CT 18-0011

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

Division of Medicaid and Children's Health Operations / Boston Regional Office

June 6, 2018

Roderick Bremby, Commissioner
Department of Social Services
55 Farmington Avenue
Hartford, CT 06105

Dear Commissioner Bremby:

We are pleased to enclose via email, a copy of approved Connecticut State Plan Amendment (SPA) No. 18-0011, submitted to my office on March 27, 2018 and approved on May 7, 2018. This SPA amends the Medicaid State Plan in order to continue the implementation of and make updates to ·the Person-Centered Medical Home Plus (PCMH+) program, as described in detail in the cover letter for this SPA. PCMH+ is an Integrated Care Model implemented in accordance with section 1905(a)(29) of the Social Security Act (the "Act"). This SPA involves shared savings payments and care coordination add-on payments for primary care case management (PCCM) services, as defined by section 1905(t) of the Act.

This SPA has been approved effective January 1, 2018, as requested by the State.

Changes are reflected in the following sections of your approved State Plan:

- Attachment 3.1A, page 16-17
- Attachment 4.19B, page 16-17
- Attachment 4.19B, page 30-38

If you have any questions regarding this matter you may contact Marie DiMartino (617) 565-9157 or by e-mail at Marie.DiMartino@cms.hhs.gov

Sincerely,

/S/

Richard R. McGreal
Associate Regional Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 18-0011

2. STATE: CT

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE:
January 1, 2018

5. TYPE OF STATE PLAN MATERIAL (Check One):
___ NEW STATE PLAN ___AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
Sections 1905(a)(29) and 1905(t) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2018 $2.9 million (costs)
b. FFY 2019 $3.6 million (costs)

8. ~~PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:~~
Attachment 3.1A, Pages 16-17
Attachment 4.19B Pages 16-17
Attachment 4.19B Pages 30-38

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If applicable)
Attachment 3.1A Pages 16-17
Attachment 4.19B Pages 16-17
Attachment 4.19B Pages 30-38

10. SUBJECT OF AMENDMENT: Effective January 1, 2018, this SPA amends Attachment 4.19-B of the Medicaid State Plan in order to continue the implementation of and make updates to the Person-Centered Medical Home Plus (PCMH+) program, as described in detail in the cover letter for this SPA. PCMH+ is an Integrated Care Model implemented in accordance with section 1905(a)(29) of the Social Security Act (the "Act"). This SPA involves shared savings payments and care coordination add-on payments for primary care case management (PCCM) services, as defined by section 1905(t) of the Act. The federal budget impact listed above is the Department's estimate of care coordination add-on per member per month payments that will be made to PCMH+ Participating Entities that are federally qualified health centers (FQHCs). It is not possible to predict the amount of shared savings payments that may be paid because such payments will be based on Medicaid expenditures, quality measures, and measures of under-service for dates of service in each of calendar years 2018 and 2019.

11. GOVERNOR'S REVIEW (Check One):

X GOVERNOR'S OFFICE REPORTED NO COMMENT
__COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
__NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
_OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
/S/

13. TYPED NAME: Roderick L. Bremby

14. TITLE: Commissioner

15. DATE SUBMITTED:
March 27, 2018

16. RETURN TO:

State of Connecticut
Department of Social Services
55 Farmington Avenue – 9th floor
Hartford, CT 06105
Attention: Ginny Mahoney

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: March 27 2018

18. DATE APPROVED: May 7, 2018

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL:
/S/

21. TYPED NAME: Richard R. McGreal

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health Operations

23. REMARKS: state approved pen and ink changes to box 6 and 7 adding additional pages on 5/2/18

FORM CMS-179 (07-92)

29. Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary

g. Integrated Care Models

1. PERSON-CENTERED MEDICAL HOME PLUS (PCMH+) PROGRAM

The overall goals of the Person-Centered Medical Home Plus (PCMH+) program are to improve health outcomes and care experience for Medicaid beneficiaries who are PCMH+ members, while building upon and preserving both the PCMH program in particular (as described in section 5 of Attachment 4.19-B), as well as overall improvement in quality, access, and cost control in Connecticut's Medicaid program. Participating Entities that meet identified benchmarks on quality measures, while also demonstrating shared savings (and complying with measures to prevent under-service) will be eligible to receive shared savings payments, all as described in more detail below and in Attachment 4.19-B.

