) services
- use of data analytics to improve care
- activities designed to improve access to and use of primary care
- efforts to integrate health, long-term services and supports (LTSS) and social services
- **initiatives designed to "re-balance" spending on LTSS (shifting from institutional to community-based care)**
- efforts to promote the use of health information technology (HIT)

Looking for information on LTSS?

Access MyPlace CT at the following link:

http://www.myplacect.org/

MY PLACE CT

What Do We Mean by Person-Centered Care?

We define person-centeredness as an approach that:

- provides the individual with needed information, education and support required to make fully informed decisions about his or her care options and, to actively participate in his or her self-care and care planning;

- supports the individual, and any representative(s) whom he or she has chosen, in working together with his or her non-medical, medical and behavioral health providers and care manager(s) to obtain necessary supports and services; and

- reflects care coordination under the direction of and in partnership with the individual and his/her representative(s); that is consistent with his or her personal preferences, choices and strengths; and that is implemented in the most integrated setting.

Re-balancing is an overarching agenda that is focused on enabling choice for consumers, optimizing use of public spending on long-term services and supports, and diversification of provider services.

Key Strategies:

- **Money Follows the Person.** The Money Follows the Person (MFP) initiative has led efforts toward systems change in LTSS. In addition to having transitioned over 5,000 individuals from nursing facilities to the community, MFP is implementing diverse strategies that support system change. These include housing development, workforce development, LTSS service and systems gap analysis/recommendations and hospital discharge planning interventions.

- **Universal Assessment and Allocation Methodology.** Connecticut received a federal grant of $72.8 million under the Balancing Incentive Program (BIP), and an additional performance-related award of $4.2 million in 2012. One significant accomplishment of the award was the development and implementation of a universal assessment across all LTSS populations. The assessment tool is linked to an algorithm which uses clinical data to develop level of need groupings. The level of need groupings and associated budget allocation methodology aims at ensuring equitable distribution of funds across all LTSS populations.

- **MyPlaceCT.** An additional accomplishment of the BIP was the establishment of a web-based platform called "MyPlaceCT". Coordinated with 2-1-1, MyPlaceCT increases access to comprehensive information regarding LTSS.

- **Community First Choice (CFC).** Launched in July, 2015, CFC enables Medicaid members who require nursing facility or other institutional level of care to self-direct community-based services including personal care attendants under individual budgets, with the support of a fiscal intermediary.

- **Nursing Home Diversification.** Another important feature of rebalancing is $40 million in grant and bond funds through SFY 2017 that was dedicated to nursing facilities that were interested in diversifying their scope to include home and community-based services.

- **Waiver services.** Connecticut is continuing to expand the scope of its Medicaid "waiver" coverage. "Waivers" permit the state to cover home and community-based long-term services and supports using Medicaid funds. Existing waivers enable services to older adults, individuals with physical disabilities, individuals with behavioral health conditions, children with complex medical profiles, individuals with intellectual disabilities, children with autism spectrum disorder (ASD) and individuals with acquired brain injury (ABI).

- **Preadmission Screening.** The Department utilizes a web-based system for the federally mandated Preadmission Screening Resident Review (PASRR) program. The system identifies persons who are in need of both long-term and short-term institutional care, and recommends alternatives to those whose preference is for home and community-based services options.

Connecticut HUSKY Health: Promotion of Health Information Technology (HIT)

Information Sharing Among Providers and Patients

Historically, medical providers kept unique paper records for each of their patients, and aside from making referrals to colleagues in other specialties, did not share much information in support of diagnosis, transitions across care settings (e.g. home to hospital, hospital to nursing home) or management of chronic health conditions. Indeed, providers themselves could not easily retrieve information from their own records. As technology has developed, there is emerging agreement that it would serve both provider and patients' needs to better support collaboration and information sharing. The aims are that 1) patients will be more capable of engaging with their providers around health care decisions; 2) patients will better understand the cost of care; 3) providers will benefit from data that helps them to assess whether their patients' health status is improving; and 4) patients' clinical information will go along with them as they navigate the health care system. That said, there are many important aspects to be taken into account in developing means of sharing information. These include, but are not limited to, patient choice regarding disclosure of information, privacy, security, and means of retaining and disposing of data. Certain health conditions – notably behavioral health, substance abuse and HIV/AIDS – require specific permissions for information to be shared. All of this must be carefully considered in establishing systems and also creating procedures for use of HIT.

Why Are We Focusing Here?

Certified Electronic Health Record (EHR) systems enable medical providers to collect complete records of patients' treatment history while allowing for automation and streamlining of their workflows. EHR's can also facilitate increased patient safety through evidence-based decision support, quality management, and outcomes reporting. In addition, the secure sharing of personal health information improves care coordination while reducing duplication of effort across providers.

Key Strategies:

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- **efforts to promote the use of health information technology (HIT)**

What is an Electronic Health Record (EHR)?

EHRs are digital (computerized), real-time, patient-centered versions of patients' paper charts. A key feature of an EHR is that it can be created, managed, and consulted by authorized providers and staff across more than one health care organization. A single EHR can bring together information from current and past doctors, emergency facilities, school and workplace clinics, pharmacies, laboratories, and medical imaging facilities.

HUSKY Health Key Strategies

Health information technology is on the vanguard of connecting people and providers with the information that they need to make informed choices about health care.

- **Medicaid Electronic Health Record Incentive Program:** Utilizing 100% federal funding for payments and 90% for administration as authorized by Section 4201 of the *American Recovery and Reinvestment Act of 2009* (ARRA), this program provides incentive payments to Medicaid-enrolled hospitals and "eligible professionals," which include physicians, physician assistants, nurse practitioners, certified nurse-midwives, and dentists, for the adoption and meaningful use of certified electronic health record technology. Enhanced funding is also available through the federal Medicaid EHR program to support various health information technologies (HIT) and health information exchange efforts.

- **Medicaid Provider Directory:** The Department is developing an electronic directory that will serve as an authoritative source of provider information for electronic exchanges. An accurate provider directory will enhance the utility of secure health information exchange, including DIRECT messaging.

- **Promotion of DIRECT Messaging:** Using federal funding, the Department is offering free DIRECT accounts for one year to eligible professionals to enable exchange of messages between providers that are secure and HIPAA compliant. This effort supports overall care coordination and enables timely data exchange and secure exchange of documents (e.g. discharge summaries, assessments, continuity of care documents, and durable medical equipment prescriptions).

- **Medicaid Personal Health Record (PHR):** The Department will leverage existing PHR efforts in the state to provide Medicaid members with the option to access a Personal Health Record. A PHR enables members to view their healthcare information, including records from multiple providers, using a single log in ID and password.

- **Project Notify:** Project Notify supports a real-time notification of a patient admission, discharge, or transfer encounter between providers. DSS intends to use Project Notify to reduce preventable readmissions and improve care coordination for better health outcomes for Connecticut's Medicaid members.

- **Strategic HIT Planning:** Expanding beyond Medicaid, an interagency planning process is underway to create a common vision, identify common goals, identify and support an interoperability framework, and operationalize HIT governance across several state health and human services agencies.