State Discussion: How Connecticut Leverages Their Health Information Exchange and NCQA's Person-Centered Outcome Measures in Their VBP Program

December 8, 2025

Agenda

UCONN HEALTH: CONNECTICUT VALUE-BASED PAYMENT PROGRAM

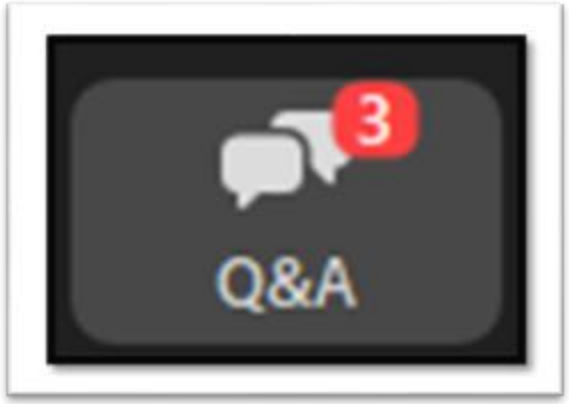
CONNIE: THE ROLE OF THE HEALTH INFORMATION EXCHANGE (HIE)

NCQA: PERSON-CENTERED OUTCOME (PCO) MEASURES

CONNECTICUT COMMUNITY CARE: THE ROLE OF THE ACCESS AGENCY

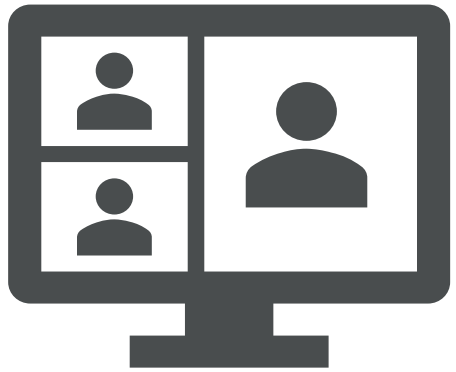
CONNECTICUT DEPARTMENT OF SOCIAL SERVICES: GOALS AND NEXT STEPS

Housekeeping



Ask Now

Enter your questions in the Q&A function in Zoom



Engage After

A recording of the event and slides/supporting materials will be sent to attendees.

Polling Question

What is the current state of your Health Information Exchange (HIE)?

A. Mature system with minimal issues.

B. Maturing system with ongoing data issues.

C. Maturing system with other issues (legal, funding, etc.)

D. Immature or fragmented system, or still in the planning stage.

E. No HIEs, but in the planning stage.

F. No HIEs, and no plans for a system.

Polling Question

Do you have experience with implementing VBP for HCBS or behavioral health?

A. Yes, we are implementing VBP for HCBS or BH.

B. No, but we are planning to implement in either HCBS or BH.

C. No, but there is interest in VBP in HCBS and BH.

D. No, VBP for HCBS or BH is not currently being considered.

Connecticut HCBS VBP Background

Value-based payments (VBP) are well-developed for hospitals & physicians but have not been available to HCBS providers

- CT Medicaid initiative:
  - Develop and implement VBP performance measures for HCBS providers
- Goals:
  - Use incentives to drive change
  - Create partnerships across diverse providers
  - Use ARPA funding to support high quality HCBS services

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HCBS VBP Performance Measures

Collaboration among multiple entities to develop and test performance measures, benchmarks and payment structure

- CT Department of Social Services: Medicaid Agency
- 2 Universities: UConn Center on Aging & Yale Center for Outcomes Research and Evaluation
- Connie: Connecticut's Health Information Exchange
- National Committee for Quality Assurance (NCQA)
- Community-based case management organizations
- HCBS provider organizations

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HCBS VBP Performance Measures

Three VBP performance measures:

- **Decrease avoidable hospitalizations**
  - Based on CMS measure (Potentially Preventable Hospitalization Measure for the Home Health Quality Reporting Program)
- **Increase hospital discharges to community**
  - For people receiving post-acute care/long term services and supports
- **Achievement of person-centered goals**
  - Using SMART goals & Goal Attainment Scaling

VBP development based on Medicare/Medicaid claims, adjusting for provider size & client health status and data from statewide case management organizations and admission/discharge/transfer (ADT) data sent to Connie

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VBP Performance Measures Implementation

- Waiver care managers develop, track and measure individuals' goal achievement of NCQA person-centered outcomes (PCO)
- Connie calculates performance benchmark results using PCO data and ADT data from hospitals and skilled nursing facilities
- Performance benchmark results displayed in Connie at both individual and provider level
- Providers enrolled in Connie can see their clients' current and previous VBP performance
- Assists providers to identify clients in need of more support
- 3-tiered Value-Based Payments distributed twice annually

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Why Connie?

Connie is uniquely positioned to support this collaboration because:

- Connie is Connecticut's independent, not-for-profit, statewide **Health Information Exchange (HIE)**
- Connected to over 1400 facilities across the state, including all hospital systems and 25% Long Term/Post Acute facilities.
- Receive near real-time encounter and clinical information to support care coordination.
- Master Patient Index enables patient data matching across providers and organizations.
- Work closely with CT Department of Social Services to support Medicaid priorities.

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HIE DATA SOURCES

Hospital / Labs / Radiology
Patient Demographics,
Encounter, Diagnosis,
Treatment, Labs, Radiology

Ambulatory Practices / SNF
Patient Demographics,
Encounter, Diagnosis,
Treatment

Pharmacy
Patient Demographics,
Medications filled

PROGRAM SOURCES

Access Agencies
Patient Centered Goals

CT Medicaid
Prior Authorization
Electronic Visit Verification
Universal Assessment

Connie

Technical Infrastructure

Clinical Data Repository

HCBS Program Data Repository

Master Patient Index

Connie Portal

Clinical Data

Care Team

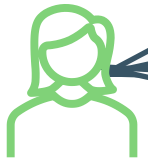
HCBS Program Tool

USE CASES

I'm a home health nurse and need to know my patient's discharge orders and medication list.

Who is my patient's PCP? When did they last see them?

I am an administrator at an HCBS organization. How well is my organization doing in relation to the VBP benchmarks for this program?



I am a care coordinator at an HCBS organization. What other HCBS services is my client receiving?

Did my client miss an appointment due to a hospitalization?

Might my client benefit from an updated Universal Assessment?