I. Provider Qualifications

Under the PCMH+ program, the State will contract with PCMH+ Participating Entities (Participating Entities), which are Federally Qualified Health Centers (FQHCs) or Advanced Networks, each as defined below, to provide the care coordination services described below. Participating Entities must include primary care providers (primary care physicians, advanced practice registered nurses (APRNs) / nurse practitioners, and/or physician assistants) who provide primary care case management (PCCM) services in accordance with section 1905(t) of the Social Security Act (Act), which includes location, coordination and monitoring of health care services. Pursuant to section 1905(t)(2)(A)-(B) of the Act, a Participating Entity must be, employ, or contract with a physician, a physician group practice, APRNs/nurse practitioners, physician assistants, or an entity employing or having other arrangements with physicians to provide such services. The Participating Entity provides services in the following specialty areas: internal medicine, general medicine, geriatric medicine, family medicine, and pediatrics.

A. Federally Qualified Health Centers (FQHCs)

An FQHC is an entity, as defined in section 2 of Attachment 3.1-A, including an FQHC look-alike (but not an Advanced Network that includes one or more FQHCs), which must:

1. Meet all requirements of an FQHC under section 1905(l)(2)(B) of the Social Security Act.
2. Meet all requirements of the Health Resources and Services Administration (HRSA) Health Center Program and have either: (A) HRSA grant funding as an FQHC under Section 330 of the Public Health Services Act or (B) HRSA designation as an FQHC Look-Alike.
3. Operate in Connecticut and meet all federal and state requirements applicable to FQHCs.
4. Be a current participant in the Department of Social Services (DSS) PCMH program (Glide Path practices are excluded) and hold current Level 2 or 3 Patient-Centered Medical Home recognition from the National Committee for Quality Assurance (NCQA) or Primary Care Medical Home certification from The Joint Commission. Glide Path practices are excluded from PCMH+ because they provide some, but not all, of the Medicaid services required for NCQA or The Joint Commission PCMH recognition. In order to qualify for Glide Path, a practice must have demonstrated to DSS that it has begun providing a more advanced standard of primary care and has committed to achieving NCQA or The Joint Commission PCMH recognition in a set period of time.
5. Identify a clinical director and senior leader to represent the FQHC and champion PCMH+ goals.

B. Advanced Networks

An Advanced Network is a provider organization or group of provider organizations that must include one or more physician group(s) (primary care physician(s), APRN(s), and/or physician assistant(s)), APRN group(s), individual physician(s), and/or individual APRN(s)) and/or one or more FQHCs (a "practice") that practices primary care and is currently participating in the DSS PCMH program (other than a Glide Path practice), as described in section 5 of Attachment 4.19-B. Glide Path practices are excluded from PCMH+ because they provide some, but not all, of the Medicaid services required for NCQA PCMH recognition. In order to qualify for Glide Path, a practice must have demonstrated to DSS that it has begun providing a more advanced standard of primary care and has committed to achieving NCQA or The Joint Commission PCMH recognition in a set period of time. Acceptable options for Advanced Network composition include:

1. One or more DSS PCMH practice(s);
2. One or more DSS PCMH practice(s) plus specialist(s), which could include physical health, behavioral health, and oral health providers;

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g. Integrated Care Models

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The overall goals of the Person-Centered Medical Home Plus (PCMH+) program are to improve health outcomes and care experience for Medicaid beneficiaries who are PCMH+ members, while building upon and preserving both the PCMH program in particular (as described in section 5 of Attachment 4.19-B), as well as overall improvement in quality, access, and cost control in Connecticut's Medicaid program. Participating Entities that meet identified benchmarks on quality measures, while also demonstrating shared savings (and complying with measures to prevent under-service) will be eligible to receive shared savings payments, all as described in more detail below and in Attachment 4.19-B.

