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PCMH+ UNDER-SERVICE UTILIZATION MONITORING STRATEGY

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Draft and Subject to Revision

Purpose

The goal of Person-Centered Medical Home Plus (PCMH+) is to improve the member experience, increase the quality of Medicaid primary care, and enhance care coordination activities such that medically unnecessary and inappropriate utilization is decreased and member health outcomes are improved. The Connecticut Department of Social Services (DSS) recognizes there is a potential risk in a shared savings model that members are diverted from a provider practice or discouraged from medically necessary services in an effort to drive increased savings or limit the number of high-risk members a provider may serve. The PCMH+ Under-Service Utilization Strategy was developed in response to this potential risk and is an approach designed to identify potential under-service utilization or inappropriate reductions in access to medically necessary care. It is important to also note that the Connecticut Medicaid fee-for-service model offers limited financial incentives to under-service utilization practices. At its core, the program is not a gate-keeper or managed care model, and members are allowed to self-refer to any participating provider. As part of their oversight of the PCMH+ program, DSS will implement the following five-pronged approach in an effort to identify underservice utilization practices within the program.

Five-Pronged Approach

DSS recognizes that identification of under-service utilization practices is complex, and no one strategy alone can adequately ameliorate the risk. For PCMH+, DSS proposes a strategy that encompasses several monitoring methods. These methods are demonstrated in the diagram on the right and represent an approach designed to provide the best opportunity to identify under-service utilization practices, inappropriate member-shifting (sometimes referred to as “cherry-picking”), diminished access to medically necessary services, or other early warning indicators of under-service utilization practices.

1. Preventative and Access to Care Measures

Of the 27 PCMH+ Quality Measures, 21 track preventative care rates or monitor appropriate clinical care for specific health conditions. Tracking these measures, and comparing to historical rates, can provide actionable information regarding clinical quality and act as a bellwether for decreased access to medically necessary care. The preventative and access to appropriate clinical care measures include the following:

Table 1: Preventative Care and Access to Appropriate Clinical Care Measures		
Adolescent Well Care Visits	Annual Fluoride Treatment Ages 0<4	Annual Monitoring for Persistent Medications
Asthma Medication Ratio	Behavioral Health Screening ages 1–17	Breast Cancer Screening
Cervical Cancer Screening	Chlamydia Screening in Women	Developmental Screening in First three Years of Life
Diabetes Eye Exam	Diabetes HbA1c Screening	Diabetes: Medical Attention for Nephropathy
Follow-up Care for Children Prescribed ADHD Medication	Human Papillomavirus Vaccine for Female Adolescents	Medication Management for People with Asthma
Metabolic Monitoring for Children and Adolescents on Antipsychotics	Oral Evaluation; Dental Services	Post-Hospital Admission Follow-up
Prenatal Care and Postpartum Care	Well-Child Visits in the first 15 Months of Life	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

2. Member Surveys

Person-Centered Medical Home (PCMH) Consumer Assessment of Healthcare Providers (CAHPS)[1] survey will be conducted in the spring of 2018 to gauge member experience for the 2017 performance year. PCMH CAHPS is a standardized member survey, conducted annually to determine member satisfaction with services and service providers. Many of the survey questions solicit information that may suggest under-service utilization practices. Below are a few examples of questions that may inform whether under-service utilization may be present.

- In the last 12 months, how many days did you usually have to wait for an appointment when you needed care right away?
- In the last 12 months, how often were you able to get the care you needed at your provider's office during evenings, weekends, or holidays?
- Did this provider's office give you the information about what to do if you needed care during evenings, weekends, or holidays?

In addition to the PCMH CAHPS survey, DSS may add specific questions from the CAHPS Cultural Competency Supplemental Item Set[2] as a mechanism to monitor PCMH+ cultural competency care coordination requirements. While not a direct indication of under-service utilization practices, they provide important information regarding the member experience that can discourage members from accessing needed care. (The number in parenthesis indicates the question number from the survey).

- In the last 12 months, how often have you been treated unfairly at this provider's office because of your race or ethnicity? (CU14)
- In the last 12 months, how often were you treated unfairly at the provider's office because you did not speak English very well? (CU24)

[1] PCMH Consumer Assessment of Healthcare Providers (CAHPS) Survey: https://cahps.ahrq.gov/surveys-guidance/survey4.0-docs/1314_About_PCMH.pdf

[2] CAHPS Cultural Competency Supplemental Item Set: https://cahps.ahrq.gov/surveys-guidance/survey4.0-docs/2312_about_cultural_comp.pdf

- An interpreter is someone who helps you talk with others who do not speak your language. Interpreters can include staff from the provider's office or telephone interpreters. In the last 12 months, was there any time when you needed an interpreter at this provider's office? (CU25)
- In the last 12 months, did anyone in this provider's office let you know that an interpreter was available free of charge? (CU26)
- In the last 12 months, how often did you use an interpreter provided by this office to help you talk with his provider? (CU27)

3. Member Education and Grievances

All PCMH+ assigned members will receive a Member Welcome Letter providing them information on the program and their opt-out rights. The notice will contain information sufficient to inform the member that their primary care provider has the opportunity to receive a portion of any avoided costs if the care provided meets minimum quality thresholds. All members retain all Medicaid grievance processes and are educated on the process to submit grievances through their Member Handbook. Grievances may be submitted in several ways; in writing, by fax, by email or by phone. In addition to submitting a grievance through the State of Connecticut's (State's) Administrative Services Organization, members are provided information on submitting a grievance directly to DSS, the Office of the Healthcare Advocate or to the Office of Civil Rights in Washington, DC. Monitoring these grievances is an oversight function currently incorporated in the program and will continue to be monitored and PCMH+ specific grievance reporting is being developed for DSS to identify issues and trends within the PCMH+ program specifically. DSS will also be providing Community Information Sessions prior to program go-live to provide an overview of the PCMH+ program, outline the enhanced care coordination available to members of participating providers, educate members on the grievance and opt-out process and allow for member and stakeholder questions. These Informational Sessions are planned for December 2016 in two locations in the State. Public notices will be sent out to invite attendance by members, families and community stakeholders.

4. Utilization Trend Tracking

DSS is working with their vendors to develop targeted utilization reporting to monitor trends for specific services and benefits within the program to identify shifts in service utilization within the population. In addition, DSS will monitor overall service cost reports, movement of members between providers, levels of member opting-out of PCMH+ and members moving into Long-Term Services and Supports services.

5. Shared Savings Design Elements

The PCMH+ model design has several elements that may act as deterrents to providers underserving members as a means of increasing potential shared savings. Elements in the model design include the following:

- Savings Cap: A Participating Entity will not be allowed to contribute more than 10% of its expected expenditures to their individual savings pool.
- Upside-only Model: As part of the individual savings pool, if a Participating Entity's performance year costs exceed their expected costs, then that Participating Entity will not be required to pay back the costs that exceed the expected costs.
- High Cost Claims Truncation: Annual claims costs for each PCMH+ member that exceeds $100,000 will be excluded from the shared savings calculation.
- Concurrent Risk Adjustment Methodology: Risk scores will be calculated to compare a PCMH+ Participating Entity's level of risk relative to non-Participating Entities.