What are my client's person-centered goals?

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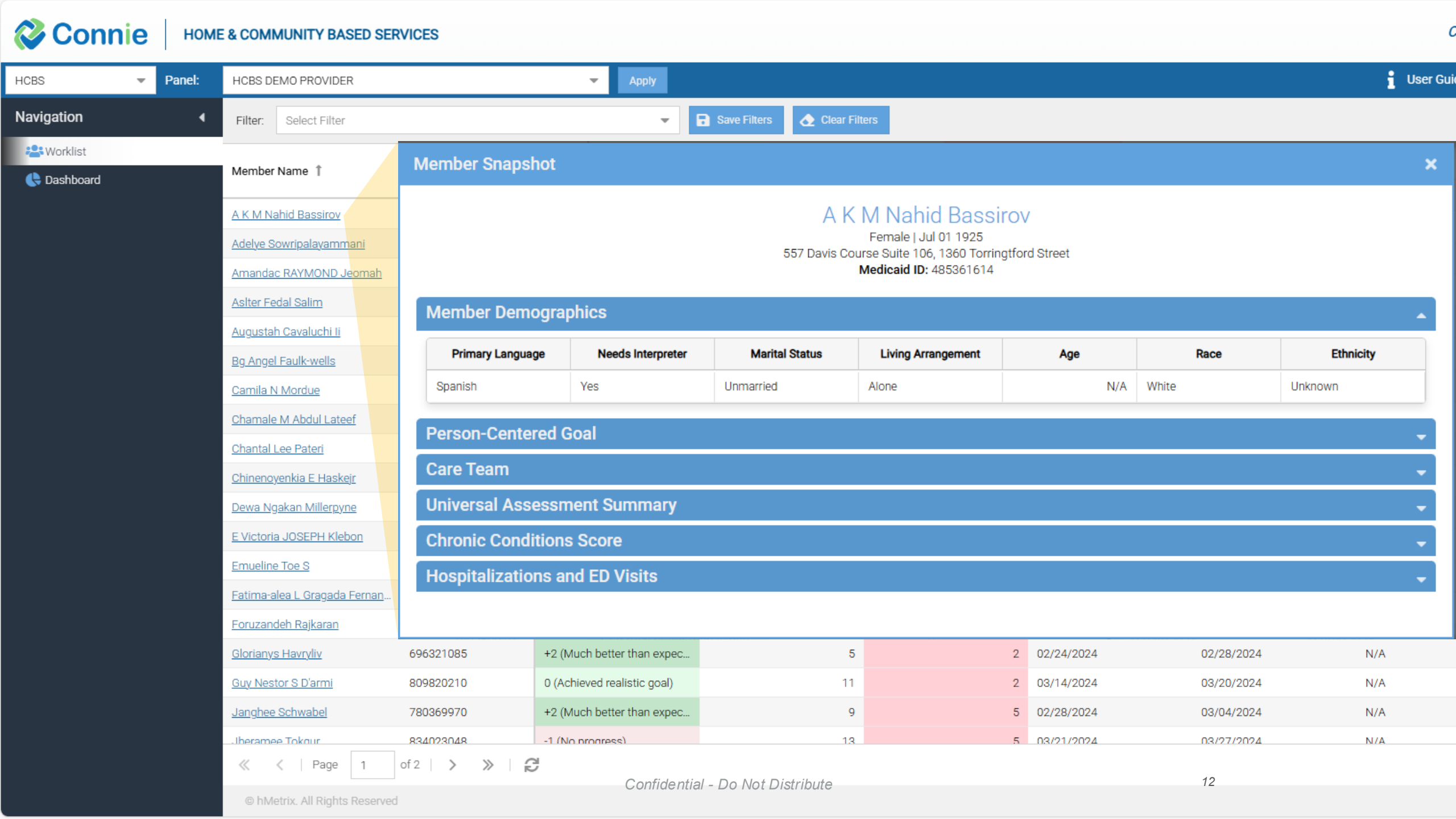
Connie
HOME & COMMUNITY BASED SERVICES
HCBS
Panel:
HCBS DEMO PROVIDER
Apply
User Gui
Navigation
Worklist
Dashboard
Filter:
Select Filter
Save Filters
Clear Filters
Member Name
A K M Nahid Bassirov
Adelye Sowripalayammani
Amandac RAYMOND Jeomah
Aslter Fedal Salim
Augustah Cavaluchi Ii
Bg Angel Faulk-wells
Camila N Mordue
Chamale M Abdul Lateef
Chantal Lee Pateri
Chinenoyenkia E Haskejr
Dewa Ngakan Millerpyne
E Victoria JOSEPH Klebon
Emueline Toe S
Fatima-alea L Gragada Fernan...
Foruzandeh Rajkaran
Member Snapshot
A K M Nahid Bassirov
Female | Jul 01 1925
557 Davis Course Suite 106, 1360 Torringtford Street
Medicaid ID: 485361614
Member Demographics
Primary Language
Needs Interpreter
Marital Status
Living Arrangement
Age
Race
Ethnicity
Spanish
Yes
Unmarried
Alone
N/A
White
Unknown
Person-Centered Goal
Care Team
Universal Assessment Summary
Chronic Conditions Score
Hospitalizations and ED Visits
Glorianys Havryliv 696321085 +2 (Much better than expec... 5 2 02/24/2024 02/28/2024 N/A
Guy Nestor S D'armi 809820210 0 (Achieved realistic goal) 11 2 03/14/2024 03/20/2024 N/A
Janghee Schwabel 780369970 +2 (Much better than expec... 9 5 02/28/2024 03/04/2024 N/A
Jberamee Tokgur 834023048 -1 (No progress) 13 5 03/21/2024 03/27/2024 N/A
Page 1 of 2
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Connie | HOME & COMMUNITY BASED SERVICES