I. Provider Qualifications

Under the PCMH+ program, the State will contract with PCMH+ Participating Entities (Participating Entities), which are Federally Qualified Health Centers (FQHCs) or Advanced Networks, each as defined below, to provide the care coordination services described below. Participating Entities must include primary care providers (primary care physicians, advanced practice registered nurses (APRNs) / nurse practitioners, and/or physician assistants) who provide primary care case management (PCCM) services in accordance with section 1905(t) of the Social Security Act (Act), which includes location, coordination and monitoring of health care services. Pursuant to section 1905(t)(2)(A)-(B) of the Act, a Participating Entity must be, employ, or contract with a physician, a physician group practice, APRNs/nurse practitioners, physician assistants, or an entity employing or having other arrangements with physicians to provide such services. The Participating Entity provides services in the following specialty areas: internal medicine, general medicine, geriatric medicine, family medicine, and pediatrics.

A. Federally Qualified Health Centers (FQHCs)

An FQHC is an entity, as defined in section 2 of Attachment 3.1-A, including an FQHC look-alike (but not an Advanced Network that includes one or more FQHCs), which must:

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1. Meet all requirements of an FQHC under section 1905(l)(2)(B) of the Social Security Act.
2. Meet all requirements of the Health Resources and Services Administration (HRSA) Health Center Program and have either: (A) HRSA grant funding as an FQHC under Section 330 of the Public Health Services Act or (B) HRSA designation as an FQHC Look-Alike.
3. Operate in Connecticut and meet all federal and state requirements applicable to FQHCs.
4. Be a current participant in the Department of Social Services (DSS) PCMH program (Glide Path practices are excluded) and hold current Level 2 or 3 Patient-Centered Medical Home recognition from the National Committee for Quality Assurance (NCQA) or Primary Care Medical Home certification from The Joint Commission. Glide Path practices are excluded from PCMH+ because they provide some, but not all, of the Medicaid services required for NCQA or The Joint Commission PCMH recognition. In order to qualify for Glide Path, a practice must have demonstrated to DSS that it has begun providing a more advanced standard of primary care and has committed to achieving NCQA or The Joint Commission PCMH recognition in a set period of time.
5. Identify a clinical director and senior leader to represent the FQHC and champion PCMH+ goals.

B. Advanced Networks

An Advanced Network is a provider organization or group of provider organizations that must include one or more physician group(s) (primary care physician(s), APRN(s), and/or physician assistant(s)), APRN group(s), individual physician(s), and/or individual APRN(s)) and/or one or more FQHCs (a "practice") that practices primary care and is currently participating in the DSS PCMH program (other than a Glide Path practice), as described in section 5 of Attachment 4.19-B. Glide Path practices are excluded from PCMH+ because they provide some, but not all, of the Medicaid services required for NCQA PCMH recognition. In order to qualify for Glide Path, a practice must have demonstrated to DSS that it has begun providing a more advanced standard of primary care and has committed to achieving NCQA or The Joint Commission PCMH recognition in a set period of time. Acceptable options for Advanced Network composition include:

1. One or more DSS PCMH practice(s);
2. One or more DSS PCMH practice(s) plus specialist(s), which could include physical health, behavioral health, and oral health providers;

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29. Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary (continued)

g. Integrated Care Models

1. PERSON-CENTERED MEDICAL HOME PLUS (PCMH+) PROGRAM

I. Overview

Person-Centered Medical Home Plus (PCMH+) Participating Entities that generate savings for the Medicaid program and that meet identified benchmarks on quality performance standards will be eligible to receive shared savings payments in accordance with the methodology described below, so long as they comply with under-service prevention requirements. Shared savings payments will be made to qualifying Participating Entities following the end of a Performance Year. Once data is collected and analyzed at the end of a performance year, savings payments will be made to qualifying Participating Entities no later than the last day of December following the end of that Performance Year. If the Participating Entity is an Advanced Network, the Advanced Network Lead Entity will receive the shared savings payment and distribute the payment among its participating providers according to their participation agreements, which must be approved by DSS before any payments are made.

Shared savings payments are available to eligible Participating Entities through two savings pools. The first pool is an Individual Savings Pool, where each Participating Entity that meets the quality benchmarks will receive a shared savings payment based on a portion of the savings it achieved individually. The second pool is a Challenge Pool that aggregates all savings not awarded to Participating Entities in the Individual Savings Pool, such as due to failure to meet identified benchmarks on quality performance standards or because DSS determined that the Participating Entity systematically engaged in under-service for Medicaid members. To be eligible for a Challenge Pool payment, a Participating Entity must improve quality in total year-over-year and must meet DSS's benchmarks on four Challenge Pool quality measures.

