Connecticut HUSKY Health:

Person-Centered Medical Home +

(PCMH+)

Update

Presentation to MAPOC

July 14, 2017

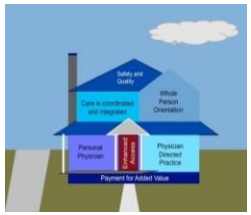
Agenda:

- Context
- Relationship to Person-Centered Medical Home (PCMH) initiative
- Care management activities
- Use of data
- Evaluation
- Transparency

Context

HUSKY Health 2017 and Ongoing

On a foundation of



Person-Centered Medical Homes

ASO-Based Intensive Care Management (ICM)

Pay-for-Performance (PCMH, OB)

Data Analytics/ Risk Stratification

we are building in

Community-based care coordination through expanded care team (health homes, PCMH+)

Supports for social determinants (ICM, transition/tenancy sustaining services, interventions for childhood trauma)

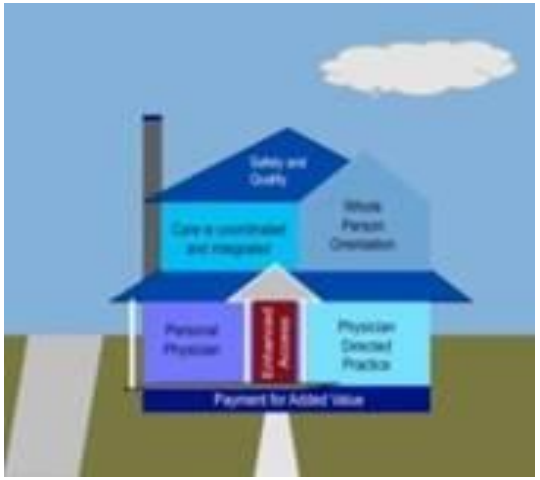
PCMH+

with the desired result of creating

Multi-disciplinary (medical, behavioral health, dental services; social supports) health neighborhoods

Relationship to PCMH Initiative

PCMH+ is using the existing Connecticut Medicaid Person-Centered Medical Home (PCMH) initiative, under which 45% of Medicaid members are being served, as an essential building block to expand upon current practice transformation work



PCMH participation:

- As of July, 2017, **110 practices** (representing **474 sites** and **1,633 providers**) were participating

- These practices are serving **348,506 Medicaid members** – **over 45%** of all members

From a practical standpoint:

- CHNCT is continuing to provide practice transformation coaching to and annual reviews of practices that are participating in the Connecticut Medicaid PCMH program

- See this link for detailed information on the PCMH program:

http://www.huskyhealthct.org/providers/pcmh.html#

- Connecticut Medicaid PCMH program non-FQHC practices are continuing to receive enhanced fee-for-service payments and also are eligible for performance and year-over-year improvement payments on a range of established quality measures

- See this link for 2016 quality measures:

http://www.huskyhealthct.org/providers/PCMH/pcmh_postings/PCMH_Quality_Performance_Measures_2016.pdf

"Participating in the PCMH program has been a most positive experience. We now have systems in place to track and measure the care and management of our patients. As a result, the patients are more actively involved in the management of their own well-being. Our Community Practice Transformation Specialist has been a wonderful asset in getting us through this process. She has provided us with resources and guidance which enabled us to handle the many challenges of achieving PCMH."

~ Internal Medicine of Greater New Haven, Hamden

PCMH

- PCMH+ Participating Entities (PEs) must include one or more practice(s) that are participating in the DSS PCMH program and hold Level 2 or 3 PCMH recognition from the National Committee for Quality Assurance (NCQA) or other equivalent accrediting body

- DSS regards PCMH recognition as an important prerequisite for PCMH+ since it indicates that practices already have an orientation to improving access and quality for Medicaid members

PCMH has also illustrated where PEs have opportunities to improve quality.