Connecting People for Better Health

HCBS | Panel: HCBS DEMO PROVIDER | Apply | User Guide | Wilson, Heidi | Logout

Navigation

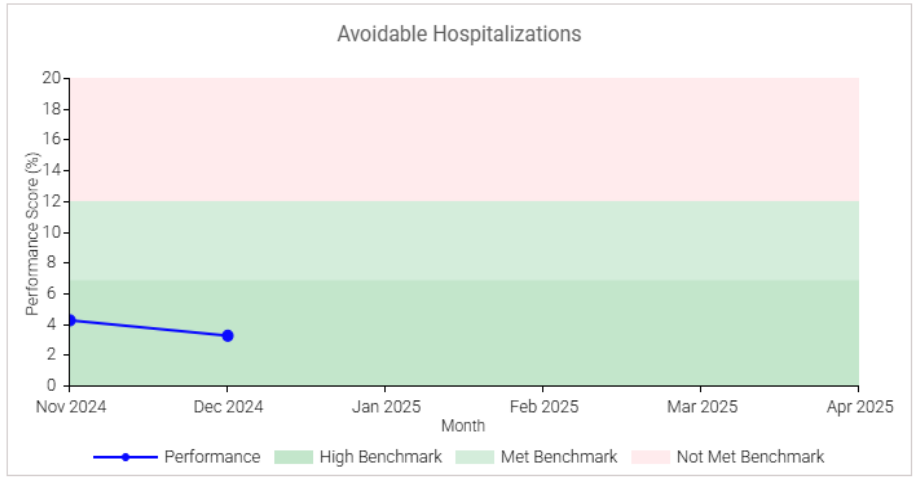
- Worklist
- Dashboard

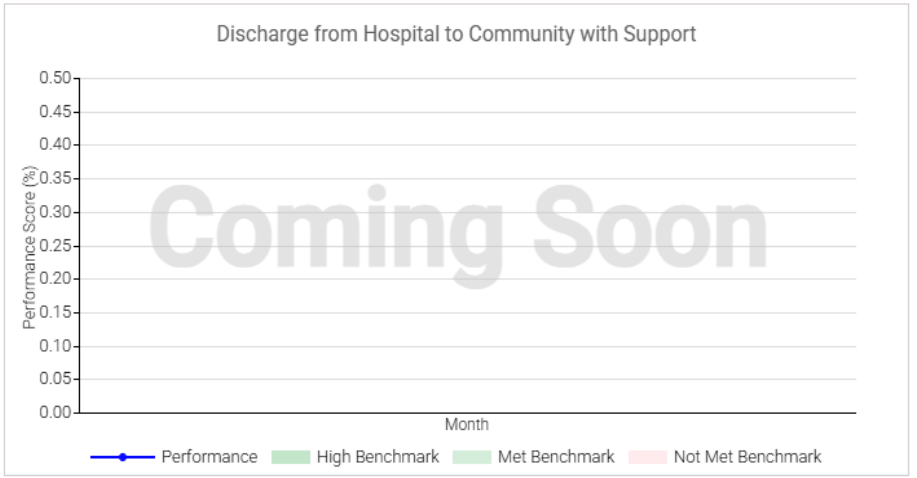
Dashboard Info

Dashboard

HCBS DEMO PROVIDER

Outcome Measure	Description	Benchmarks	Previous Performance Period (May 2024 - Oct 2024)	Current Performance Period (Nov 2024 - Apr 2025)
Avoidable Hospitalizations	Percent of a participating organization's Medicaid population with avoidable hospitalizations during the performance period after adjusting for population risk. Scores at or below the benchmark meet the payment benchmark requirements.	11.90% High: 6.74%	6.06% (Met)	3.73% (Scoring in Progress)
Discharge from Hospital to Community with Support	Percent of a participating organization's Medicaid population discharged from hospital to community (vs institution) with support during the performance period. Scores at or above the benchmark meet the payment benchmark requirements.	N/A	N/A	N/A



