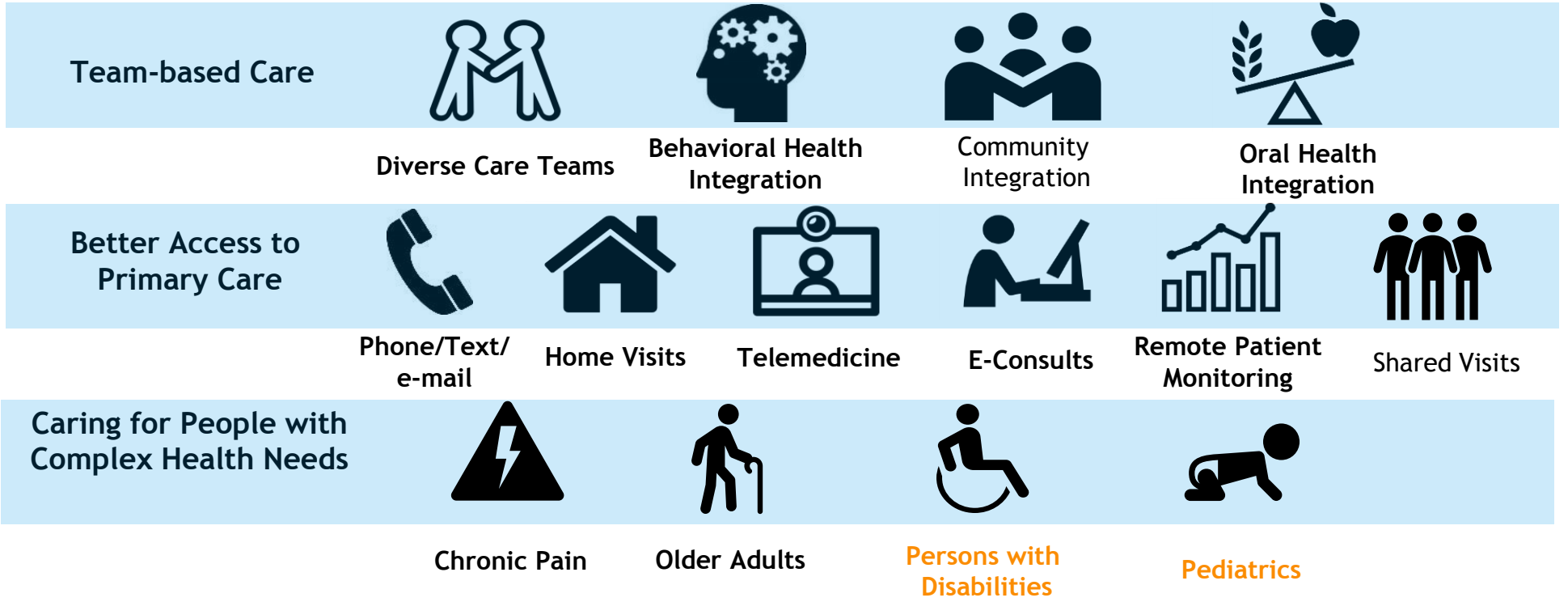
CONNECTICUT
Office of Health Strategy

FQHC Meeting Three Appendix

SIM connecticut state innovation model

Care Delivery Goal: Increase the Ability of Primary Care to Meet Consumers' Needs



Bold = Required
Not Bold = Optional
Orange = Task Force has not yet reviewed capability

Expand Primary Care Team Functions and Roles

Care team members like Community Health Workers can help reduce disparities by:

- Linking patients to housing, food, transportation and other community resources
- Advocating for patients as a member of their community
- Understanding and communicating how culture impacts health decisions
- Navigating billing and insurance issues for people with financial barriers to care

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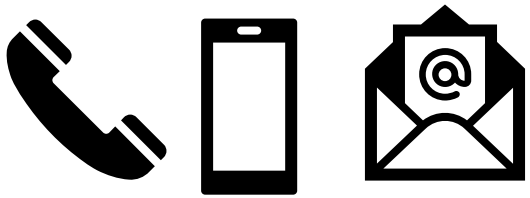
Support and Engage Patients in Alternative Ways