PCMH Practice Setting Results Comparison CY 2014 vs. CY 2015

Health Quality Measures - Higher Rate Indicates a Better Result	CY 2014 Admin Rate	CY 2015 Admin Rate	Rate Difference	% Change
Asthma Medication Ratio	63.3%	67.8%	4.5%	7.1%
Adolescent Well Care Visits[1]	70.9%	70.8%	-0.1%	-0.2%
Behavioral Health Screening (Ages 1-17)[2,3]	N/A	23.9%	N/A	N/A
Comprehensive Diabetes Care - Eye Exam[1]	54.6%	54.2%	-0.4%	-0.8%
Comprehensive Diabetes Care - Hemoglobin A1c (HbA1c) Testing[1]	87.9%	87.0%	-0.9%	-1.0%
Medication Management for People with Asthma	44.9%	43.6%	-1.3%	-2.9%
Post-Admission Follow-Up within Seven Days of an Inpatient Discharge (Physical Health and Behavioral Health)	44.7%	47.3%	2.5%	5.6%
Well-Child Visits in the First 15 Months of Life - 6 or More Visits[1]	80.7%	82.8%	2.1%	2.6%
Well-Child Visits in the Third, Fourth, Fifth ,and Sixth Years of Life[1]	85.9%	86.4%	0.4%	0.5%
Health Quality Measures - Lower Rate Indicates a Better Result				
Ambulatory Care - ED Visits per 1000 MM	63.70	60.88	-2.8	-4.4%
Asthma Patients with One or More Asthma-Related Emergency Room Visits (Ages 2-20)	7.8%	7.0%	-0.8%	-10.2%
Readmissions within 30 Days - Physical Health Only	9.90%	9.91%	0.0%	0.1%

[1] Hybrid measure reported using only administrative data.

[2] New DSS custom measure starting in CY 2015.

[3] CY 2015 uses screening procedure codes 96110 and 96127. Prior to CY 2015 only procedure code 96110 was used. Therefore CY 2014 is not reported as it is not comparable.

FQHC Results Comparison
CY 2014 vs. CY 2015

Health Quality Measures - Higher Rate Indicates a Better Result	CY 2014 Admin Rate	CY 2015 Admin Rate	Rate Difference	% Change
Asthma Medication Ratio	60.3%	63.6%	3.3%	5.5%
Adolescent Well Care Visits[1]	65.8%	64.1%	-1.7%	-2.5%
Behavioral Health Screening (Ages 1-17)[2,3]	N/A	10.2%	N/A	N/A
Comprehensive Diabetes Care - Eye Exam[1]	50.4%	52.8%	2.3%	4.6%
Comprehensive Diabetes Care - Hemoglobin A1c (HbA1c) Testing[1]	87.7%	89.6%	1.9%	2.2%
Medication Management for People with Asthma	41.3%	38.6%	-2.6%	-6.3%
Post-Admission Follow-Up within Seven Days of an Inpatient Discharge (Physical Health and Behavioral Health)	37.2%	38.6%	1.3%	3.6%
Well-Child Visits in the First 15 Months of Life - 6 or More Visits[1]	70.1%	73.1%	3.0%	4.3%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life[1]	82.9%	81.7%	-1.2%	-1.4%
Health Quality Measures - Lower Rate Indicates a Better Result				
Ambulatory Care - ED Visits per 1000 MM	99.90	95.88	-4.0	-4.0%
Asthma Patients with One or More Asthma-Related Emergency Room Visits (Ages 2-20)	13.6%	11.7%	-1.9%	-13.9%
Readmissions within 30 Days - Physical Health Only	13.31%	13.38%	0.1%	0.5%

[1] Hybrid measure reported using only administrative data.

[2] New DSS custom measure starting in CY 2015.

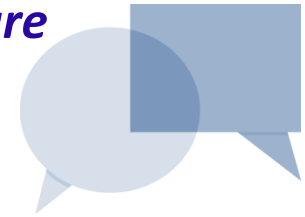
[3] CY 2015 uses screening procedure codes 96110 and 96127. Prior to CY 2015 only procedure code 96110 was used. Therefore CY 2014 is not reported as it is not comparable.

Care Management Activities

Care Management

Deliberately organizing patient care activities

Sharing information among all of the participants concerned with a patient's care



Achieving safer and more effective care

This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.

- Agency for Healthcare Quality and Research

Care Management (cont.)

PCMH+ requires PEs to build on the limited, embedded care coordination in PCMH with **enhanced care coordination activities** focused upon:

- behavioral health integration
- cultural competency, including use of the national Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) standards
- children and youth with special health care needs
- disability competency

See this link for more detail:

http://www.ct.gov/dss/lib/dss/pdfs/ratesetting/pcmhplus/enhanced_care_coordination_guide_11_30_16.pdf

Care Management (cont.)

An extremely important initial task in PCMH+ was to develop protocols for and to achieve warm, person-centered transitions of members from CHNCT Intensive Care Management (ICM) to PEs.

Care Management (cont.)