In addition, Participating Entities that are FQHCs (but not Advanced Networks that include one or more FQHCs) will receive monthly per-member-per-month (PMPM) payments for Care Coordination Add-On Payment Activities that the FQHC provides to PCMH+ members, as described below.

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PCMH+ does not change any other reimbursement methodology that is available to any provider, including providers that are PCMH+ Participating Entities (or providers that are included in PCMH+ Participating Entities, including one or more PCMH practices within a PCMH+ Participating Entity). Accordingly, applicable fee-for-service payments will continue to be made to all qualified Medicaid providers that provide any Medicaid covered service to a beneficiary assigned to a PCMH+ Participating Entity.

II. Covered Populations

For the purposes of calculating shared savings, all Connecticut Medicaid beneficiaries attributed to the Department of Social Services (DSS) PCMH program are eligible for PCMH+ except for the categories of individuals listed as excluded from PCMH+ in Attachment 3.1-A.

III. Assignment Methodology

Eligible beneficiaries (*i.e.*, excluding categories of beneficiaries listed as excluded from PCMH+ in Attachment 3.1-A) will be assigned to PCMH+ Participating Entities on the basis of the PCMH retrospective attribution methodology described in section 5 of Attachment 4.19-B. Beneficiaries may affirmatively select a PCMH practice as their primary care provider. In the absence of beneficiary selection, the PCMH attribution methodology retrospectively assigns beneficiaries to primary care practitioners based on claims volume. If a beneficiary receives care from multiple providers during a given period, the beneficiary is assigned to the practice that provided the plurality of care and, if there is no single largest source of care, to the most recent source of care.

A Participating Entity's assigned beneficiaries are the beneficiaries attributed to its PCMH practices using this methodology less beneficiaries that are not eligible for PCMH+ as provided in Attachment 3.1-A. Even if an Advanced Network includes other providers, only the beneficiaries attributed to the PCMHs (or a PCMH practice entity) in the Advanced Network will be assigned to the PCMH+ Participating Entity.

PCMH+ assignment will occur once annually, and will last for the entire Performance Year (unless during the course of the Performance Year, an individual opts out of PCMH+, loses eligibility for Medicaid, or falls into a category of individuals excluded from PCMH+, as

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

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

If, over the course of a Performance Year, a PCMH+ member Medicaid eligibility or moves into a population that is not eligible for PCMH+ (see Attachment 3.1-A), that change has the same effect as if an individual opts out of assignment to a PCMH+ Participating Entity, as described immediately above. If a PCMH+ member temporarily loses eligibility for Medicaid but is retroactively reinstated so that there is no gap in continuous eligibility, then each Participating Entity that is an FQHC will receive Care Coordination Add-On Payments for such members for all months of continuous eligibility, including the retroactively reinstated months, but only if the eligibility is restored not later than 120 days after temporarily losing coverage. Otherwise, if a PCMH+ member loses eligibility for Medicaid, that loss of eligibility has the same effect as if an individual opts out of assignment to a PCMH+ Participating Entity.

IV. Benefits Included in the Shared Savings Calculation

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

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V. Shared Savings Payment Methodology: Individual Savings Pool

A. Individual Savings Pool Quality Measures

The quality measures applicable to the payment methodology are described in Attachment 3.1-A. Specified quality measures apply to a Participating Entity's Individual Savings Pool payment, other specified quality measures will be used in calculating the Challenge Pool payment, and a final category of specified measures will be reporting-only measures and will not be included in the shared savings payment calculation.

B. Individual Savings Pool Quality Scoring

The Participating Entity's shared savings payment in the Individual Savings Pool will be determined in part by the Participating Entity's total quality score. A Participating Entity's total quality score will be based on three components of quality measurement (maintain quality, improve quality, and absolute quality) for each of the nine quality measures. A maximum of one point is available for each component of quality measurement for each measure:

1. Maintain Quality: One point is awarded if a Participating Entity's Performance Year quality score is greater than or equal to its Prior Year score. (A statistically significant threshold may be established based on historical quality measure data to account for unexpected annual variation, which results in lower scores).