Phone, Text, Email Encounters

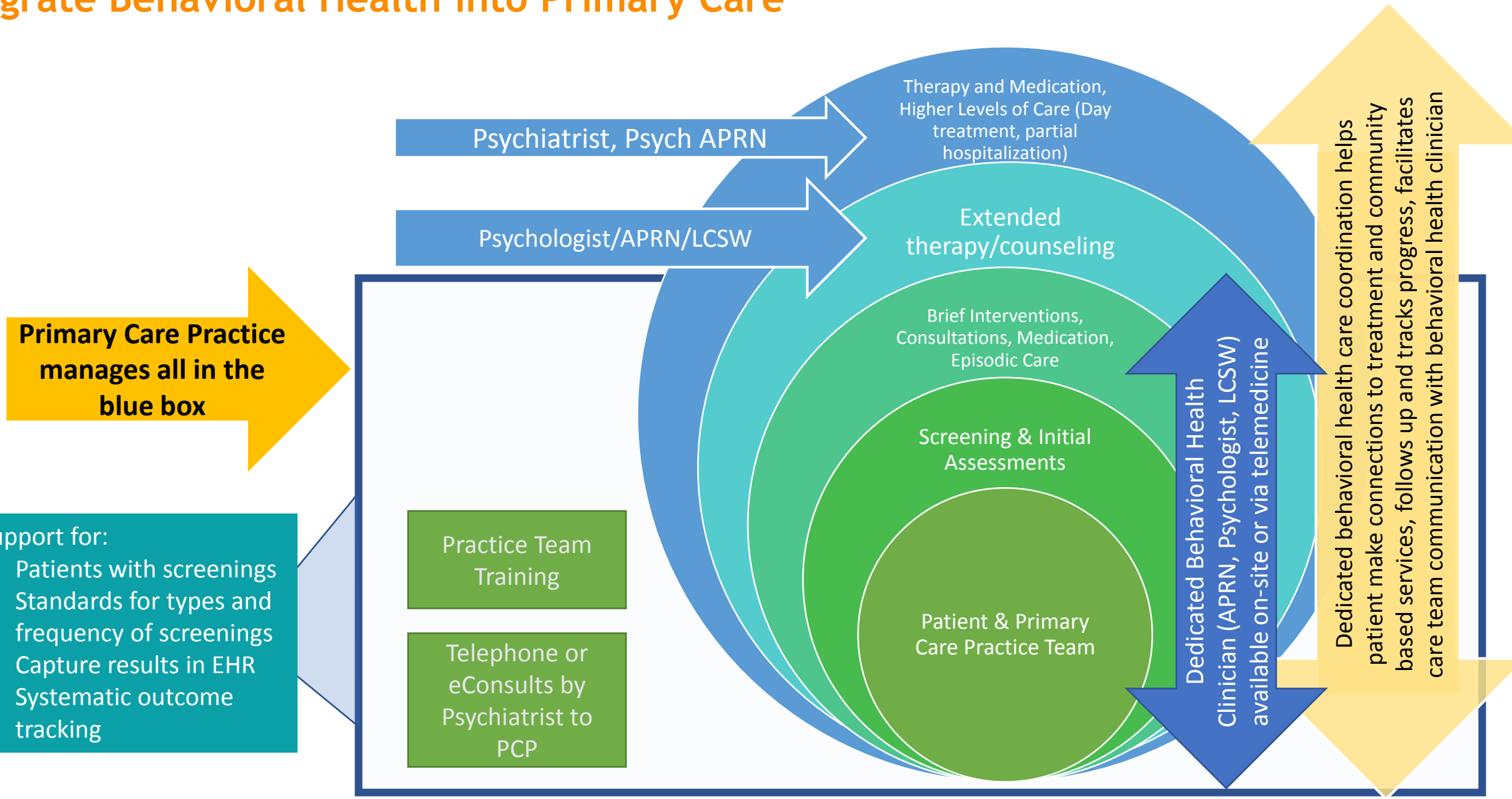
- More access to care and medical guidance
- More opportunities to establish patient-provider relationship
- Frees up clinician to focus on complex needs in-office

