FQHC Meeting Three Appendix
Care Delivery Goal: Increase the Ability of Primary Care to Meet Consumers’ Needs

**Team-based Care**
- Diverse Care Teams
- Behavioral Health Integration
- Community Integration
- Oral Health Integration

**Better Access to Primary Care**
- Phone/Text/e-mail
- Home Visits
- Telemedicine
- E-Consults
- Remote Patient Monitoring
- Shared Visits

**Caring for People with Complex Health Needs**
- Chronic Pain
- Older Adults
- Persons with Disabilities
- Pediatrics

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

Therapy and Medication, Higher Levels of Care (Day treatment, partial hospitalization)
Extended therapy/counseling
Brief Interventions, Consultations, Medication, Episodic Care
Screening & Initial Assessments
Patient & Primary Care Practice Team

Psychiatrist, Psych APRN
Psychologist/APRN/LCSW

Practice Team Training
Telephone or eConsults by Psychiatrist to PCP

Primary Care Practice manages all in the blue box

Support for:
- Patients with screenings
- Standards for types and frequency of screenings
- Capture results in EHR
- Systematic outcome tracking

Dedicated Behavioral Health Clinician (APRN, Psychologist, LCSW) available on-site or via telemedicine

Based on feedback prior to September 25, 2018
Increase Expertise in Pain Management

Primary care referrals to subspecialty care for pain, and Centers of Excellence for pain for most complex cases

Centers of Excellence in Pain Management
- Pain re-assessment service
- Multidisciplinary team-based care
- Advanced pain medicine diagnostics and interventions

Routine Care for Acute and Chronic Pain
- Team-based, biopsychosocial approach to care
- Treatment for acute and chronic pain
- Appropriate prescribing and management for pain meds

Preventive Care to Avoid Acute to Chronic Pain Progression
- Basic assessments, diagnosis and care planning
- Self care, e.g. nutrition, exercise, meditation, and self-management resources
- Referrals of complex cases to advanced treatment

Medication Assisted Treatment (MAT)
- Treatment for opioid addiction

Advanced Primary Care Chronic Pain Management
- Chronic pain management and re-assessment
- Specialized expertise in alternative therapies, e.g. behavioral health, acupuncture, self-management, etc.

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

Subset of Primary Care Providers with specialized expertise in pain management or MAT

All Primary Care Providers

Advanced Network / FQHC

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

Increasing pain acuity and treatment complexity

Patient education and engagement at all levels of care
Offer Specialized Care for Older Adults with Complex Needs

**Health Neighborhood**

**Specialty Care**
- Subspecialists (e.g. cardiologist, pulmonologist, etc.)
- Acute care settings

**Community & State Services for High Risk Older Adults**
- Home care/aides
- Hospice providers
- Assisted Living Facilities
- Connecticut Community Care
- Caregiver support programs

**Community Supports for all Older Adults**
- Meals
- Transportation
- Housing
- Handyman (Hand rails, etc.)
- Community centers

**Advanced Network/FQHC**

**Subset of Primary Care Practices Specialize in Geriatrics for Patients with Complex Needs**
- Home-based Primary Care
- Dementia Care
- Palliative Care
- Advance Care Planning
- Acute care setting rounding & care transitions support

Specialized expertise supported by Project Echo guided practice, practice experience, expertise and technical assistance for Advance Care Planning

Primary care teams link to services and work with other service providers as appropriate, coordinate between PCP and subspecialists

**All Primary Care Practices in AN/FQHC**
- Diverse care teams (CHWs, pharmacists, care coordinators, BH clinicians, etc.)
- eConsults between PCPs and subspecialists
- Phone, text, email encounters
- Telemedicine visits
- Remote patient monitoring for CHF, post-acute care

Patients and families choose primary care providers depending on needs, and level of provider expertise and practice capabilities to meet those 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.

**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.

Both adjusted to reflect differences in patient needs and expected costs.
Calculating the supplemental bundle:

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

<table>
<thead>
<tr>
<th>Core Capabilities</th>
<th>Estimated Cost PMPM</th>
<th>Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone, Text, Email</td>
<td>$0</td>
<td>Assumes AN/FQHC has necessary technology. Care team members included in basic bundle and expanded care teams estimates.</td>
</tr>
<tr>
<td>Telemedicine</td>
<td>$0</td>
<td>Assumes AN/FQHC has necessary technology. Care team members included in basic bundle and expanded care teams estimates.</td>
</tr>
</tbody>
</table>
| Remote Monitoring                  | $.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

<table>
<thead>
<tr>
<th>TIER ONE</th>
<th>TIER TWO</th>
<th>TIER THREE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Core Capabilities</strong></td>
<td><strong>Core Capabilities</strong></td>
<td><strong>Core Capabilities</strong></td>
</tr>
<tr>
<td>$19</td>
<td>$24</td>
<td>$35</td>
</tr>
<tr>
<td><strong>Elective Capabilities</strong></td>
<td><strong>Elective Capabilities</strong></td>
<td><strong>Elective Capabilities</strong></td>
</tr>
<tr>
<td>$0</td>
<td>$3</td>
<td>$5</td>
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<tr>
<td><strong>Target Supplemental Bundle</strong></td>
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<td><strong>Target Supplemental Bundle</strong></td>
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<tr>
<td>$18-$20</td>
<td>$25-$28</td>
<td>$35-$40</td>
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<tr>
<td><strong>Description:</strong></td>
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<td><strong>Description:</strong></td>
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<tr>
<td><strong>Availability:</strong></td>
<td><strong>Availability:</strong></td>
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<tr>
<td>Years 1-2</td>
<td>Years 1-5</td>
<td>Years 2-5</td>
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</tbody>
</table>

* 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.

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OHS Connecticut Office of Health Strategy

DRAFT FOR DISCUSSION ONLY
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
  

DRAFT FOR DISCUSSION ONLY
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.

- **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.