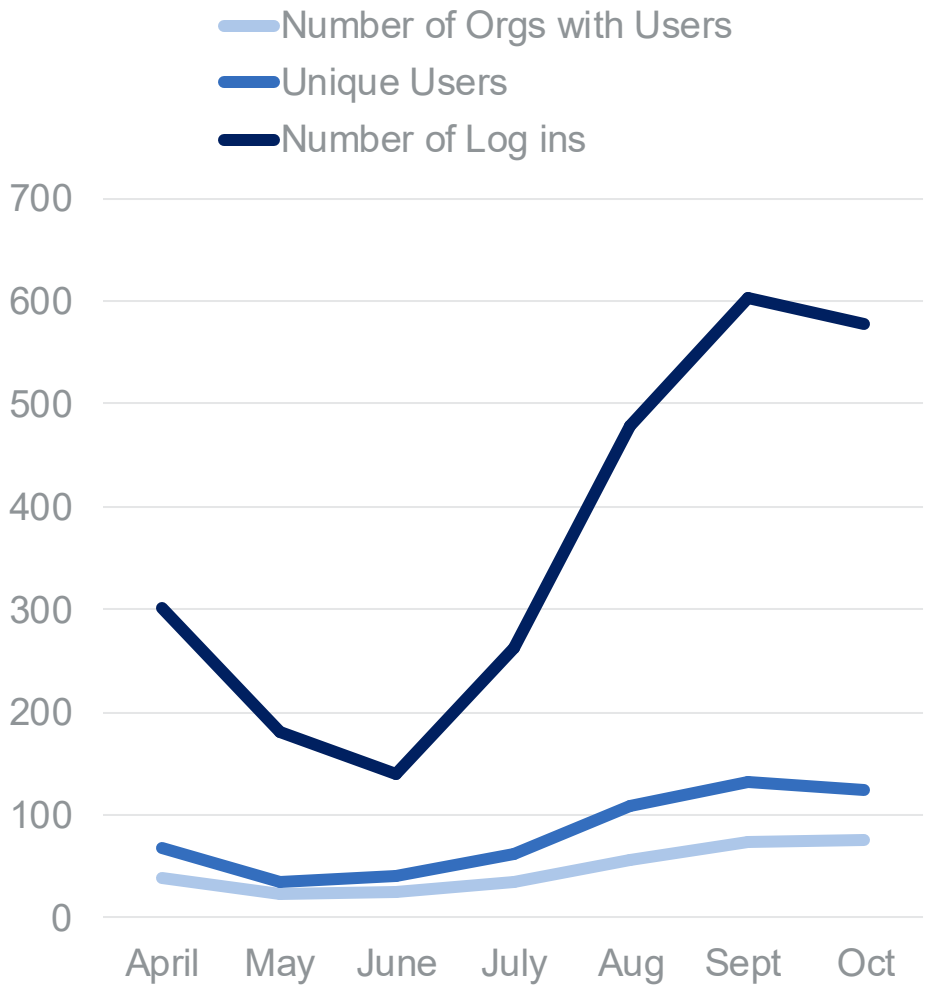


Results

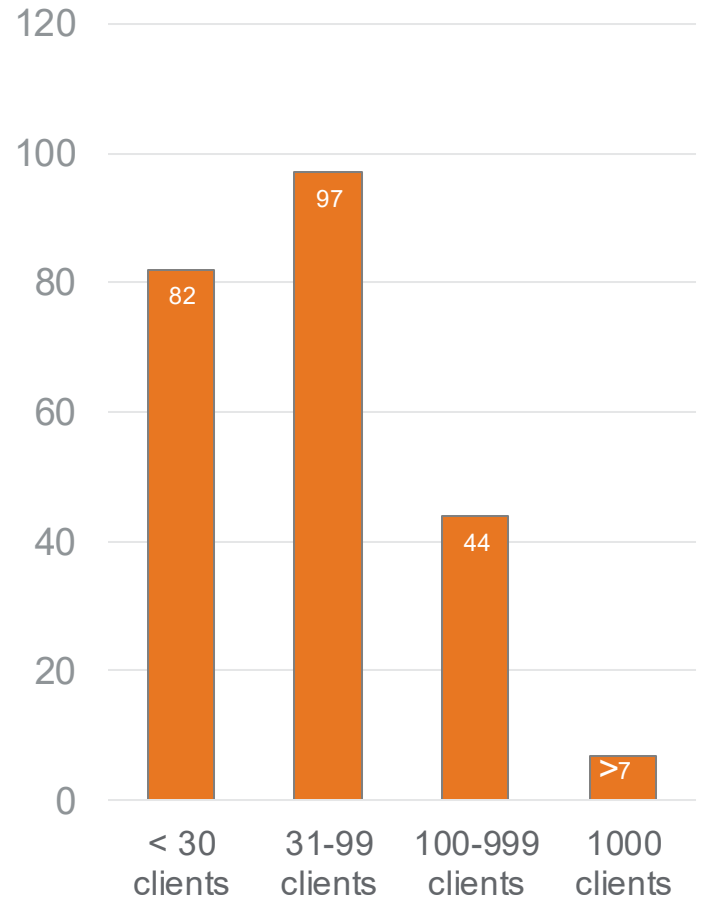
230 Participating Organizations of which:

- 60% of POs assigned at least 1 user for a total of 130 provisioned users.
- 44 organizations averaged 122 users accessing at least one time for Aug, Sept, Oct
- Users average 8 minutes per session in April, and 5 mins in Oct.

Monthly User Engagement



Participating Organization Size

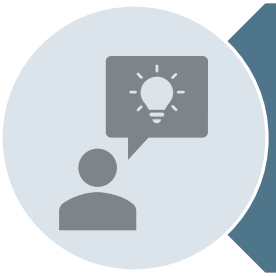


Person-Centered Outcome Measures

Background and Importance

- For **individuals with complex care needs,** care should align with what matters to them, their person-centered outcome goals.
- **Measurement can be used to drive goal-oriented care** and encourage clinicians to deliver care aligned with these goals.
- Goal-oriented care is the **basis for shared-decision making and an accepted way for caring for individuals with complex care needs.**
- For quality measures, person-centered outcome **goals must be measured and tracked in a standardized way.**

Person-Centered Outcome Measures



Measure 1 - Goal Identification: The percentage of individuals 18 years of age and older with a complex care need who had **a person-centered outcome goal identified resulting in documentation of a goal domain, completion of Goal Attainment Scaling (GAS)** or patient-reported outcome measure (PROM)*, and **development of action steps.**

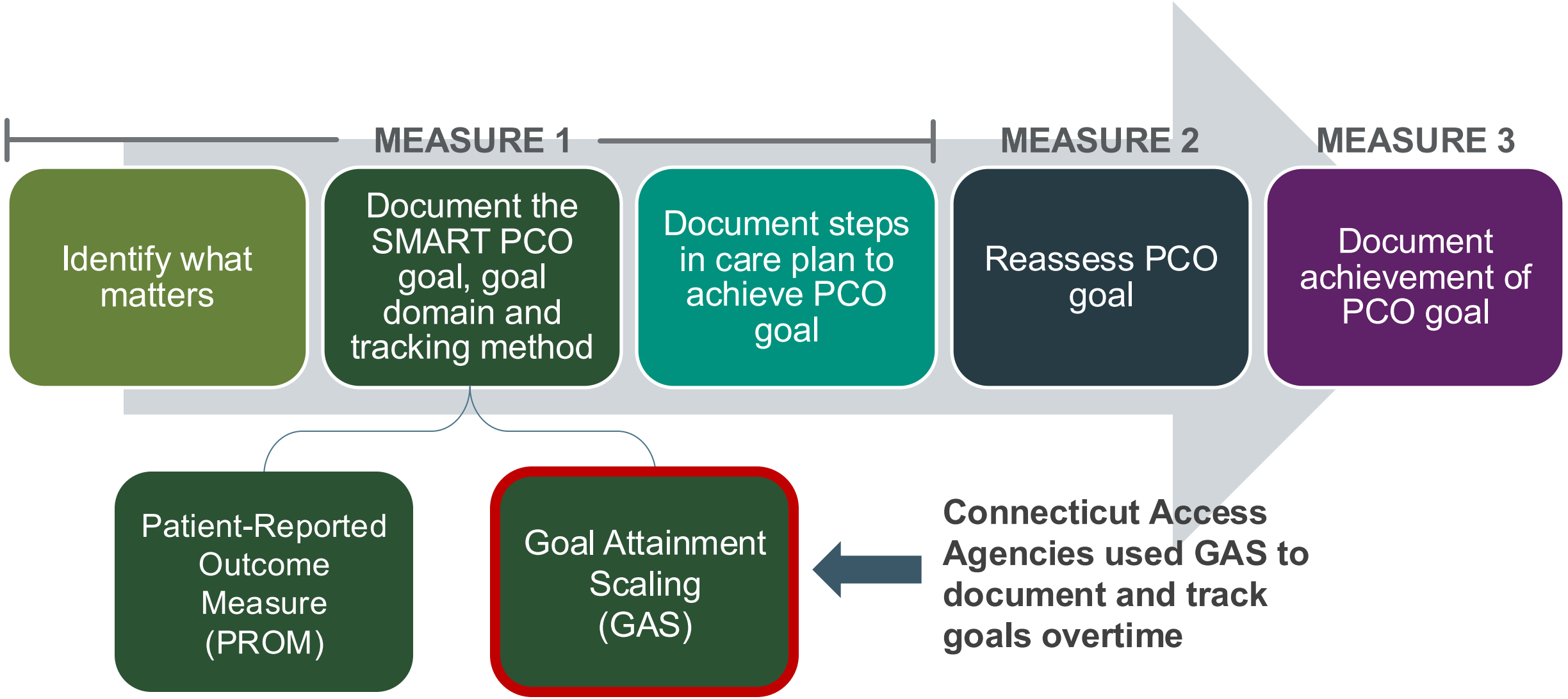
Measure 2 – Goal Follow-up: The percentage of individuals 18 years of age and older with a complex care need who **received follow-up on their person-centered outcome goal within two weeks to six months of when the person-centered outcome goal was identified** resulting in documentation of a goal domain, completion of Goal Attainment Scaling (GAS) or patient-reported outcome measure (PROM)*, and development of action steps.