Telemedicine (Video) Visits

- Medical appointments at the time of need
- Avoid time off work, childcare and travel costs
- Usually pay less than an in-office visit

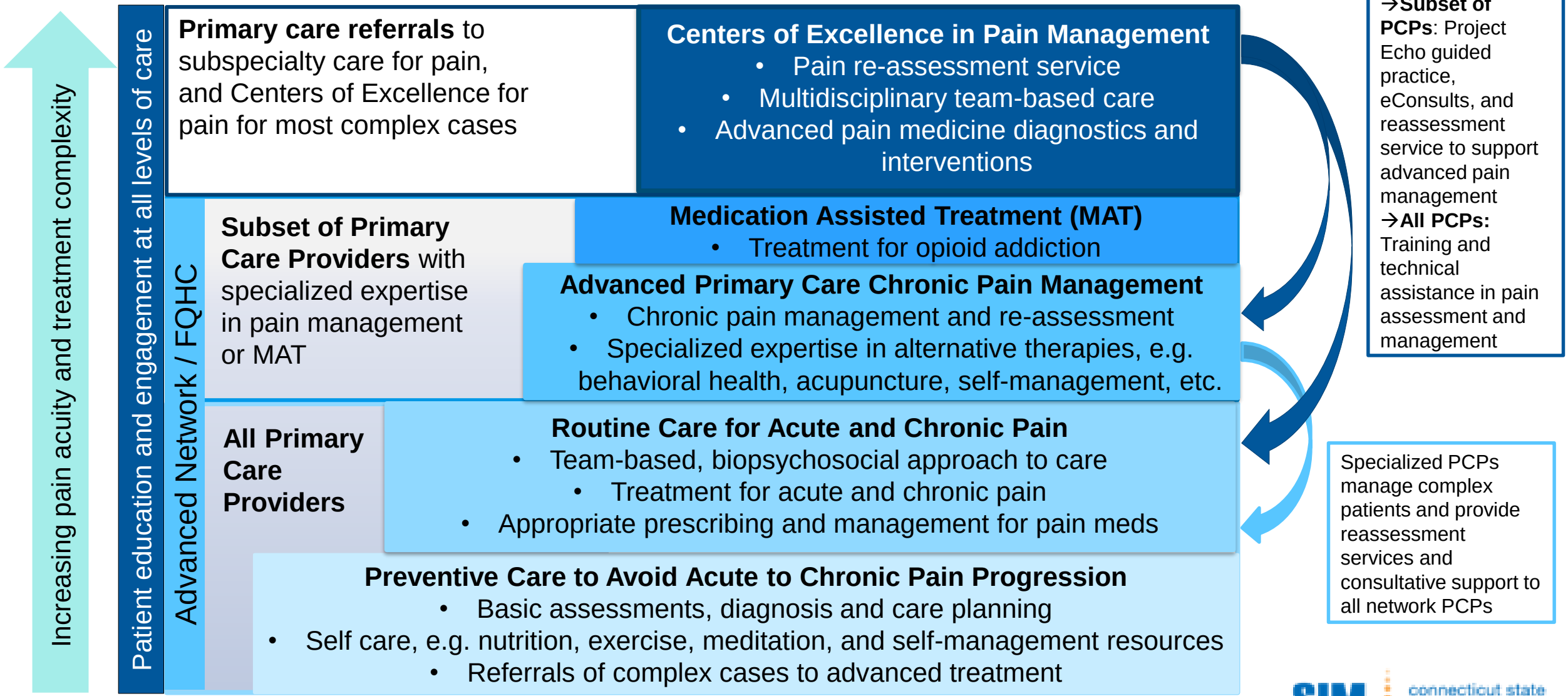
Telemedicine and other non-visit based technologies help address access to care barriers like transportation, especially for populations experiencing health disparities.

