PCMH+ Information Session for Providers

December 13-14, 2016

Connecticut Department of Social Services

Making a Difference

What we will cover today

PCMH+ Overview

Provider Information

Member Information

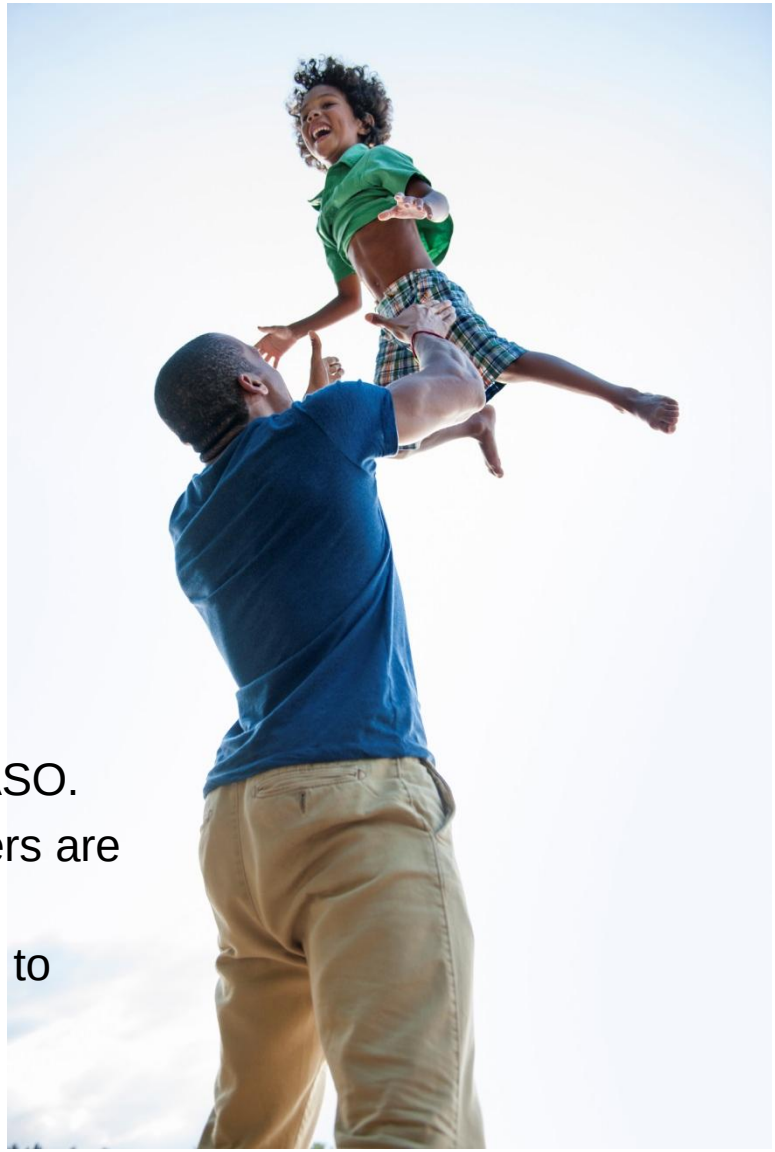
Shared Savings

PCMH+ Overview

Purpose: *Improve health outcomes and the care experience of Medicaid members and to contain the growth of health care costs.*

Guiding Values:

- Protect the interests of Medicaid members.
- Build on platform of the CT PCMH program.
- Utilize strengths of the Medicaid program's ASO.
- Enhance capacity at practices where members are seeking care.
- Encourage use of effective care coordination to address social determinants of health.



PCMH+ was formerly known as Medicaid Quality Improvement and Shared Savings Program (MQISSP)

CT Medicaid: PCMH Program Success

- Over 43% of Connecticut HUSKY members are being served by a PCMH provider.
- This has led to improved quality of care for HUSKY Members.
- PCMH's have improved the member's experience with primary care.