Measure 3 – Goal Achievement: The percentage of individuals 18 years of age and older with a complex care need who **achieved their person-centered outcome goal within two weeks to six months of when the person-centered outcome goal was identified** resulting in documentation of a goal domain, completion of Goal Attainment Scaling (GAS) or patient-reported outcome measure (PROM)*, and development of action steps.

**Connecticut Access Agencies are using goal attainment scaling to document and track goals.*

Person-Centered Outcomes Approach

Measuring What Individuals Say Matters Most to Them



Goal Attainment Scaling

Example: 82-year-old person with mobility problem, depression, history of arthritis and heart failure

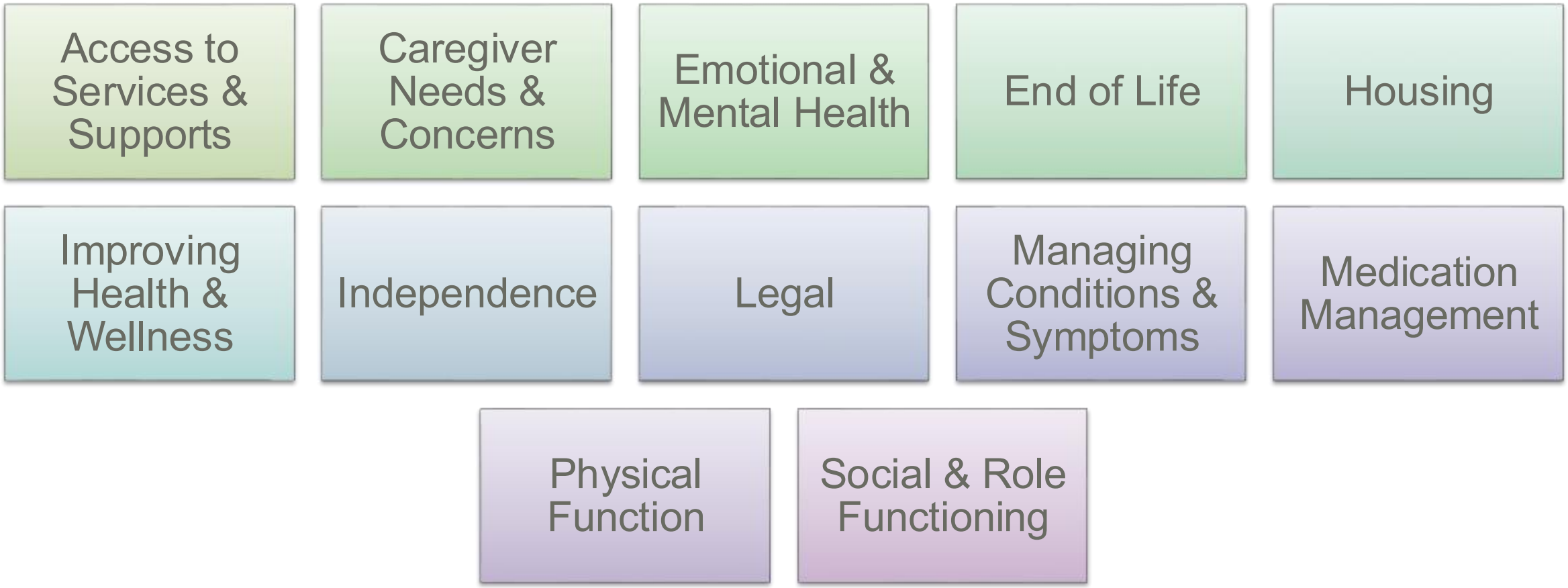
Goal: Walk her dog outside once a week for the next 2 months.
Goal Domain: Physical Function

Worse (-2)	Current State (-1)	Realistic Goal (0)	Stretch Goal (+1)	Super Stretch Goal (+2)
Unable to let the dog outside.	Does not go outside to walk her dog	Walk her dog outside once a week for the next 2 months.	Walk her dog outside twice a week for the next 2 months.	Walk her dog outside three times a week for the next 2 months.

