Attachment no. 2 (rev. July 2020)

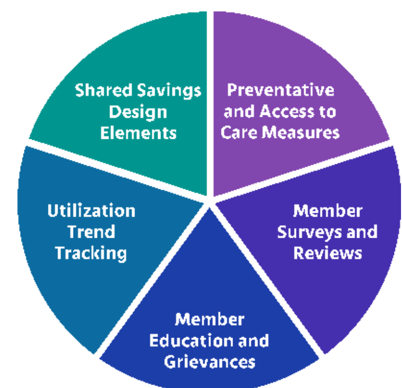
PCMH+ UNDER-SERVICE UTILIZATION MONITORING STRATEGY

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 prevent and identify potential under-service utilization or inappropriate reductions in access to medically necessary care. It is important to 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 gatekeeper 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 has implemented the following five-pronged approach in an effort to identify underservice utilization practices within the program. DSS continues to evolve this strategy as additional methods of detecting and preventing under-service utilization are identified. As reflected throughout the document below, no evidence of Under-service utilization has been found in the early years of 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

In the early phases of PCMH+, of the 27 PCMH+ Quality Measures, 21 measures tracked preventative care rates and monitored appropriate clinical care for specific health conditions. These measures assessed and compared data to historical rates, which provided actionable information regarding clinical quality and provided predictive methods to decreased access to medically necessary care. These individual scoring results were reported publicly for each year of the program. No evidence of PCMH+ underutilization has been found in the review of Quality Metrics in the early years of the program. Similar to years past, PCMH+ will continue to track Quality Measures. Currently there are 30 Quality Measures, 24 of which track preventative care or appropriate care for specific health conditions:

Preventative Care and Access to Appropriate Clinical Care Measures*		
Adolescent Well-Care Visits	Annual Fluoride Treatment Ages 0<4	Annual Monitoring for Persistent Medications (Roll-up)
Anti-Depressant Medication Management	Asthma Medication Ratio	Avoidable Emergency Department (ED) Visits
Avoidable Hospitalizations	Behavioral Health Screening 1-17	Breast Cancer Screening
Cervical Cancer Screening	Chlamydia Screening in Women	Developmental Screening in the First Three Years of Life
Diabetes Eye Exam	Diabetes HBA1C Screening	Diabetes: Medical Attention for Nephropathy
Follow Up After ED Visit for Mental Illness	Follow Up After Hospitalization for Mental Illness	Follow Up Care for Children Prescribed ADHD Medication
Human Papillomavirus Vaccine (HPV) for Female Adolescents	Medication Management for People with Asthma	Metabolic Monitoring for Children and Adolescents on Antipsychotics
Oral Evaluation, Dental Services	Prenatal and Postpartum Care (PPC)	Well Child Visits in the Third, Fourth, Fifth and Sixth years of Life

*Note: Measures may be subject to change from year to year based on the evolution and advancement of the program.

2. Member Surveys and Reviews

Person-Centered Medical Home (PCMH) Consumer Assessment of Healthcare Providers (CAHPS)[1] survey is conducted annually to gauge member experience for each PCMH+ performance year. PCMH CAHPS is a standardized member survey to determine member satisfaction with services and service providers. Many of the survey questions solicit information that may suggest under-service utilization practices.

[1] PCMH Consumer Assessment of Healthcare Providers (CAHPS) Survey: https:/ANww.ahrg.gov/sites/default/filesANysiwyg/cahps/surveys-guidance/item-sets/PCMH/about-pcmh-item-set-cg30-2314.pdf

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)
- 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 this provider? (CU27)

In addition to CAHPS member surveys, in the early years of the program, DSS attempted to contact every member who opted-out of PCMH+ after the initial enrollment period.

In the early years of the program, participating entities (PEs) were subject to an onsite review that assessed for compliance, quality and effectiveness in achieving the goals of the PCMH+ program. As part of the desk review, onsite review and chart review, data that could help identify underservice was examined. Reviewers understood that PEs would be disqualified from receiving shared savings if they

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[2] CAHPS Cultural Competency Supplemental Item Set: https://www.ahrq.gov/topics/externai/Cultural-and-Linguistic-Competence.html

demonstrated repeated or systematic failure to offer medically necessary services or manipulate their member panel, whether or not there is evidence of intentionality. Individual PE Assessment Reports included detailed findings, areas of strength and recommendations for improvement as well as the methods PEs used to detect underservice (including PEs reviewing member complaints). Additionally, PE policies were reviewed to detect whether or not underservice methodologies existed to monitor, prevent and address underutilization of clinically appropriate services. No evidence of underservice was detected during the onsite reviews.

Another integral portion of the onsite review included in-person interviews to garner member experience. The input of members is key to the success of the PCMH+ program. Interviews with current PCMH+ members and/or designated family representatives focused on the member experience with PCMH+. In particular, interview questions solicited information about the member's experience with PCMH+ care coordination services and overall satisfaction regarding delivery of these services. Each PE selected assigned PCMH+ member(s) (and/or their representative) to voluntarily participate in an interview and requested that priority be given to members who participate on the PCMH+ oversight committee or to members with at least one PCMH+ care coordination contact in the review period. The majority of interviews were conducted face-to-face; the interview team accommodated members' schedules during the onsite review and conducted phone interviews when necessary. No evidence of underservice was detected during the member interviews.

The level of continued compliance oversight and monitoring will be determined by DSS based on the needs of the program, duration of the PE in the PCMH+ program and identified findings through regularly submitted reports and quality metrics.

3. Member Education and Grievances

All PCMH+ assigned members receive a Member Welcome Letter providing information on the program and opt-out rights. 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 also provided community information sessions in the early years of the program. The information sessions provide an overview of the PCMH+ program, outline the enhanced care coordination available to members of participating providers, educate members on the grievance process, opt-out process and allow for member and stakeholder questions. These informational sessions were held in various locations in the State. Public notices were sent to invite attendance by members, families and community stakeholders. Information sessions were also held for providers/potential providers to inform them of their responsibilities in the program and to allow providers to ask questions. DSS also maintains a

website for PCMH+ members with important information that is also shared at the community information sessions.[3]

4. Utilization Trend Tracking

DSS has monitored and will continue to monitor overall service cost reports, movement of members between providers, levels of members opting-out of PCMH+ and members moving into PCMH+ excluded categories. All PCMH+ PEs are provided exhibits with claim count per 1,000 members for major categories of service as part of the shared savings deliverables. These major categories are tracked for both the prior and performance years for each year of PCMH+ and allow DSS to monitor trends for specific services within the program. No evidence of underservice was detected during utilization trend tracking.

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: APE 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 PE's performance year costs exceed their expected costs, then that PE 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+ PE's level of risk relative to non-PEs.
- Requirements to Receive Savings Payments: Providers will only receive a shared savings payment if they meet quality performance standards and under-service prevention requirements. Providers will be disqualified from shared savings payments if there is a repeated or systematic failure to withhold medically necessary care or manipulate their member panel, whether or not there is evidence of intentionality.
- All PEs have been required to self-report on a variety of measures to show the level of effort being produced and to show the PEs are meeting all required request for proposal metrics. PEs are allowed to report quarterly after the first year of being in the program unless DSS determines that monthly

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[3] https://portal.ct.gov/DSS/Health-And-Home-Care/PCMH-Plus-Members/PCMH-Plus-Member-Information

monitoring is necessary. Results are monitored on a monthly and quarterly basis and questionable results are followed up on by DSS. No evidence of underservice was detected in the reviews of PE reports.