Integrate Behavioral Health into Primary Care



Based on feedback prior to September 25, 2018

Increase Expertise in Pain Management



COEs provide
→**Subset of PCPs**: Project Echo guided practice, eConsults, and reassessment service to support advanced pain management
→**All PCPs:** Training and technical assistance in pain assessment and management

Specialized PCPs manage complex patients and provide reassessment services and consultative support to all network PCPs

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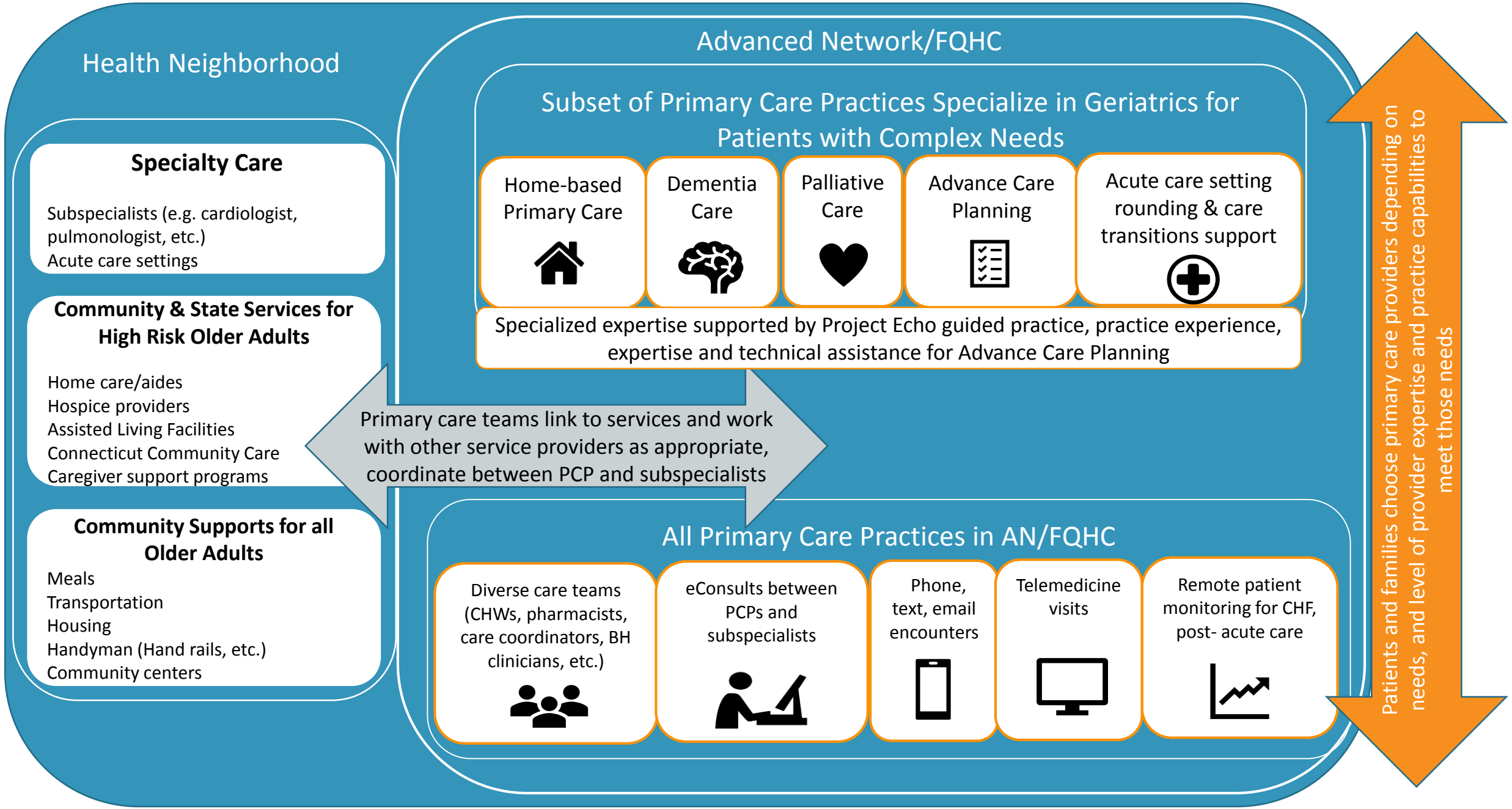
Offer Specialized Care for Older Adults with Complex Needs



How would care be paid for?