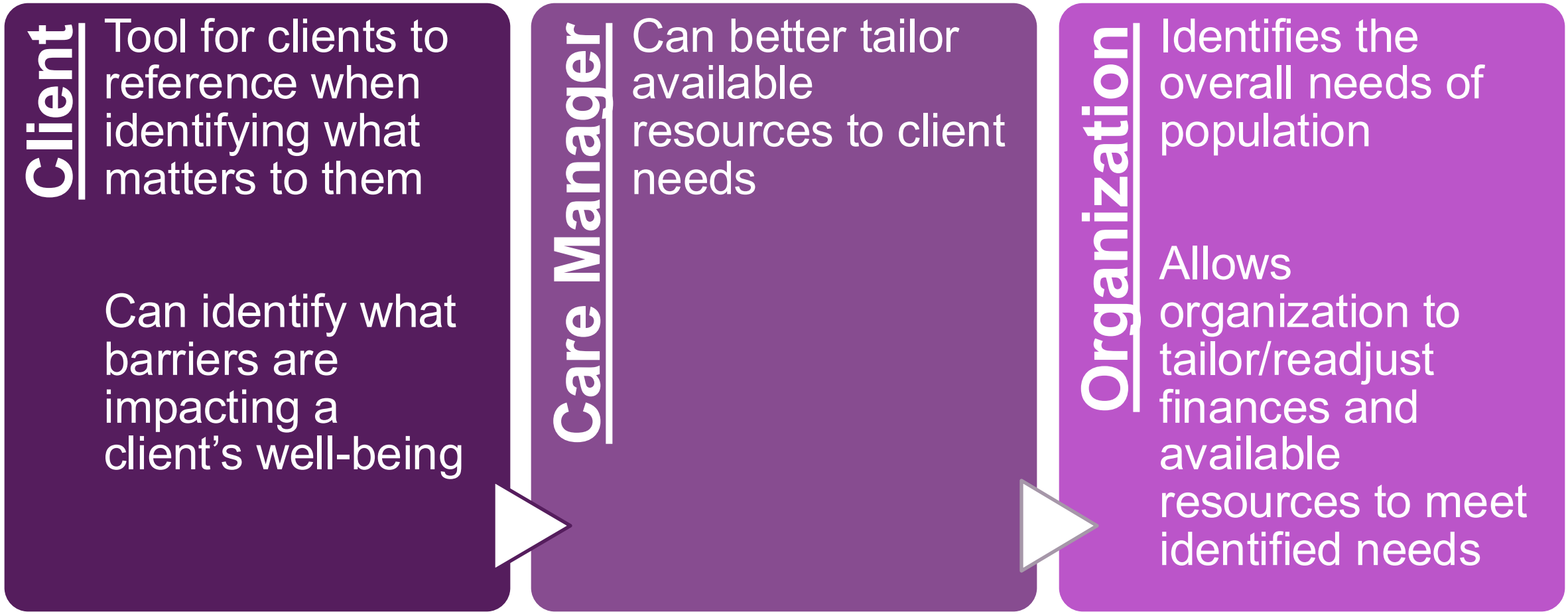
What could be worse — **Current State** — **Where they want to be** →

For goal achievement, both the clinician and individual's progress score must be ≥ 0 at follow-up for goal achievement.

Goal Domains



Opportunities with Goal Domains



System Integration

Data Collection and Reporting	Training	Technical Assistance	Audit	Benchmarks
				
Worked with Access Agencies to implement necessary data collection and reporting changes.	Trained Access Agency care managers on goal identification and using GAS to track goals overtime.	Provided quarterly Webinars to support care managers with implementation.	Audited Access Agency data and systems to ensure appropriate implementation.	Developed benchmarks for value-based payment program.

The Role of the Access Agency

- Connecticut Community Care, Inc. is a non-profit Care Management organization deemed an Access Agency by the state of Connecticut
- We serve roughly 16,000 clients in 3 main regions of Connecticut most of whom receive HCBS through Medicaid waiver programs
- Care management services include:
  - Education and outreach
  - LTSS service coordination with providers
  - Crisis management and intervention
  - Connection to community-based supports

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Interoperability – Why It Matters

Mr. Cruz is a client of CT Community Care and receives services through The CT Home Care Program for Elders Medicaid Waiver. He receives personal care attendant services 5 hours 7 days a week. Mr. Cruz sustains a fall in the morning hours before his PCA arrives. He is transported by ambulance to a local hospital who assesses him in the emergency room….

Scenario 1: Mr. Cruz tells the social worker that he has help from a PCA at home. The social worker believes he needs more services than what he was getting so they discuss discharge plans to a skilled nursing facility. Mr. Cruz forgot his wallet at home with his care manager's contact information and is an agreeable man so he OK's the plan to go to a nursing facility for short-term rehab. The social worker begins the discharge paperwork and locates a skilled nursing facility and he is transported same day.

Scenario 2: The emergency department social worker access Connie (CT's Health Information Exchange), CT Community Care is listed as a provider. At the same time, CCC receives notification that Mr. Cruz is at Hartford Hospital. The care manager calls the ED social worker to discuss. Together, with Mr. Cruz, the social worker and CCC care manager discuss a change in services to support his recovery. CCC called the LTSS provider and changes the service package that can begin same day. Mr. Cruz is discharged home same day with PCA services 8 hours a day 7 days a week.

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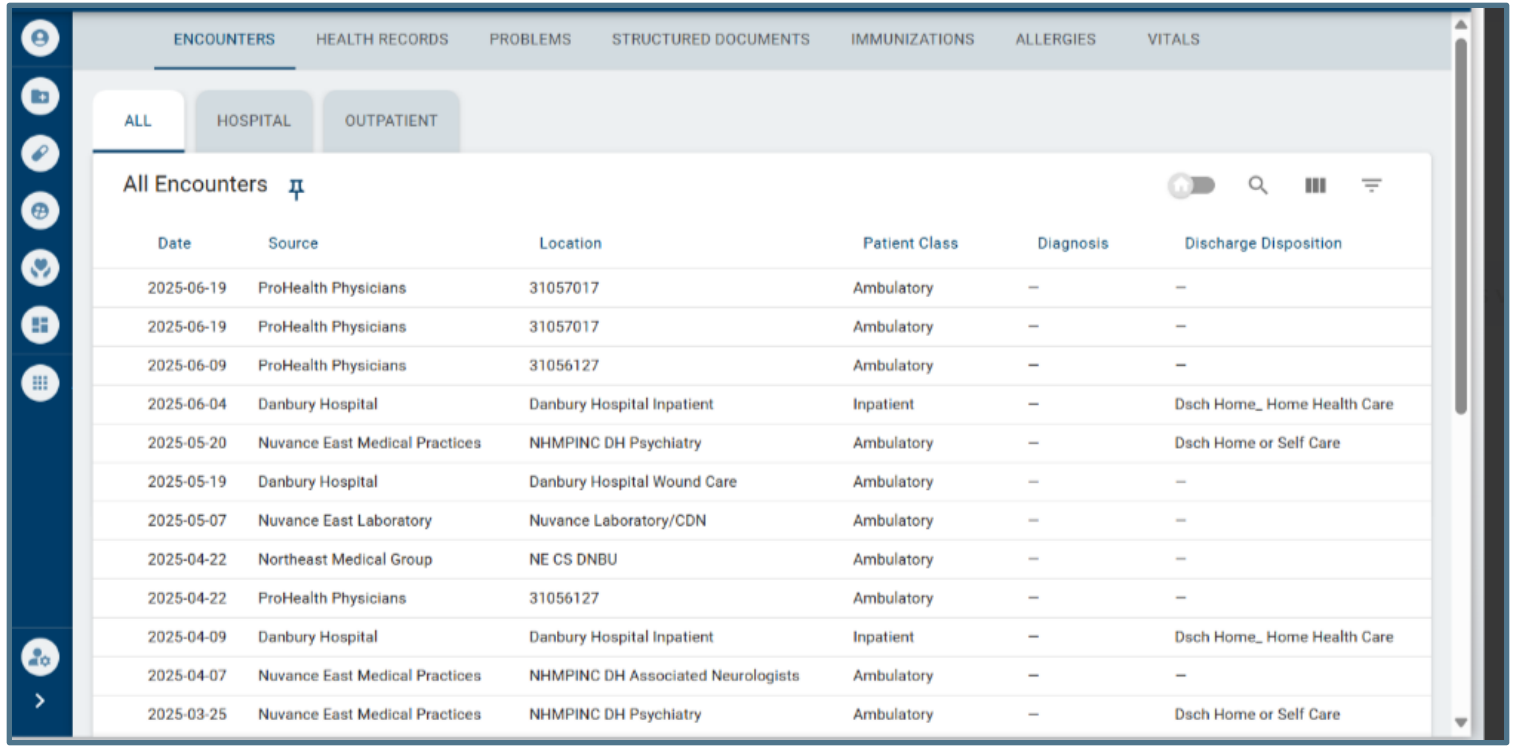
Leveraging Connie to Improve Client-Centered Outcomes

