# PCMH+ Informational Session for Providers

May 15, 2018

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 the platform of the Connecticut 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.

# Connecticut Medicaid: PCMH Program Success

- Over 45% of Connecticut HUSKY members are being served by a PCMH provider.
- This has led to improved quality of care for HUSKY Members.
- PCMHs 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 (Legacy)
  - Seven FQHCs, two Advanced Networks.
- Wave 2 (calendar year 2018) Participating Entities
  - Two FQHCs, three Advanced Networks awarded the right to negotiate a contract.
- 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 Behavioral Health Home or Money Follows the Person participants.
  - Who are on hospice.

# PROVIDER INFORMATION

# Provider Responsibilities

- Providers must implement and enhance contractual relationships or informal partnerships with local community resource agencies to help members find and obtain non-health resources.
- Providers must sponsor local community collaborative forums or participate in existing collaborative forums to develop broader understanding of partnerships between health providers and community resource agencies.
- 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 Care Coordination Add-On 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.*

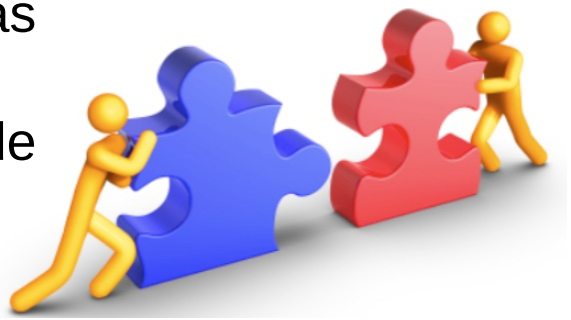
- Agency for Healthcare Quality and Research

# 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 physical and behavioral health care. | Build on provider competencies to support members with complex medical conditions and disabilities. | Promote linkages to community supports that can assist members in maximizing their Medicaid benefits. | Promote overall health and wellness for members. |

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

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

**2. Behavioral Health/Physical Health (BH/PH) Integration:**
- **Employment of care coordinator with BH education, training and/or experience**
- **Screening**
- **Psychiatric Advance Directives for Adults**
- **Wellness Recovery Action Plan (WRAP) or other recovery planning tool**

**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**

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

*Care Coordination Add-on Activities*

**Behavioral Health/Physical Health Integration**

1. Care coordinator with behavioral health education, training and/or experience
2. Wellness Recovery Action Plan (WRAP) or other recovery planning tool
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.