Because of the success of the DSS PCMH program, only PCMH- recognized providers can participate in PCMH+

PCMH+ Overview

- Wave 1 (calendar year 2017) Participating Entities
  - Seven FQHCs.
  - Two Advanced Networks.
- Member Eligibility
  - Connecticut Medicaid members who have received care from a DSS PCMH practice.
- All Medicaid members are eligible to participate, with the exception of those:
  - who have another source of health care coverage (e.g., Medicare).
  - who have a limited Medicaid benefit (tuberculosis, family planning, etc.).
  - who receive care coordination through other programs. (e.g., waivers, nursing facilities).
  - who are on hospice.

PROVIDER INFORMATION

Provider Responsibilities

- Providers must have partnerships with community resource agencies to help members find and obtain non-health resources.
- Providers must work with members in a person-centered way to provide care that meets the member's values and preferences.
- Providers must have members on their advisory board and help members participate on these boards.
- Providers must provide all of the required Enhanced Care Coordination activities and FQHCs must also provide the Add-On Care Coordination activities.

What is Care Coordination?

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

Why Care Coordination?

Managing one's health and navigating the health system can be confusing and challenging.

Care Coordination, provided as part of a member's visit with their primary care provider, has shown tremendous promise in improving member health outcomes.

On a national basis, care coordination is seen as the critical link between members, their family members and the multiple providers who provide their care.

Building on Connecticut's PCMH Model

PCMH+ Key Areas					
Integration of primary care and behavioral health care.	Expanding linkages and supports to include community services and natural support systems.	Promoting linkages to community supports that can assist members in maximizing their Medicaid benefits.	Improve provider's expertise in managing members who have disabilities.	Promoting overall health and wellness for members.	Increasing provider competencies to support members who have disabilities and special healthcare needs.

Five Required Enhanced Care Coordination Activities for **ALL** PCMH+ Participating Entities

1. Care Coordinator:
- **Availability**
- **Education**

2. Behavioral Health/Physical Health (BH/PH) Integration:
- **Screening**
- **Psychiatric Advance Directives for Adults and Transition Age Youth**
- **Wellness Recovery Action Plan (WRAP)**

3. Culturally Competent Services Requirements:
- **Annual cultural competency training**
- **Expanding care plan**
- **CLAS Standards**

4. Children and Youth with Special Health Care Needs:
- **Inclusion of information in the health assessment and health information record**
- **Advance care planning**

5. Competencies in Care for Individuals who have Disabilities:
- **Increasing Competencies in care: Health assessment, appointment times, training, equipment, communication aids and resource list**

Four Additional Enhanced Care Coordination Activities for **FQHCs only**

Care Coordination Add-on Activities

Behavioral Health / Physical Health

1. Care Coordinator with behavioral health education, training and/or experience
2. Wellness Recovery Action Plan (WRAP)
3. Transition Age Youth (TAY) Care Plans
4. Use of Interdisciplinary Teams

Care Coordination Example 1

Alex is an 8 year old boy who has been having vision problems at school. He has no other health concerns.

How the Care Coordinator can help

- Referral to a pediatric eye doctor
- Help obtaining glasses if prescribed for Alex

Care Coordination Example 2

Jane is a 38 year old who has recently found out she has high blood pressure. Jane doesn't understand high blood pressure and is worried about getting her medications because she does not have a car.

How the Care Coordinator can help

- Education on managing high blood pressure
- Education on taking medications correctly
- Help finding healthy food in her neighborhood
- Help finding a pharmacy that can deliver medications

Care Coordination Example 3

Mary is a 45 year old who has diabetes and is also homeless and living in a shelter. Mary does not understand diabetes or what she should be eating. She does not check her blood sugar levels because she doesn't have a glucometer. She wants a safe place to live.

- Educating about diabetes and healthy blood sugar levels
- Educating about healthier food options at the shelter
- Obtaining a blood sugar testing kit and teaching Mary how to use it
- Talking to the local housing agency(s) to identify housing options and eligibility standards
- Scheduling follow up appointments and arranging transportation
- Frequent call checks between physician appointments
- Finding a pharmacy to deliver medications to the shelter
- Teaching Mary what to do if her blood sugar is low or high

Community Partnerships

To assist members to obtain needed social services and resource supports, providers will partner with community organizations to address social, economic and environmental issues that can adversely impact health.