Patient Encounter Data

- Real-time access necessary for crisis intervention



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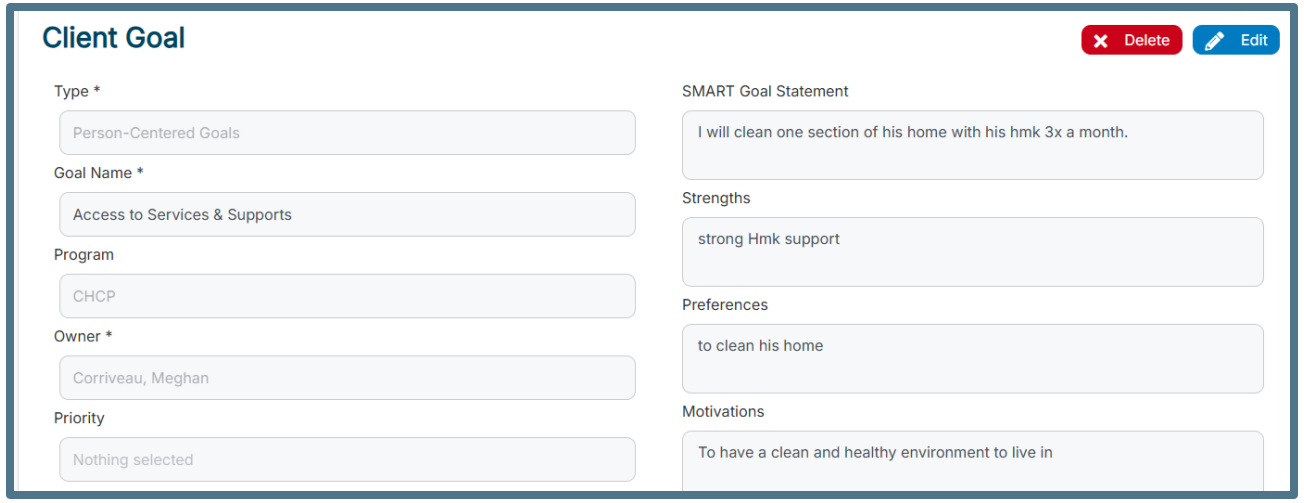
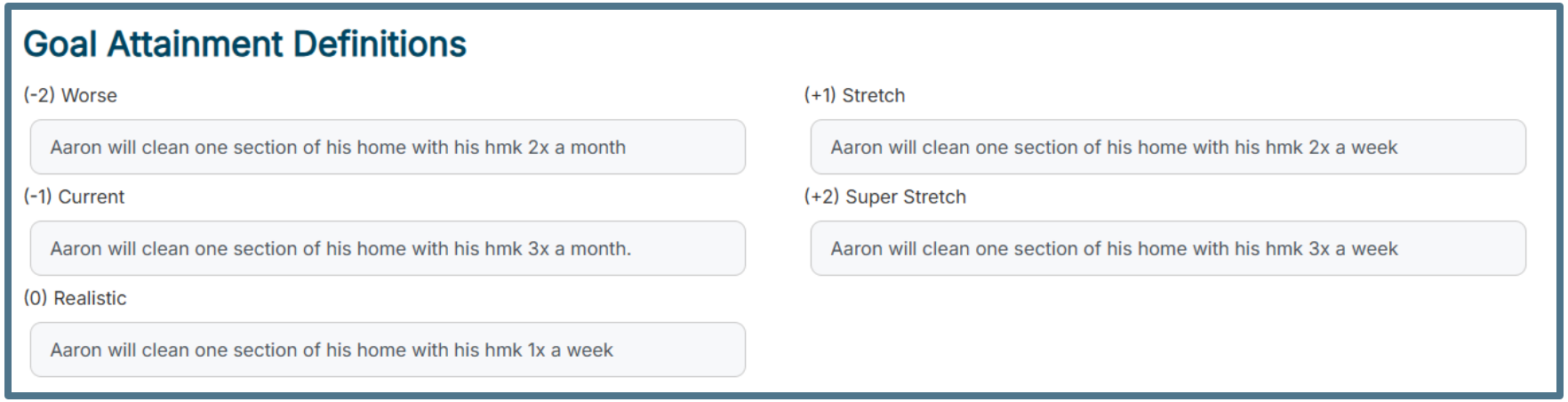
Goal Setting in Practice



Goal setting includes a conversation about what is important to the client. We coach our clients to develop SMART goals that are measurable and realistic. Follow up on goal progress happens at monthly intervals.