Basic Bundle

PCP's Time
(MD, DO, APRN, PA)

- **Office visits, phone, text, email, telemedicine, home visits, shared visits.**
- Leading care teams.
- Participation in technical assistance to offer more specialized care.
- Supporting e-Consult.

Both adjusted to reflect differences in patient needs and expected costs.

Supplemental Bundle

New Expenses Necessary to Achieve Capabilities

- **Expanded, diversified care teams that connect with patients through office visits, phone, text, email, telemedicine, home visits, shared visits.**
- Primary care integration with behavioral health services and community-placed resources.
- New investments in technology and infrastructure to support achieving the capabilities.
- Specialist payments for e-Consult.
- Patient-specific expenses to address SDOH needs such as food security/food as medicine, housing instability and transportation.

Context for Reviewing Capabilities Cost Estimates

1. Estimates based on the literature, not actuarial assessments reflecting the specific needs of Connecticut residents. Actuarial assessments will come later.

2. PCM assumes some foundational investments in HIT. The supplemental bundle may not cover all costs for some capabilities for some provider organizations and may cover more than the cost for others. Organizations have made different historical investment decisions.

3. PCM supplemental bundle payments intend to cover the cost of new care team members, new investments in technology directly related to achieving the capabilities and the training and technical assistance necessary to position providers for success.

4. Investments in new care teams will look different for different provider organizations depending on the patient needs, practice type (adult v. pediatric), organizational culture and budget.

Calculating the supplemental bundle:

Hypothetical Cost Estimates for Core Capabilities

Core Capabilities	Estimated Cost PMPM	Assumptions (*all cost estimates based on an "average" multi-payer, 1500/per FTE MD panel*)
Phone, Text, Email	$0	Assumes AN/FQHC has necessary technology. Care team members included in basic bundle and expanded care teams estimates.
Telemedicine	$0	Assumes AN/FQHC has necessary technology. Care team members included in basic bundle and expanded care teams estimates.
Remote Monitoring ***(For conditions where there is proven benefit)***	$.50-$1.50	**One-time Fixed Cost** $20,000 Implementation; $15,000 Integration Fee; $15,000 Training Fee **Annual Fixed Cost** - $175,000 Platform fee **Annual Variable Cost** - $7 Transaction cost per patient Assumes 80,000 covered lives. Costs would vary depending vendor, AN size and the targeted conditions.
eConsult	$2.94	Assumes 12 eConsults per week per PCP ($85 each including specialist time and technology platform)
Expanded Care Teams	$10.00-$15.00	Using CPCI, "fully-enabled" PCM estimates
BH Integration	$0	Assumes AN/FQHC has necessary technology. Care team members included in basic bundle and expanded care teams estimates.
Specialized Practices	$2.00-$6.00	Technical assistance, equipment, access to support networks like Project Echo. May include some additional care team members specific to the need of the specialized practice. Recognizes panel sizes may need to be smaller than a standard practice.
Training and Technical Assistance	$3.00	Training in collaboration and leadership for expanded care teams.

Supplemental Bundle Target Ranges – Medicare Model Options

TIER ONE	
Core Capabilities	**$19**
Elective Capabilities	**$0**
Target Supplemental Bundle*	**$18-$20**
Description: Expanded Care Teams, BH Integration, Training and Technical Assistance, Few Specialized Practices	
Availability: Years 1-2	

TIER TWO	
Core Capabilities	**$24**
Elective Capabilities	**$3**
Target Supplemental Bundle*	**$25-$28**
Description: Expanded Care Teams, BH Integration, Training and Technical Assistance, Additional Specialized Practices, Some Investment in Elective Capabilities	
Availability: Years 1-5	

TIER THREE	
Core Capabilities	**$35**
Elective Capabilities	**$5**
Target Supplemental Bundle*	**$35-$40**
Description: Maximizes Care Team Potential, BH Integration, Training and Technical Assistance, Strong Cadre of Specialized Practices, Greater Investment in Elective Capabilities	
Availability: Years 2-5	

* Please note these targets are not risk adjusted, **not adjusted based on FQHCs existing infrastructure/care teams** and these numbers will be further adjusted subject to a Medicare claims-level analysis.