2. Improve Quality: A Participating Entity will earn points in accordance with the sliding scale included below based on its year-over-year performance (quality improvement performance) against the quality improvement trend derived from all Participating Entities.

Quality Improvement Measured as Percentile	*Points Awarded*
49.99% or less	0.00
Between 50.00% and 59.99%	0.25
Between 60.00% and 69.99%	0.50

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Quality Improvement Measured as Percentile	*Points Awarded*
Between 70.00% and 79.99%	0.75
80.00% or greater	1.00

3. Absolute Quality: A Participating Entity will earn points in accordance with the sliding scale included below for its ability to reach absolute quality targets, derived from a comparison group's quality scores.

Quality Performance Measured as Percentile	**Points Awarded**
49.99% or less	0.00
Between 50.00% and 59.99%	0.25
Between 60.00% and 69.99%	0.50
Between 70.00% and 79.99%	0.75
80.00% or greater	1.00

To calculate each Participating Entity's total quality score, its points will be summed and then divided by a maximum score of 27 points (three possible points per quality measure with nine total quality measures). The total quality score, expressed as a percent, will be used in calculating the portion of a Participating Entity's Individual Savings Pool that will be returned to the Participating Entity as shared savings.

C. Individual Savings Pool Calculation

Each Participating Entity's Individual Savings Pool will be funded by savings it generated during the Performance Year. The 12-month period of the first Performance Year will be January 1, 2017 through December 31, 2017, and the prior year will be January 1, 2016 through December 31, 2016. Each subsequent Performance Year will be January 1st through December 31st of each year and the prior year will be January 1st through December 31st of the previous year. For the 2018 Performance Year, the Performance Year will be measured based on the entire 2018 calendar year for claim cost and quality data. This analysis applies to all Participating Entities, including those who did not participate in PCMH+ for the calendar year 2017 Performance Year and began participating in the program effective on or after April 1, 2018. As described in more detail below, the calculated savings will be subject to a minimum savings rate (MSR),

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limited by a savings cap, and multiplied by a sharing factor to generate the available Individual Savings Pool shared savings payment amounts, if any.

For each Participating Entity, the calculation of savings will be based on the extent to which the Participating Entity achieved a lower cost trend than a comparative trend to be derived from non-participating entities.

Savings will only be calculated based on PCMH+ members who remain eligible for PCMH+ for at least 11 months of the Performance Year. Cost data of members who opt out of PCMH+ will not be used in the calculation of shared savings. In addition, to avoid unwanted bias due to outlier cases, for each PCMH+ member, annual claims will be truncated at $100,000, so that expenses above $100,000 will not be included in the calculation.

The first step in calculating savings is to derive the Prior Year Cost and the Performance Year Cost for each Participating Entity. Risk adjustment methods (based on existing Johns Hopkins Adjusted Clinical Groups (ACG) retrospective risk scores) will be used to adjust both Prior Year and Performance Year costs for underlying differences in illness burden.

A Participating Entity's Risk Adjusted Expected Performance Year costs will be developed by multiplying the Entity's Risk Adjusted Prior Year Cost by the comparative trend. A Participating Entity's savings will be the difference between its Risk Adjusted Expected Performance Year costs and its actual Risk Adjusted Performance Year costs. Participating Entities that demonstrate losses (i.e., higher than expected expenditures for beneficiaries assigned to the Participating Entity) will not return these losses.

*Savings = (Risk Adjusted Prior Year Costs * comparative trend) – Risk Adjusted Performance Year Costs*

Minimum Savings Rate: A Participating Entity's risk-adjusted savings must meet the MSR requirement, which is greater than or equal to 2% of the expected Performance Year Costs. If a Participating Entity meets the MSR requirement, then the first-dollar savings (*i.e.*, all savings generated, including amounts below the MSR threshold) will be considered as savings. If a Participating Entity does not meet the MSR requirement, its

savings will not be considered. Likewise, losses between 0% and -2% will not be considered credible when deriving the aggregate program savings.

*MSR Adj. Savings = IF (Savings ≥ 0.02 * Expected Risk Adj. Performance Year Costs, Savings, 0)*

Savings Cap: A Participating Entity's savings will be capped at 10% of its Risk Adjusted Expected Performance Year Costs, so that any savings above 10% will not be included in its Individual Savings Pool.