Goal attainment scaling helps clients and care managers pinpoint progress towards goals using numeric scoring. The attainment definitions help clients understand exactly what they need to work towards



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Goal Setting in Practice

Mrs. Chapman receives services and care management through the Personal Care Attendant Medicaid Waiver. She receives 4 hours of PCA's per day and has in home physical therapy to improve mobility. Her son is getting married in 6 months and she wants to be able to walk in the wedding processional and have the stamina to take pictures and enjoy the evening. She discusses this goal with her care manager at her reassessment visit and discusses progress towards the goal at monthly check-in's.

Scenario 1: Mrs. Chapman told her PCA that this was her goal but the PCA went on a month-long vacation and she forgot to mention this to her new one. Physical therapy just discharged her for meeting her baseline. 5 months go by and Mrs. Chapman realizes she is not going to be able to meet her goal.

Scenario 2: The care manager inputs this into Mrs. Chapman's electronic record which integrates with the Health Information Exchange. The PCA and physical therapy agencies review this goal in the HIE prior to a shift. Every shift includes exercises geared to address her stamina and ambulation. 5 months go by and Mrs. Chapman is confident she will meet her goal and her care team is too.

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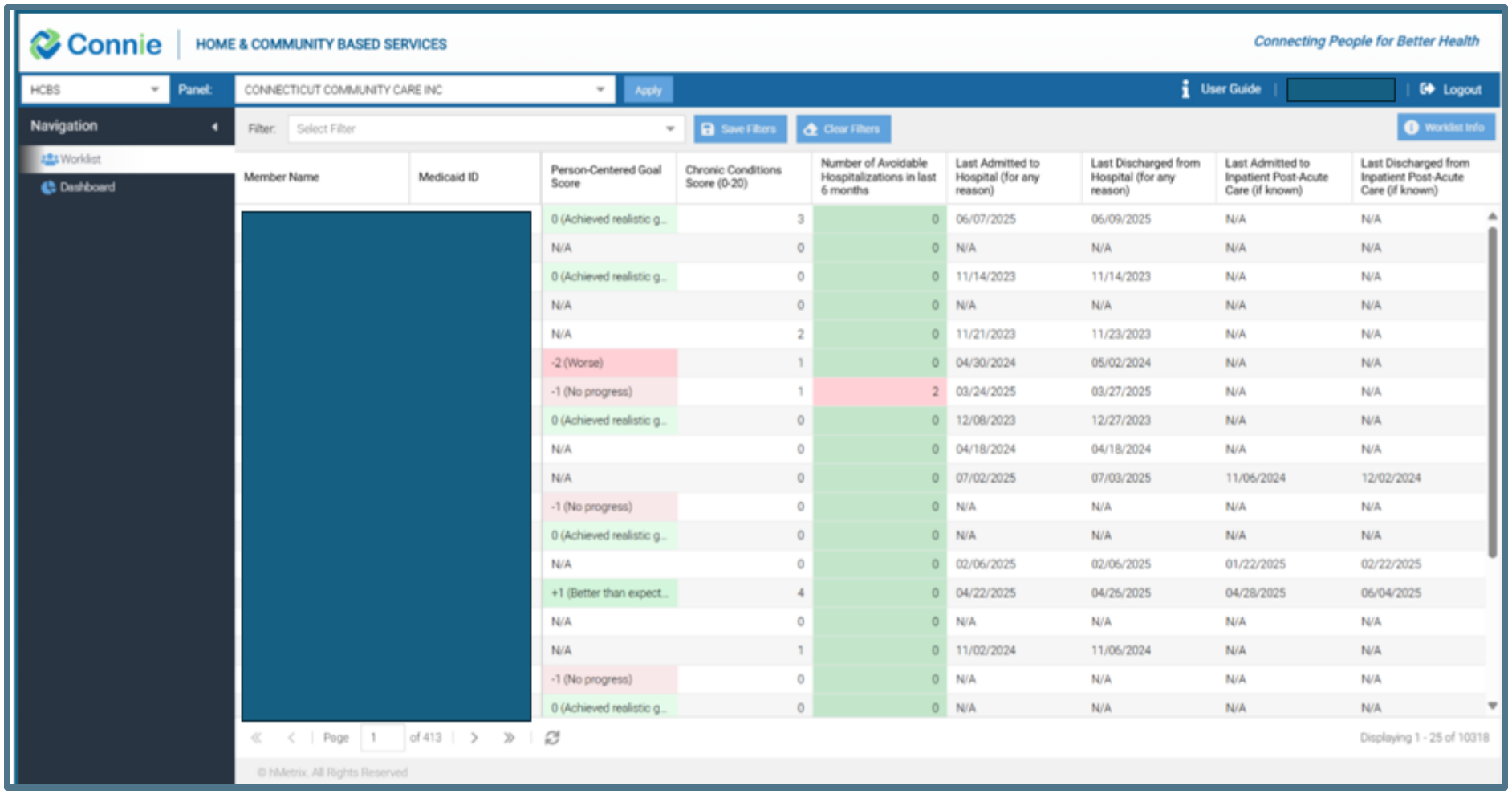
Using Data to Improve Outcomes and Change Service Delivery



The HCBS application within Connie provides pivotal data points that can flag providers and care managers to follow up or change the course of service delivery.

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Connecticut Department of Social Services

Context

- CT has a diverse HCBS system: Fee for Service; large (panel >4000) and small providers (<20)
- HCBS providers often work in silos, separate from medical providers

Our Goals

- Using VBPs to incentivize HCBS and medical providers to work together to:
  1. Implement a more consistent & coordinated approach among providers
  2. Collectively deliver high quality services that address individual client goals

Next steps

- Increase engagement of providers: testing communication strategies
- Increase use of Connie: VBP only available to providers accessing Connie
- VBP calculations and payments every six months
- Evaluate outcomes and progress

Thank you!

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Michael Peccerilli, CT Dept. of Social Services, Community Options, HCBS Integration and MFP Program Manager
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Questions

Polling Question

Are you interested in meeting with a member of the State Affairs Team to discuss how to incorporate the PCO measure into your VBP program?

A. Yes.

B. No.

C. I'm not sure.

Upcoming NCQA HEDIS Updates

Public Comment Period 2/13-3/13

NCQA HEDIS Public Comment opens February 13 to March 13!

Please submit comments through you're my.ncqa account.

NCQA is planning a state only webinar in February to offer insights and discussion about the changes to HEDIS measures. Make sure to look for an email from us and register!


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Thank you