- Meaningfully impact social determinants of health.
- Promote physical and behavioral health integrated care.
- Facilitate rapid access to care and needed resources.

Examples:

- ***Child care organizations***
- ***Housing organizations***
- ***Rent and utility assistance***
- ***Other treating providers and clinics***
- ***Nutrition and food assistance organizations***

Community Partnerships

DSS expects providers to sponsor local community collaborative forums to develop broader understanding and partnerships between health providers and community resource agencies. DSS health services and eligibility staff, as well as representatives from the Administrative Services Organization, CHNCT, would like to participate when you convene.

PCMH+ Oversight and Leadership

- All Participating Entities must have an oversight body:
  - Can overlap with an existing governing board or advisory body.
  - Requirements were described in the RFP.
  - Focus on member participation and supporting member engagement in the oversight body.

- PCMH+ leadership:
  - Clinical director and senior leader.
  - Represent the Participating Entity and champion PCMH+ goals.
  - Will be DSS' main point of contact for the program.

MEMBER INFORMATION

Member Opt-Out Process

- Members received a letter with opt-out information.
- Members may opt-out before implementation or at any time during the performance year.
- If a member opts-out:
  - Member's services will not change and member's can continue to see any qualified Medicaid provider.
  - Member cost data will be removed from the shared savings calculation (both the prior and performance years).
  - If the member was assigned to an FQHC Participating Entity, then that entity will no longer receive an enhanced care coordination add-on payment for that member.

What Does Not Change

- Member Medicaid benefits **do not** change.
- Members can still see any provider.
- Members can file a complaint or grievance if they are unhappy about their care.

Quality of Care Measures

- Measure stewards:
  - NCQA / HEDIS – National Committee for Quality Assurance / Healthcare Effectiveness Data and Information Set.
  - DSS – Connecticut Department of Social Services.
  - AHRQ – Agency for Healthcare Research and Quality.
  - MMDN – Medicaid Medical Directors Network.
  - OHSU – Oregon Health & Science University.
  - ADA – American Dental Association.
- Quality data sources:
  - PCMH+ member claims.
  - CAHPS survey.

PCMH+ Quality Measure Set

Scoring Measures	Measure Steward	National Quality Foundation #
Adolescent well-care visits	NCQA	NA
Avoidance of antibiotic treatment in adults with acute bronchitis	NCQA	0058
Developmental screening in the first three years of life	OHSU	1448
Diabetes HbA1c Screening	NCQA	0057
Emergency Department (ED) Usage	NCQA	NA
Medication management for people with asthma	NCQA	1799
PCMH CAHPS	AHRQ	NA
Prenatal care and Postpartum care	NCQA	1517
Well-child visits in the first 15 months of life	NCQA	1392

Challenge Measures	Measure Steward	National Quality Foundation #
Behavioral Health Screening 1–17	DSS	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA	NA
Readmissions within 30 Days	MMDN	NA
Post-Hospital Admission Follow up	DSS	NA