*Capped MSR Adj. Savings = Min (MSR Adj. Savings, 0.10 * Expected Risk Adj. Performance Year Costs)*

Sharing Factor: If a Participating Entity has savings following the calculation steps above, these savings will be multiplied by a Sharing Factor of 50%. The resulting amount will form the Entity's Individual Savings Pool.

*Individual Savings Pool = Capped MSR Adj. Savings * 0.50*

D. Individual Pool Shared Savings Calculation

For each Participating Entity, the Individual Savings Pool Shared Savings payment, if any, is equal to the Individual Savings Pool times the Total Individual Pool Quality Score defined above.

*Individual Savings Pool Shared Savings = Individual Savings Pool * Total Quality Score*

VI. Shared Savings Payment Methodology: Challenge Pool

A. Challenge Pool Eligibility

To be eligible for a Challenge Pool payment, a Participating Entity must improve its overall performance year-over-year on the measures that apply to the Individual Savings Pool.

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B. Challenge Pool Funding

It is expected that one or more Participating Entities may not receive 100% of their Individual Savings Pool as shared savings payments because of less than perfect scores on the applicable quality measures or because DSS determined that the Participating Entity systematically engaged in under-service for Medicaid members. The amounts not returned will be aggregated to form a target amount for the Challenge Pool. The Challenge Pool funding is limited so as to ensure that the Challenge Pool payments will not exceed the Aggregate Savings of the PCMH+ program less the Aggregate Individual Shared Savings payments. For this test, the Aggregate Savings of the PCMH+ program is defined as all credible savings and losses for all Participating Entities (*i.e.*, subject to the MSR requirement and subject to all other requirements for calculating available individual savings pool shared savings, as described above).

Aggregate Savings = $\sum$ *Savings and losses subject to the MSR for all Participating Entities*

Challenge Pool Target = $\sum$ *Not Returned Individual Savings Pool Amounts*

Challenge Pool Limit = Aggregate Savings – $\sum$ *Individual Savings Pool Shared Savings*

Challenge Pool Funding = Minimum (Challenge Pool Limit, Challenge Pool Target)

Note: The Challenge Pool Funding cannot be negative.

C. Challenge Pool Quality Measure Scoring

For each of the four Challenge Pool quality measures, Participating Entities that achieve at least the median score (of all Participating Entities) for a Challenge Pool quality measure will pass or get credit for that measure.

D. Challenge Pool Distribution

The amount of the Participating Entity's Challenge Pool payment, if any, will be the product of the number of its assigned PCMH+ members times the number of Challenge Pool quality measures passed, divided by the sum of this statistic across all Participating

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Entities. As such, it is certain that the full Challenge Pool will be returned. It should be noted that the Challenge Pool payment to any particular Participating Entity is not directly related to its individual savings.

*Challenge Pool Distribution Participating Entity A = (Participating Entity A Number of Challenge measures passed * Number Assigned PCMH+ Members in Participating Entity A) / (∑ Participating Entity Number of measures passed * Participating Entity Number of Members)*

VI. Care Coordination Add-On Payment Methodology (FQHCs Only)

DSS will make Care Coordination Add-On Payments prospectively to Participating Entities that are FQHCs (but not Advanced Networks that include one or more FQHCs) on a monthly basis using a per-member per-month (PMPM) amount for each beneficiary assigned to the FQHC, using the assignment methodology described above. DSS will factor the Care Coordination Add-On Payments in each FQHC's shared savings calculation. For the Performance Year for dates of service for calendar years 2017 and each Performance Year thereafter, except as otherwise provided below, the PMPM payment amount is $4.50.

For the Performance Year for dates of service for calendar year 2017, the total pool of funds for making Care Coordination Add-On Payments is $5.57 million. For the Performance Year for dates of service for calendar year 2018, the total pool of funds for making Care Coordination Add-On Payments is $6.1 million. For the Performance Year for dates of service for calendar year 2019, the total pool of funds for making Care Coordination Add-On Payments is $6.0 million. Notwithstanding the PMPM payment amount listed above, if DSS determines that this total pool of funds may be reached or exceeded in a calendar month, DSS shall reduce the PMPM amount for that month as necessary in order to remain within the total pool of funds and no PMPM payments will be made for any subsequent months in the performance year.