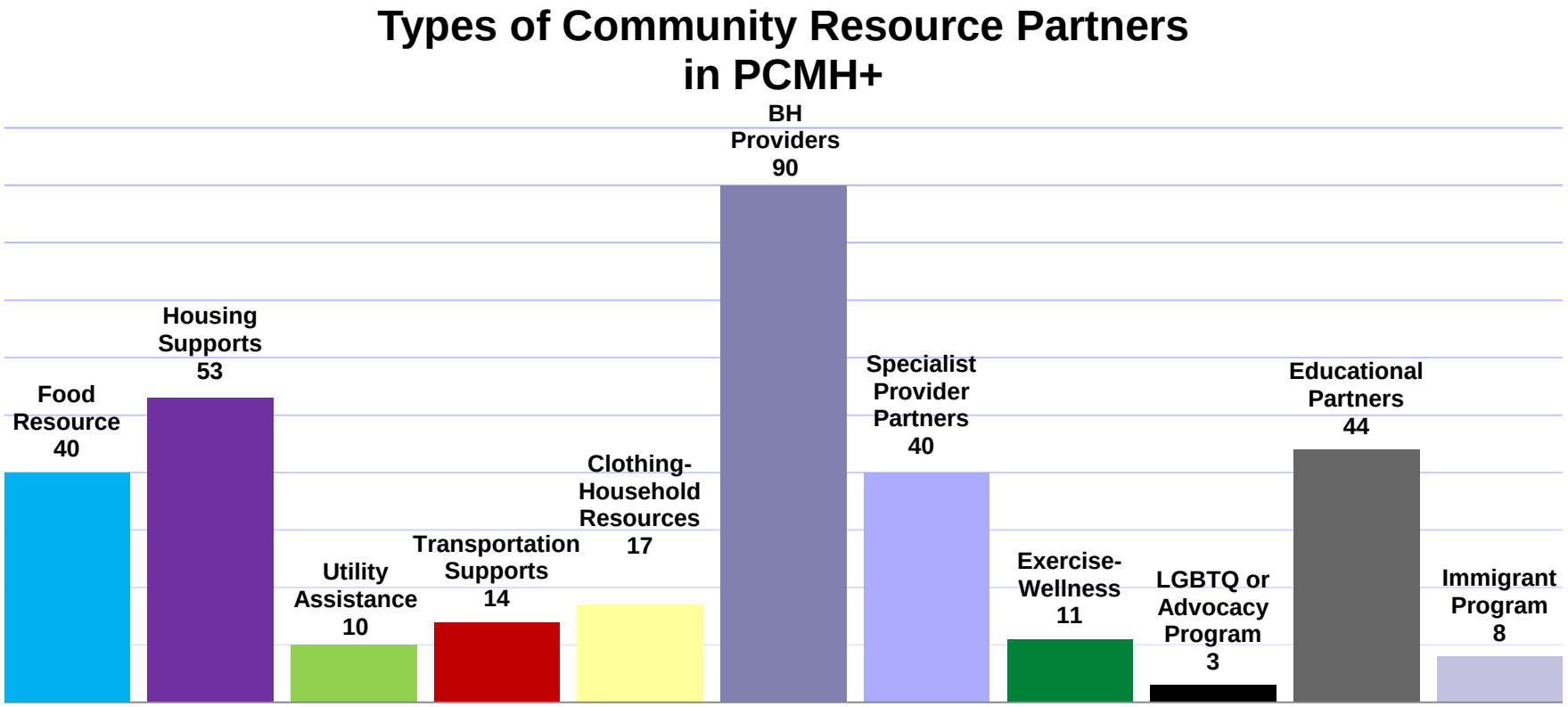
- Meaningfully impact social determinants of health.
- Promote physical and behavioral health integrated care.
- Facilitate rapid access to care and needed resources.

*Examples:*

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

# Wave 1 Community Partnerships

Legacy Participating Entities have formed partnerships with a variety of community organizations.




Note: Aggregate data from PCMH+ PE Monthly reporting April 2017 through January 2018 and not an exhaustive list of resource partners.

# Community Partnerships

DSS expects providers to sponsor local community collaborative forums or participate in existing 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 ASO, 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:
  - The member's services will not change and the member 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.
  - DSS attempts to contact every member who opts out of PCMH+ after the initial period to ask why, after having experience in the program, they chose to leave it.

# 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. The PCMH+ member welcome letter provided contact information for sharing a question or concern.

# Quality Strategy and Quality Measure Set

Goal – Improve quality and care experience of Medicaid members

Quality Strategy Components:

- Quality measure set
- Under-service prevention requirements
- Health care equity measures

# 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.

# Quality of Care Measures

| Scoring Measures |
| --- |
| Adolescent well-care visits |
| Avoidance of antibiotic treatment in adults with acute bronchitis |
| Developmental screening in the first three years of life |
| Diabetes HbA1c Screening |
| Emergency Department (ED) Usage |
| Medication management for people with asthma |
| PCMH CAHPS |
| Prenatal care and Postpartum care |
| Well-child visits in the first 15 months of life |

| Challenge Measures |
| --- |
| Behavioral Health Screening 1–17 |
| Metabolic Monitoring for Children and Adolescents on Antipsychotics |
| Readmissions within 30 Days |
| Post-Hospital Admission Follow up |