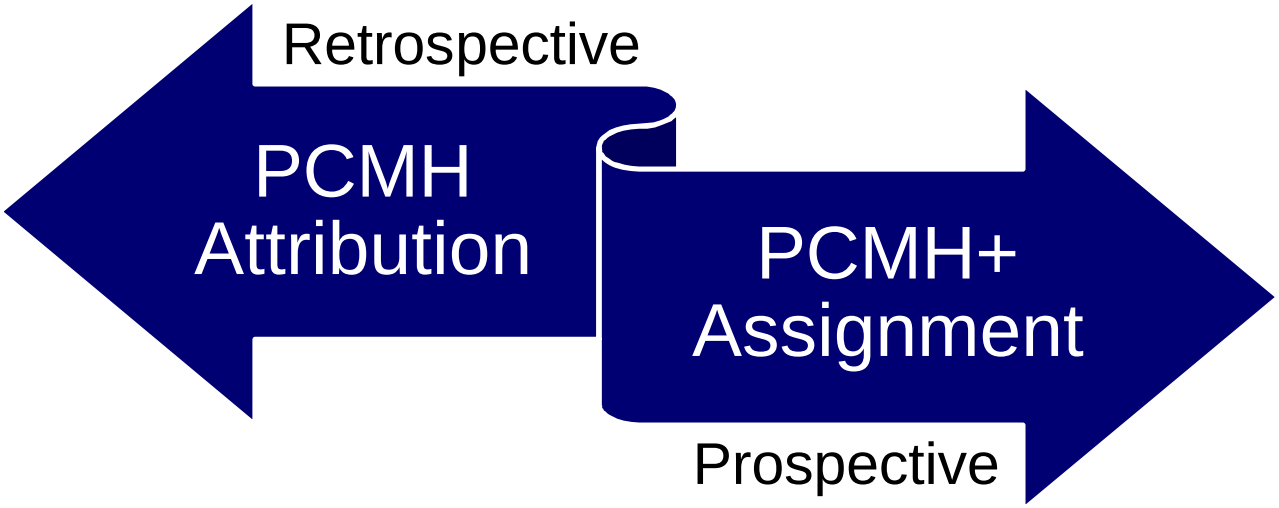
PCMH+ Quality Measure Set

Reporting Only Measures	Measure Steward	National Quality Foundation #
Annual fluoride treatment ages 0<4	DSS	NA
Annual monitoring for persistent medications (roll-up)	NCQA	2371
Appropriate treatment for children with upper respiratory infection	NCQA	0069
Asthma Medication Ratio	NCQA	1800
Breast cancer screening	NCQA	2372
Cervical cancer screening	NCQA	0032
Chlamydia screening in women	NCQA	0033
Diabetes eye exam	NCQA	0055
Diabetes: medical attention for nephropathy	NCQA	0062
Follow-up care for children prescribed ADHD medication	NCQA	0108
Human Papillomavirus Vaccine (HPV) for Female Adolescents	NCQA	1959
Oral evaluation, dental services	ADA	2517
Use of imaging studies for low back pain	NCQA	0052
Well-child visits in the third, fourth, fifth and sixth years of life	NCQA	1516

Notes:
-Updated November 10, 2016 and effective for dates of service on and after January 1, 2017.