Central themes in this effort included the following:

- DSS, CHNCT and the PEs want to ensure the most effective, possible coordination of care for PCMH+ members who need and want that support
- CHNCT and the PEs have agreed upon protocols to prevent duplication of effort
- For all PCMH+ attributed members, other than those indicated in a future slide, PE's are the primary source of care coordination
- CHNCT ICM will assist PEs in situations in which a higher level or intensity of clinical support is needed

Care Management (cont.)

HUSKY HEALTH CONNECTICUT

P.O. Box 5005 • Wallingford, CT 06492
1.800.859.9889 • www.ct.gov/husky

(Date)

<<Member Name>>
<<Member Address>>

<<Member Name>>:
Date of Birth:
Member ID#:
HUSKY Plan:

Dear <<Member Name>>

Thank you for participating in the HUSKY Health Intensive Care Management (ICM) Program.

This letter is to inform you that your Care Management will now be transitioned to a care coordinator within your Primary Care Provider's (PCP) practice. Going forward your care coordinator will be your primary contact for health related needs.

Your care coordinator will be able to help you with:

- Coordinating care for your immediate needs
- Providing answers to your questions
- Understanding the best approach to managing your health
- Recommending new ways to improve your health
- Receive/review information regarding your specific health situation
- Work with your specialty provider
- Get help between care provider's visits

As a reminder, please keep using the information and tools you have received in this program. Be sure to have regular talks with your provider and take your medication(s) as prescribed. Also, the Nurse Helpline is available 24 hours a day, Seven days a week when you can't reach your provider or your provider's answering service. The number for the Nurse Helpline is 1.800.859.9889. As always, if you have an emergency, call 911.

If you are hearing impaired and would like to speak with a program nurse or the Nurse Helpline, please call 711.

It has been a pleasure helping you coordinate your health care needs and helping you manage your condition.

Your HUSKY Health Program Nurse

Care Management (cont.)

Please note that CHNCT ICM will continue to act as the lead for care management to PCMH+ members with the following needs:

- **Transplant needs** – in order to collaborate with the CHNCT prior authorization department and various providers to expedite the approvals needed for these members.
- **Transgender needs** – in order to knowledgeably and competently engage with members on covered services and requirements for gender affirming surgery.
- **Healthy Beginnings** – in order to engage with pregnant, post-partum and NICU members in support of the specialty services that are provided, including evidence-based coaching on the importance of attending perinatal appointments, breastfeeding support, interconception care, and newborn care and safety education.
- **Sickle Cell Disease –** in order to support members with this life-long condition, through specialized staff.

Use of Data

The PEs have also been actively participating in a bi-monthly provider collaborative meeting that has focused upon identifying lessons learned, challenges, barriers and opportunities. The latest collaborative meeting featured three break-out groups on the following topics:

- Wellness Recovery Action Plan (WRAP) & Behavioral Health Advanced Directives
- Assisting members with complex Behavioral Health & Substance Abuse care
- Children & Youth With Special Health Care Needs (CYSHCN)

Care Management (cont.)

All of that said, we think that the best means of learning about how PEs are fulfilling their care management requirements is to hear from them.

Use of Data

Use of Data

One of the most important aspects of PCMH+ is that it is providing PEs with extensive data that equips them to better support attributed members.

- **Provider portal:** attribution lists and PCMH data are being made available to providers through CHN's existing PCMH provider portal, available at this link:

http://www.huskyhealthct.org/providers/providers_login.html

- In the following slides, please see a refresher on what data is being provided

Use of Data (cont.)

- **Overview of CareAnalyzer®.** CareAnalyzer® is an analytic tool used by CHNCT for population health management and to monitor performance on a variety of quality measures.
- The tool combines elements of patient risk, care opportunities, and provider performance, including the following:
  - Current and predicted risk scores for each member using the Johns Hopkins ACG® (Adjusted Clinical Group) methodology
  - Provider performance based on quality measures
  - Utilization
  - High risk member identification
  - Gaps in care
- The tool is available to primary care practices (PCPs):
  - Practice level reports are available at both a summary and detail level, and are based on members attributed to the practice.

Use of Data (cont.)

Claims, member, and provider data is utilized to create the reports.

Reports are based on a rolling one year reporting period and are refreshed monthly.

Reports within CareAnalyzer® are categorized into three modules and include both summary and detail levels.

Use of Data (cont.)