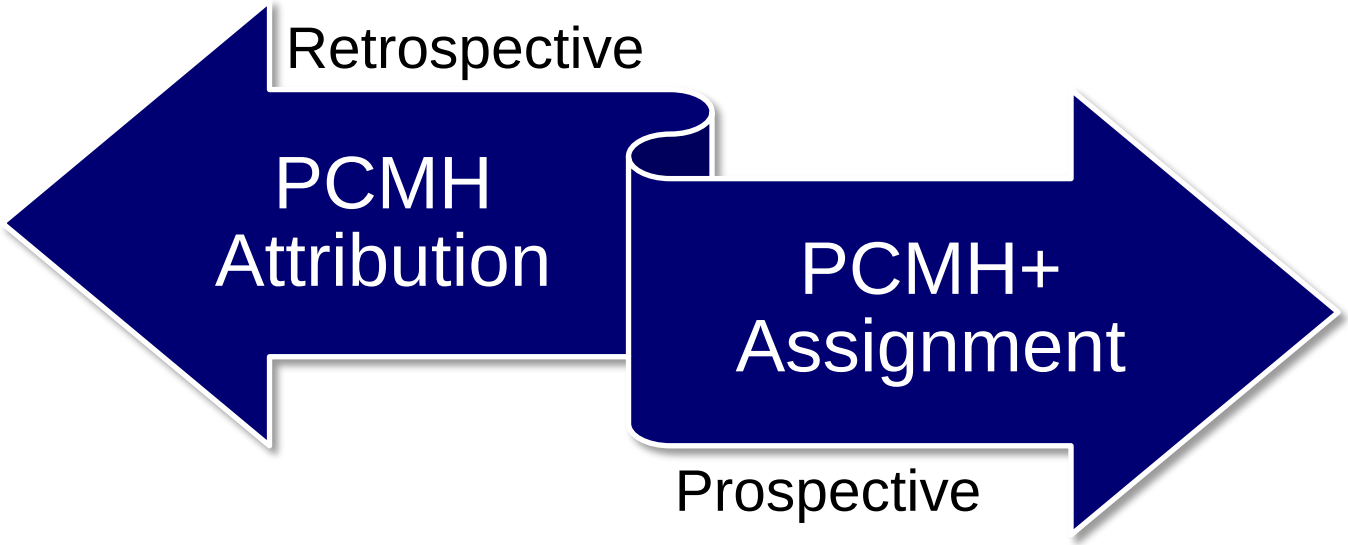
# Quality of Care Measures

| Reporting Only Measures |
| --- |
| Annual fluoride treatment ages 0<4 |
| Annual monitoring for persistent medications (roll-up) |
| Appropriate treatment for children with upper respiratory infection |
| Asthma Medication Ratio |
| Breast cancer screening |
| Cervical cancer screening |
| Chlamydia screening in women |
| Diabetes eye exam |
| Diabetes: medical attention for nephropathy |
| Follow-up care for children prescribed ADHD medication |
| Human Papillomavirus Vaccine (HPV) for Female Adolescents |
| Oral evaluation, dental services |
| Use of imaging studies for low back pain |
| Well-child visits in the third, fourth, fifth and sixth years of life |