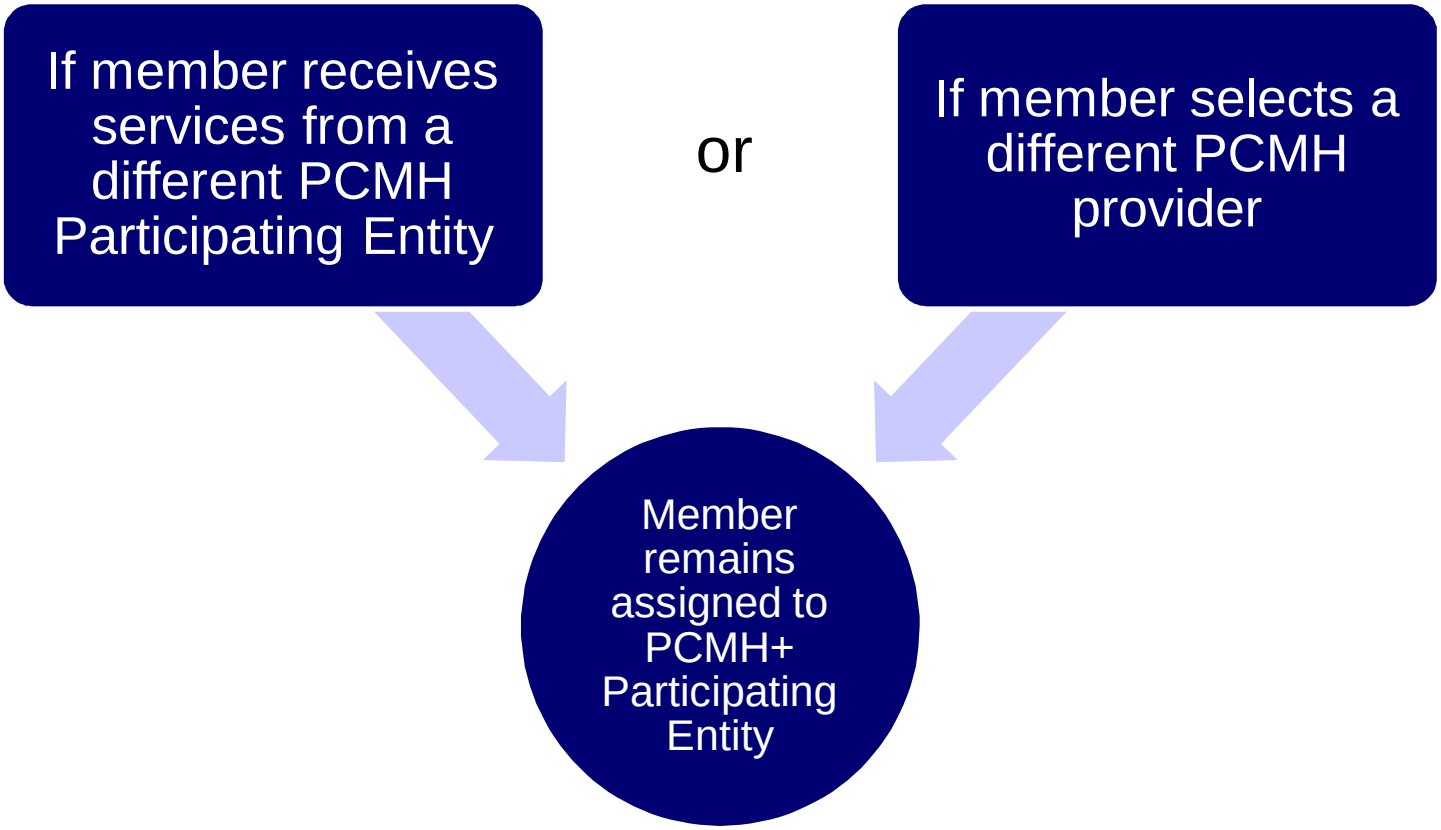
Definitions:
- **ADA**: American Dental Association
- **AHRQ**: Agency for Healthcare Research and Quality
- **DSS**: Department of Social Services
- **MMDN**: Medicaid Medical Directors Network
- **NA**: Not Applicable
- **NCQA**: National Committee for Quality Assurance
- **OHSU**: Oregon Health & Science University

Member Assignment Methodology



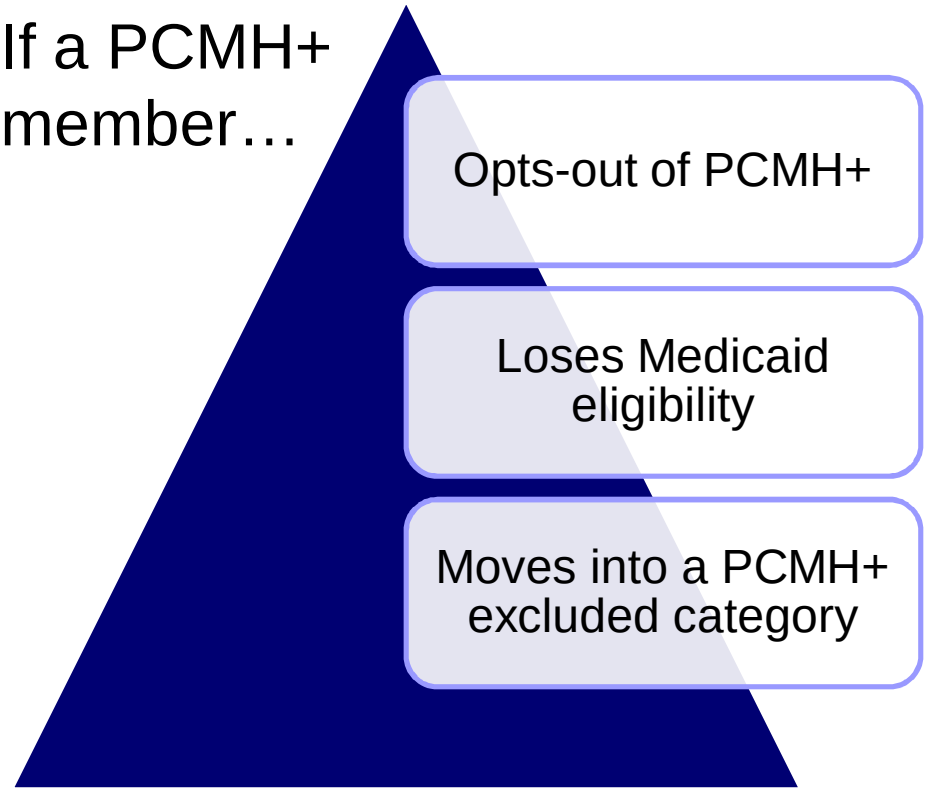
- Assignment based on member's active choice of provider.
  - DSS examines data to attribute individuals to PCMH practices from which they have received care over the last twelve months.
  - DSS then assigns those members to those PCMH practices.
- Member assigned to only one Participating Entity.
- Member assignments will be made prior to January 1, 2017.