- Reports are loaded to the secure Provider Portal by the 20th of each month.
- Emails are sent each time a report is placed on the secure Provider Portal to notify providers that the report is available.
- Reports can be downloaded, saved, and filtered for use by office staff.
- All reports are generated at the practice's Federal Tax Identification Number (TIN) level for members attributed to PE PCPs.

Use of Data (cont.)

- **Panel Reports**:
  - Patient Panel Report
  - PCMH+ Panel Report

- **Utilization Reports**:
  - ED Utilization Report
  - Inpatient Claims Report
  - Daily Admissions and Discharge Report

- **Gaps in Care Reports**:
  - Child Well-Care Visits
  - Child Diabetes Screening Tests
  - Adult Preventive Visits Age 50-64
  - Adult Diabetes Screening Tests

Use of Data (cont.)

- **Daily discharge report:**
  - This report includes all attributed members who are currently admitted to a facility, and all attributed members whose discharge information has been received within the last seven days.
  - This is a sample of the email that is sent to PCPs' secure portal accounts when the Daily Admission and Discharge report is posted to the portal:

Dear CHNCT,

The report(s) listed below from the HUSKY Health program can now be viewed online. To access the HUSKY Health Secure Provider Portal, please click here. You will only be able to access your reports by logging in with your unique username and password.

Daily Admission and Discharge Report

Note: You can now find information regarding your HUSKY members that were recently admitted and discharged from the hospital by accessing the Daily Admission and Discharge Report. It is advised that patients have a post-discharge follow-up appointment within seven calendar days of hospital discharge.

All reports available on the Provider Portal indicate whether your HUSKY patient is active or pending enrollment in the Intensive Care Management Program. To refer your patient to the ICM program, call 1.800.440.5071 and select the prompt for Intensive Care Management.

If you do not wish to receive e-mail messages from the HUSKY Health program regarding HUSKY Health Online Report Notifications, please click here to unsubscribe. Please note: This request could take 1 - 3 business days to process.

If you should have any questions, please call us at 1.877.606.5172 between the hours of 9:00 a.m. and 4:00 p.m. EST, Monday through Friday.

Thank you,
Web Support

Note: This is an electronically generated email message. Please do not try to respond to it.

Evaluation

Evaluation

- All evaluation materials are posted on a rolling basis on the DSS PCMH+ web page at this link: http://www.ct.gov/dss/pcmh+

Evaluation Tool	Details	Means and Interval
PCMH+ Monthly PE Compliance Reports	Report on PCMH+ contract compliance, including such elements as staffing, care coordination activities, and community partnerships	PEs submit reports to DSS by the mid-point of each month Reports are posted by the end of each month
PCMH+ Participation Detail Report	Report that tracks member participation	Conduent (formerly, Xerox) and CHNCT are tracking and producing monthly reports

Evaluation (cont.)

Evaluation Tool	Details	Means and Interval
Opt-Out Survey Findings	Telephone survey of individuals who opt out of participation in PCMH+ after implementation on January 1, 2017	DSS conducts surveys on a rolling basis and is tracking to determine if any pattern that causes concern is detected
Grievances Report	Report that tracks grievances by HUSKY Health members	CHNCT is producing monthly reports using a marker to compile data for PCMH+ attributed members

Evaluation (cont.)

Evaluation Tool	Details	Means and Interval
Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey	Consumer satisfaction survey	Summary of baseline CAHPS will be published in July Note that a summary of 2015 data is posted
Mystery shopper	Exercise that tests availability of appointments and effect (if any) of HUSKY Health coverage on availability	2017 survey will be conducted in October Note that a summary of 2016 data is posted

Evaluation (cont.)

Evaluation Tool	Details	Means and Interval
Claims Data	Acknowledging that full claims run-out in support of calculating eligibility for shared savings will not be complete until July 1, 2018, the following claims data is available during the Wave 1 calendar year: point-of-sale pharmacy data; medical, behavioral health, dental and pharmacy claims detail that is pushed out to PEs through the CHNCT PCMH portal	Full claims run-out by July 1, 2018 As indicated to left, data are available on a rolling basis

Evaluation (cont.)

Please also note that HUSKY Health is continuing to track diverse quality measures on behalf of all Medicaid members. See this report for a comprehensive overview:

HUSKY Health Quality Measures and Performance Results (February, 2017)

https://www.cga.ct.gov/med/council/2017/0210/20170210ATTACH_Health%20Quality%20Measures%20and%20Performance%20Results%20Presentation.pdf

Evaluation (cont.)