# Under-Service Utilization Strategy and Prevention Requirements

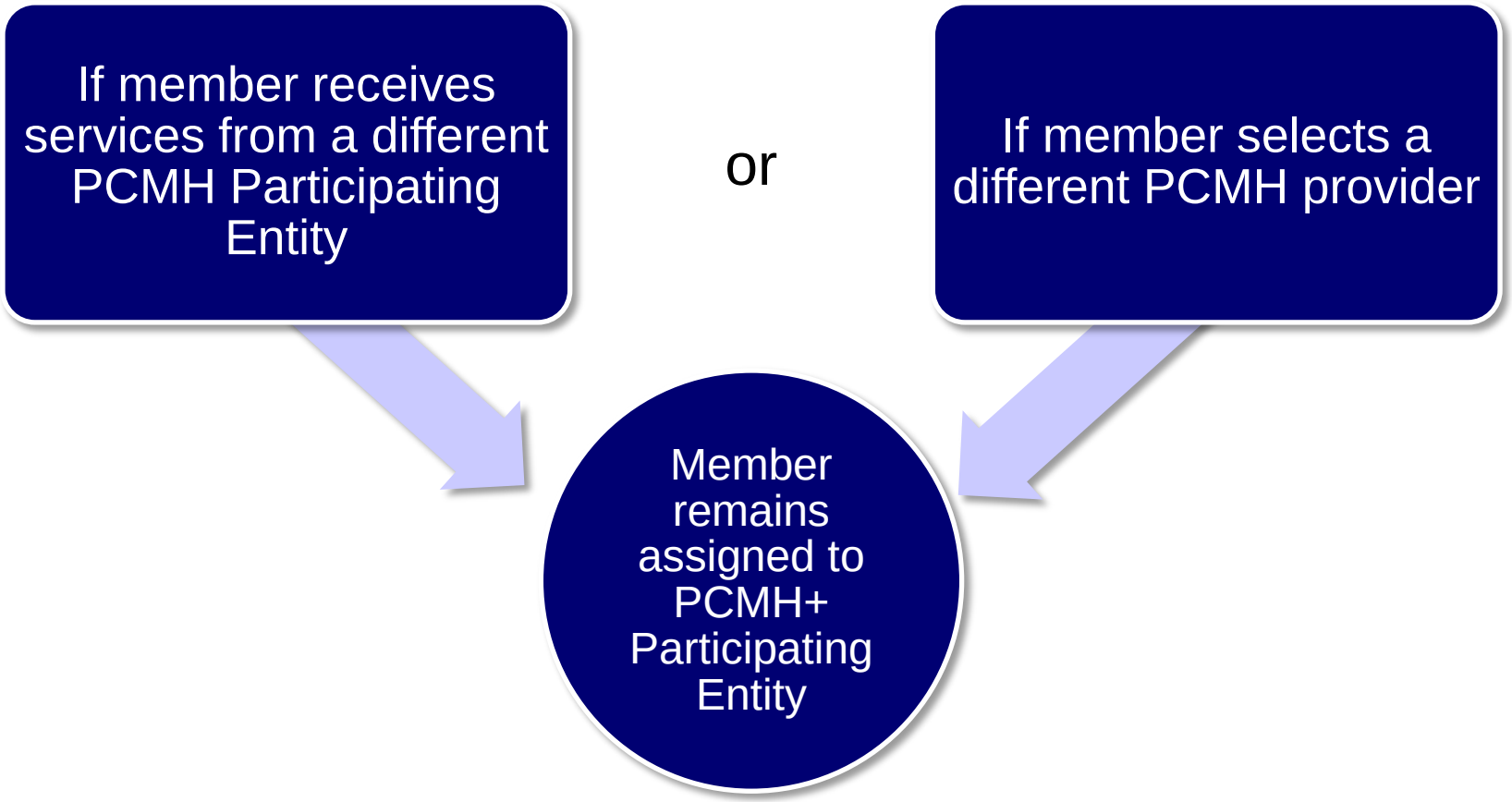
- Participating Entities must have or develop a means to monitor, identify and address under-service.
- PCMH+ uses a five-pronged approach to identify indicators of under-service utilization practices.