Member Assignment Methodology



Member Assignment Methodology

If a PCMH+ member…



then…

- Member cost data will be removed from the shared savings calculation (both the prior and performance years).
- If the member was assigned to an FQHC Participating Entity, then that entity will no longer receive the enhanced care coordination add on payment.

Member assignments will be updated annually.

QUESTIONS & ANSWERS

SHARED SAVINGS

Shared Savings Model Overview

Individual Savings Pool

- Funded by Participating Entity-specific savings.
- Nine quality measures.
- Three components of quality measurement.
- Payment based on aggregate quality score.

Challenge Pool

- Funded by unclaimed savings net of losses from individual savings pools.
- Four quality measures.
- Must achieve at least the median score of challenge pool participants.
- Pro rata distribution to Participating Entities reaching quality measure thresholds.

Shared Savings Model Overview

Minimum Savings Rate

- Symmetrical MSR of 2%

Savings Cap

- Each PE's savings will be capped at 10% of expected costs

Percent of Shared Savings

- 50% of savings will be shared with PEs

Claims Truncation

- Claim costs will be truncated at $100,000 per year

Trend

- Expected cost trends will be derived from the Comparison Group

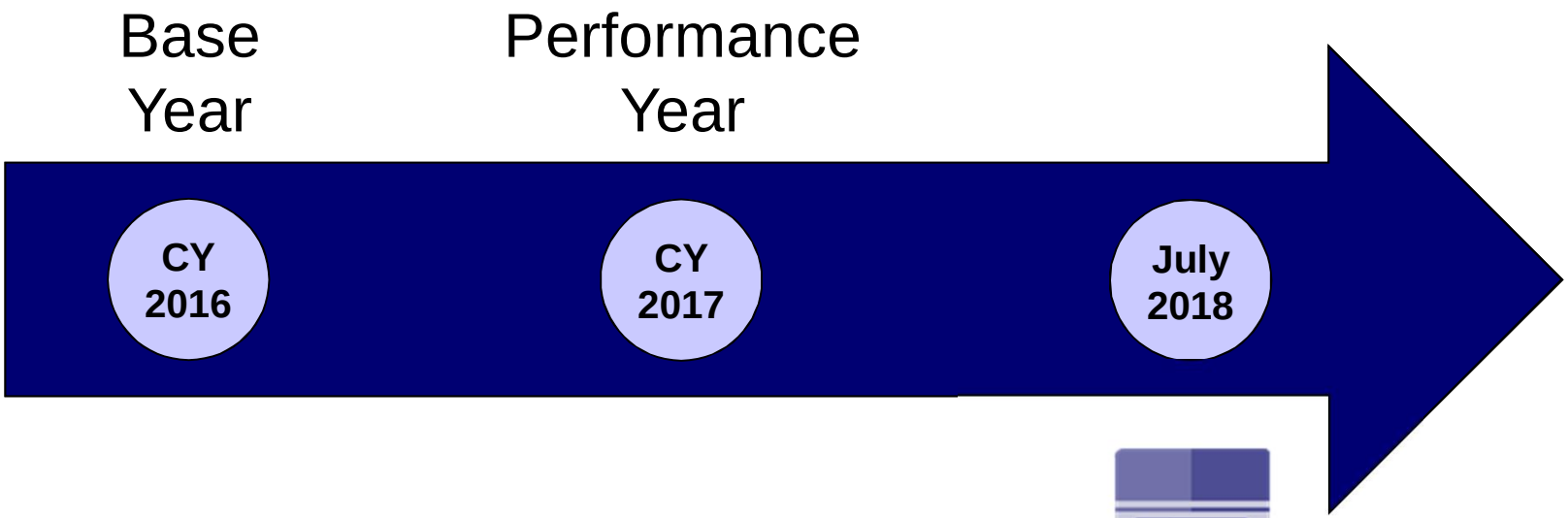
Risk Adjustment

- CareAnalyzer ACG risk scores will be aggregated for the Comparison Group and each PE

Comparison Group

- The Comparison Group will consist of a group of PCMH practices that are not participating in PCMH+ and are similar to the PCMH+ Participating Entities.
- All Participating Entities will be compared to the same Comparison Group.

Time Line



Shared savings calculations will be performed after July 2018

Quality Measure Scoring

Individual Savings Pool: Quality Components

Maintain

Improve

Absolute

- Three components for each of the nine quality measures.
- Points possible for each quality component is 1.00.
- Total points possible for Individual Savings Pool is 27.00.
- Partial points may be awarded via a sliding scale for:
  - Improve quality
  - Absolute quality

Quality Measure Scoring
Quality Component #1: Maintain Quality Example

For each quality measure, a Participating Entity will be rewarded if its performance year quality score is greater than or equal to its base year score.

Example: Quality Measure #1	