Initial indicators:

- **PE Monthly Compliance Reports:** the reports indicate that there is a range of experience across PEs that reflects that some had more initial internal capability to handle enhanced care coordination responsibilities and others had more of a lift toward hiring and launching staff

- **Opt-out survey findings:** to the extent that DSS has been able to reach respondents, the common theme is that members found the notice letter to be confusing and thought that remaining in PCMH+ would involve loss of their current Medicaid benefits

Evaluation (cont.)

Initial indicators:

- **Grievances:** there has not been any notable instance of PCMH+-related grievances

- **Eligibility status:** a notable concern is that a significant number of attributed members have lost eligibility for Medicaid since January 1, 2017 – DSS has adjusted its approach to accommodate situations in which eligibility is restored retroactively, but this has introduced uncertainty for PEs, and DSS and PEs are actively working on means of supporting members in maintaining eligibility

Transparency

PCMH+ Values

PCMH+ model design was guided by a number of important values:

1) protecting the interests of Medicaid members
2) improving overall health and wellness for Medicaid members
3) creating high performance primary care practices with integrated support for both physical and behavioral health conditions
4) building on the platform of the Department's Person-Centered Medical Home (PCMH) Program, as well as the strengths and analytic capability of the Medicaid program's medical Administrative Services Organization (ASO)
5) enhancing capacity at practices where Medicaid members are seeking care, to improve health outcomes and care experience
6) encouraging the use of effective care coordination to address the social determinants of health

Transparency

- **Stakeholder process:** DSS developed PCMH+ model design through monthly meetings and work group sessions, as well as subject specific webinars, with the Care Management Committee of the Medical Assistance Program Oversight Council (MAPOC)

- **Model design materials:** Materials memorializing the work of the Care Management Committee are posted on a rolling basis on the MAPOC web site at this link: https://www.cga.ct.gov/med/comm1.asp?sYear=2016

Transparency (cont.)

- **Dedicated web page:** DSS launched a PCMH+ web page on which it has posted the PCMH+ RFP, informational materials for providers, the State Plan Amendment, draft regulations, and evaluation tools and reports: http://www.ct.gov/dss/pcmh+

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PCMH+

The Department is implementing a new program called **Person-Centered Medical Home Plus** or **PCMH+**. PCMH+ will provide person-centered, comprehensive and coordinated care. The purpose of this webpage is to provide PCMH+ Participating Entities with program information and updates.

If you are PCMH+ Member and have questions about your provider, or questions about your care, please visit the PCMH+ Member website or call 1-800-859-9889.

The HUSKY Health Program Covered Services guide is available online and features information about covered HUSKY services.

PCMH+ Program Information and Updates

Special Notice to PCMH+ Participating Entities

Connecticut's Person-Centered Medical Home-Plus Initiative Update/June 29, 2017

PCMH+ is a State of Connecticut initiative administered by the Department of Social Services that was launched on January 1, 2017.

PCMH+ represents an opportunity for Connecticut Medicaid to build on, but not supplant, its existing and successful Person-Centered Medical Home (PCMH) initiative, through which over 43% of members are being served. While PCMH will remain the foundation of care delivery transformation, PCMH+ is building on PCMH by incorporating additional requirements for care coordination, focusing upon integration of behavioral and physical health care, children with special health care needs, health equity, and competency in care for individuals with disabilities. It also represents the Department's first use of an upside-only "shared savings" approach under which participating providers that meet specified quality standards and generate savings for Medicaid will receive a portion of the savings that are achieved.

DSS is very proud of all PCMH+ Participating Entities for committing to build on longstanding support for Medicaid members.

- All of you are deeply committed to further transforming your practices, beyond being Person-Centered Medical Homes, to make them as receptive and coordinated as possible for the people whom you serve.
- All of you are working hard to implement important and challenging new features of care coordination, including coordination of medical and behavioral health care, that will continue to improve members' care experience and outcomes.

In conclusion . . .

We are confident that the record speaks directly to a strong positive launch of PCMH+, and a great deal of potential for good on behalf of Medicaid members.

We are also proud of the open, public, collaborative process that was used to develop and implement PCMH+.