# Member Assignment Methodology



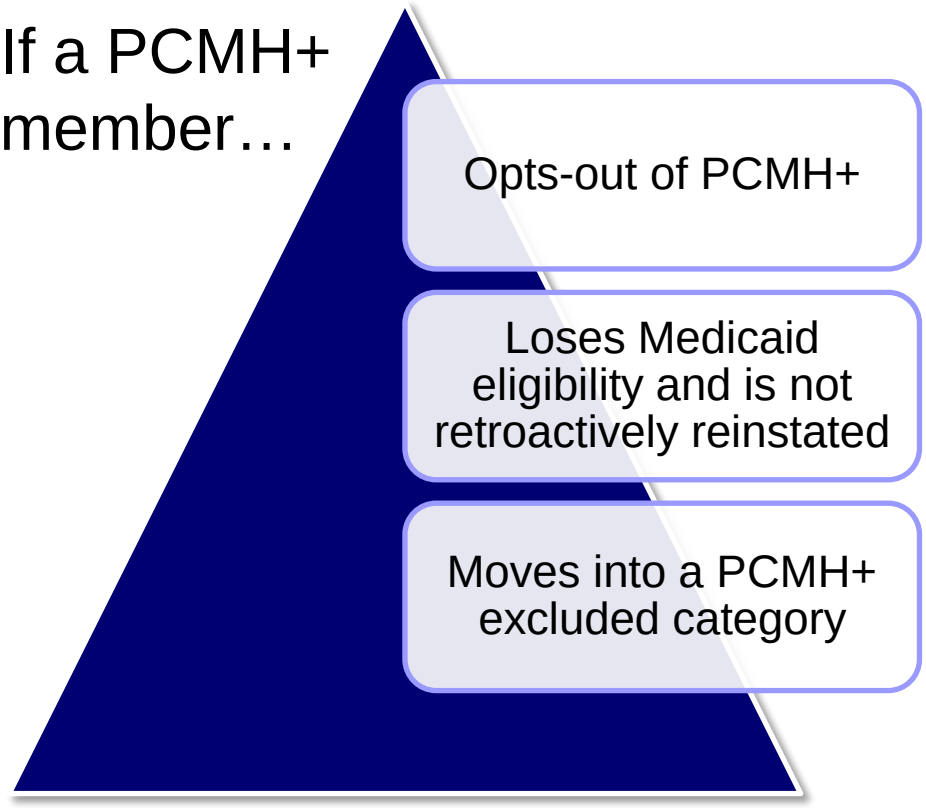

- Assignment is based on member's active choice of provider.
  - DSS examines data to attribute individuals to PCMH practices from which they have received care over the last 15 months.
  - DSS then assigns those members to those PCMH practices.
- Members are assigned to only one Participating Entity.
- Member attribution will be based on member enrollment as of March 2018. Member assignment will be sent to the Legacy Participating Entities in April and new Participating Entities in May.

# 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 after netting out losses from individual savings pools.
- Four quality measures.
- Must achieve at least the median score of challenge pool participants to claims savings for that measure.
- Pro rata distribution to Participating Entities reaching quality measure thresholds.

# Shared Savings Model Overview

### Minimum Savings Rate

- Symmetrical MSR of 2%

### Savings Cap

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

### Percent of Shared Savings

- 50% of savings will be shared with Participating Entities

### Claims Truncation

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

### Trend

- Expected cost trends will be derived from a comparison group of non-participating providers in the state

### Risk Adjustment

- CareAnalyzer ACG risk scores will be used to risk adjust costs for the prior and performance year

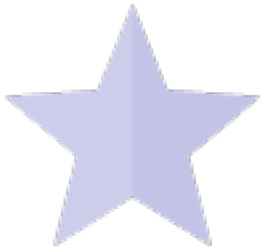
# Time Line for Wave 2


Shared savings calculations will be performed in the Fall of 2019. The calculation will use CY 2018 as the performance year and CY 2017 as the prior year.

# 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

Quality Improvement percentiles will be derived from all Participating Entities' quality improvement data.

| Quality Improvement 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 |

# Quality Measure Scoring Update

## 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 all other Participating Entities improvement trend.

| Example: Quality Measure #1 | |
|---|---|
| Participating Entity's Year-Over-Year Improvement Percentage | 2.25% |
| All Participating Entity Improvement Percentage – 60$^{th}$ Percentile | 2.00% |
| All Participating Entity Improvement Percentage – 70$^{th}$ Percentile | 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 2016 quality measure data for the Comparison Group used for Wave 1.

| Absolute Quality 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 |

# 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 80$^{th}$ 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**

Website: www.ct.gov/dss/PCMH+