Participating Entity's Base Year Score	75.00%
Participating Entity's Performance Year Score	78.00%
Points Possible	1.00
Points Awarded	**1.00**

Quality Measure Scoring

Quality Component #2: Improve Quality Sliding Scale

Base Trend is defined as the Comparison Group improvement percentage.

Improvement above the Base Trend	Points Awarded
Less than or equal to Base Trend	0.00
Between 0% and 32%	0.25
Between 33% and 66%	0.50
Between 67% and 99%	0.75
100% or greater	1.00

Quality Measure Scoring

Quality Component #2: Improve Quality Example

For each quality measure, a Participating Entity will be rewarded for its year-over-year improvement trend on a sliding scale compared to the Comparison Group improvement trend.

Example: Quality Measure #1	
Participating Entity's Year-Over-Year Improvement Percentage	4.00%
Comparison Group's Year-Over-Year Improvement Percentage	2.50%
Points Possible	1.00
Points Awarded	**0.50**

Quality Measure Scoring

Quality Component #3: Absolute Quality Sliding Scale

Absolute quality percentiles will be derived from 2015 quality measure data for the Comparison Group.

Percentile	Points Awarded
Between 0 and 49.99	0.00
Between 50 and 59.99	0.25
Between 60 and 69.99	0.50
Between 70 and 79.99	0.75
Between 80 and 99.99	1.00

Quality Measure Scoring
Quality Component #3: Absolute Quality Example

For each quality measure, a Participating Entity will be rewarded on a sliding scale for its ability to reach absolute quality targets.

Example: Quality Measure #1	
Participating Entity's Performance Year Score	78.00%
Comparison Group 80th Percentile Benchmark	75.00%
Points Possible	1.00
Points Awarded	**1.00**

Quality Measure Scoring

Individual Savings Pool: Aggregate Quality Score

For each quality measure, a Participating Entity's points for each of the three scoring components will be aggregated.

Example: Quality Measure #1	
1. Points Awarded for Maintaining Quality	1.00
2. Points Awarded for Improving Quality	0.50
3. Points Awarded for Absolute Quality	1.00
Total Points Awarded	**2.50**
Total Points Possible	3.00

QUESTIONS & ANSWERS

Resources

For PCMH+ Program Information please contact the appropriate DSS contact:

Financial: Nicole Godburn, 860-424-5393

Policy: Carolann Gardner, 860-424-5715

Clinical: Dr. Rob Zavoski, 860-424-5583

Billing: Georgia Massari, 860-424-5308

or go to our website: www.ct.gov/dss/PCMH+