Risk Adjusting the Supplemental Bundle

- **Proposed Approach**

- Since supplemental bundle funds will largely go toward supporting care management and coordination, behavioral health integration and community integration, ideally these payments should be adjusted to align with the patients' needs in those areas.
- To achieve this, supplemental payments would be adjusted using an approach similar to CPC+.
- All beneficiaries are assigned to tiers based on their risk score **but** some beneficiaries default to higher tiers if they have certain conditions or characteristics. We will call this "secondary adjustment."
- Secondary adjustment conditions and characteristics should be meaningful to primary care, able to be defined using available data, and reasonable to isolate despite increased administrative burden.

Why start with risk scores?

- Scores and underlying data are widely available
- Risk adjustment methodologies are well established and the resulting scores are meaningful representations of population risk
- Stakeholders are generally familiar with risk adjustment methodologies and they are part of the framework for much of value based payment

Example: MassHealth Social Determinants of Care Risk Adjustment Model

- Risk adjustment methodology was augmented to capture the impact of social determinants of health on medical expense.
- The model predicts costs from DxCG relative risk score and age-sex indicators (leveraging commercially available model).
- Then, it adds markers for unstable housing (3 or more addresses/yr or v-code), disability, agency relationships, severe mental illness and substance use disorders.
- The final component is a summary measure of "neighborhood stress" based upon residence in a census block group. It is defined on the next slide.

- Source: EOHHS
- Model is not commercially available

Neighborhood Stress Score

- A measure of “economic stress” summarizing 7 census variables identified in a principal components analysis:

- % of families with incomes < 100% of FPL
- % < 200% of FPL
- % of adults who are unemployed
- % of households receiving public assistance
- % of households with no car
- % of households with children and a single parent
- % of people age 25 or older who have no HS degree

- Source: EOHHS
- Model is not commercially available

Key questions to consider for PCM:

1. What criteria should be considered as we develop risk adjustment tiers for primary care modernization?

2. What process or method will be used to apply the secondary adjustment?

3. What characteristics should trigger secondary adjustment?

What's the right number of risk adjustment tiers?

- Recommendation:
- Supplemental Payments should leverage no more than 5 tiers. This is what CPC+ uses.

- Rationale:
- Sufficient number of tiers to adequately adjust for differences in populations.
- Accounting and operations are simplified.
- Allows for a meaningful difference in payment between tiers.

Which method(s) should be used to apply secondary adjustment?

- **Approach 1**:Tier jumping

- Patient's risk score falls in the tier 2 score range.
- Patient has a diagnosis of dementia.
- Patient is placed in tier 3.

- **Approach 2**: Patients with certain needs assigned to specific supplemental bundle categories, regardless of underlying risk score.

- All patients with a diagnosis of dementia would be assigned to the highest risk adjustment category, regardless of other clinical, social or behavioral health needs.

- *Both approaches may be leveraged depending on the characteristic or condition.*

Which populations should receive a secondary adjustment?

- During stakeholder meetings, several populations were identified whose clinical, behavioral and social needs may not be fully reflected in a traditional risk adjustment methodology.
- Examples included:
- Individuals with unmet social needs such as lack of stable housing.
- Individuals with behavioral health conditions and substance use disorder conditions.
- Children
- Individuals with dementia

How would providers identify these populations?

- Population: Individuals with unmet social needs such as lack of stable housing.
- Possible Approach: Massachusetts used zip code. The zip code links to a look up table that captures the community attributes included in the neighborhood stressor score. Therefore the individual's secondary adjusted reflected their community, not themselves.
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- Population: Individuals with behavioral health conditions and substance use disorder conditions.
- Possible Approach: Diagnoses found in claims. This would also provide more incentive for providers to fully implement screening.

- Population: Children
- Possible Approach: Different tiers based on risk adjustment, diagnosis, and age. All information found in claims.

- Population: Individuals with dementia
- Possible Approach: In CPC+, dementia diagnoses will be determined using information from CMS's Chronic Condition Warehouse (CCW), which is based on diagnoses codes found in the claims. The designation is updated annually.