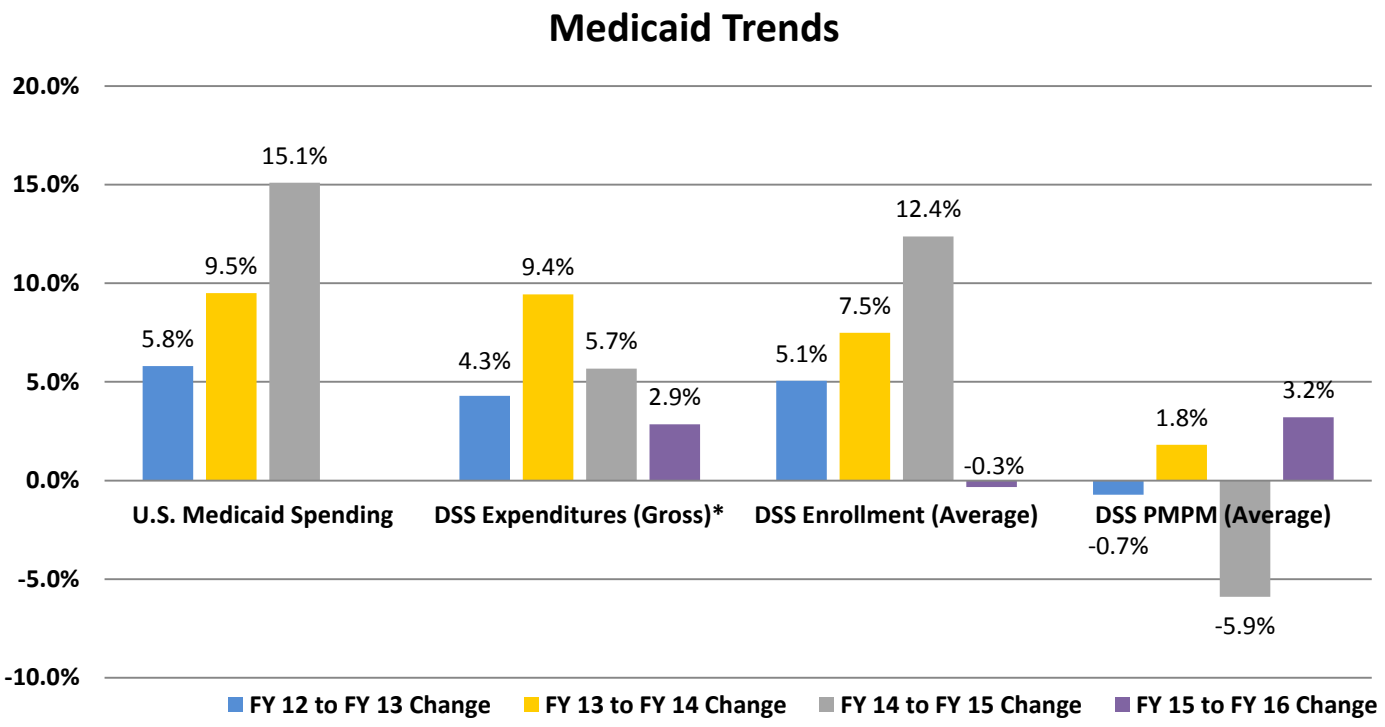
We will continue to encourage everyone involved to get to know, and monitor, our collective progress.

Questions or comments?

Appendix
HUSKY Health:
Context
Past, Present and Future At A Glance

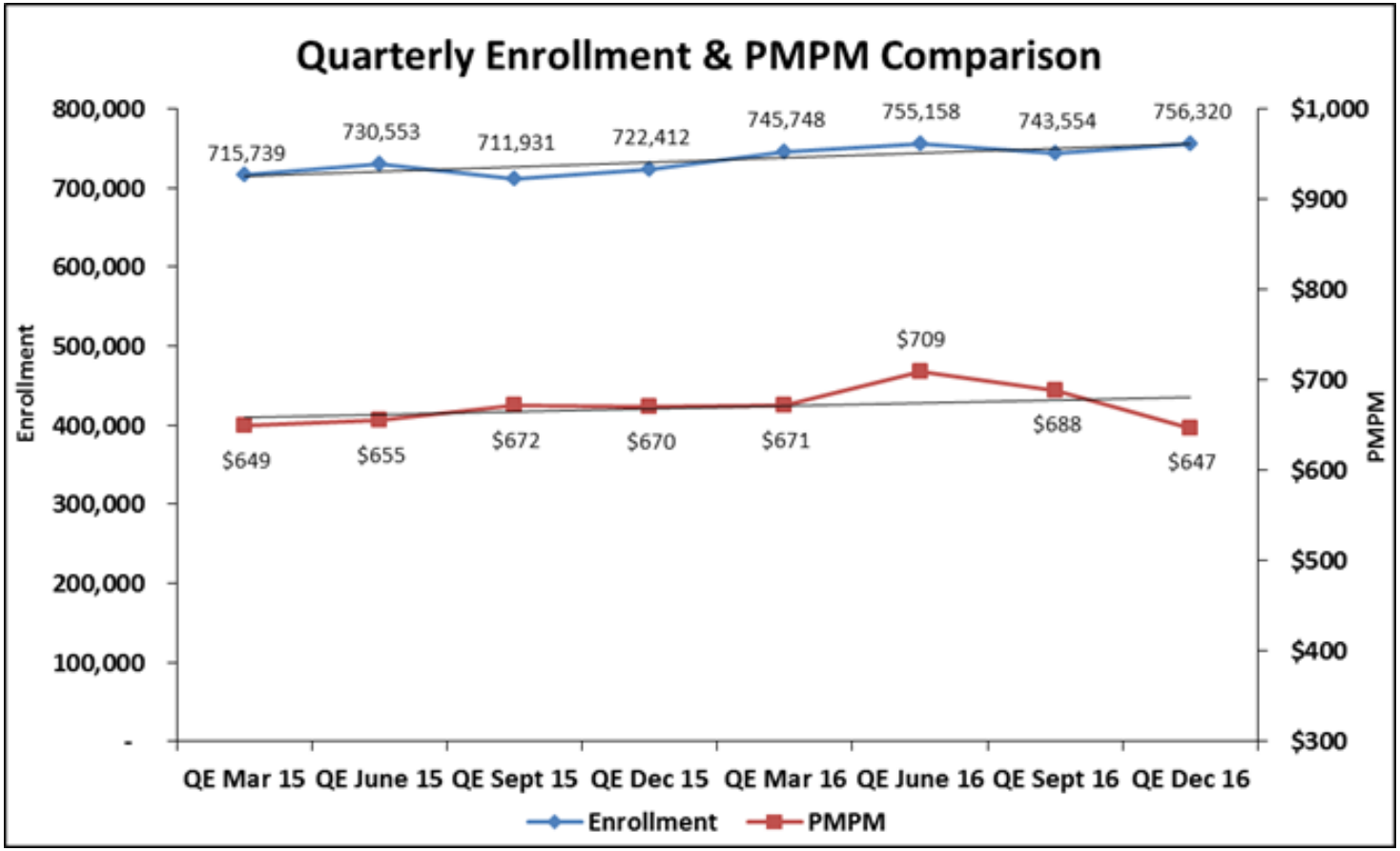
Context

Comparison with National Trends



** Expenditures are net of drug rebates and include DMHAS' behavioral health costs claimable under Medicaid. This depiction **includes** all hospital supplemental and retro payments.*

Enrollment and PMPM



Expenditures have increased proportionate to the increase in enrollment, but per member per month costs have remained remarkably steady.

Past, Present and Future at a Glance

Past, Present and Future

	Past	Present	Future
Administrative/ financial model	A mix of risk-based managed care contracts and central oversight	Self-insured, managed fee-for service model; contracts with four Administrative Services Organizations (ASOs)	Self-insured, managed fee-for-service model that incorporates health neighborhoods and Value-Based Payment (VBP) approaches
Financial trends	Double digit year-over-year increases were typical	Overall expenditures are increasing proportionate to enrollment; per member per month spending relatively stable	Quality-premised VBP strategies will enable further progress on trends
Data	Limited encounter data from managed care organizations	Fully integrated set of claims data; program employs data analytics to risk stratify and to make policy decisions	Data match across human services and corrections data sets will enable more intelligent policy making

	Past	Present	Future
Member experience	Members had different experiences depending on which MCO oversaw their services; MCOs relied upon traditional chronic disease management strategies	ASOs provide streamlined, statewide access points and Intensive Care Management; PCMH practices enable coordination of primary and specialty care; health homes enable integration of medical, behavioral health and social services	Health neighborhoods will address both health needs and social determinants of health (e.g. housing stability)
Provider experience	Provider experience varied across MCOs; payment was often slow or incomplete	ASOs provide uniform, statewide utilization management and ICM; providers can bill on a bi-weekly basis	Consideration of migration to health neighborhood self-management of provider relationships