Connecticut HUSKY Health:

Person-Centered Medical Home +

(PCMH+)

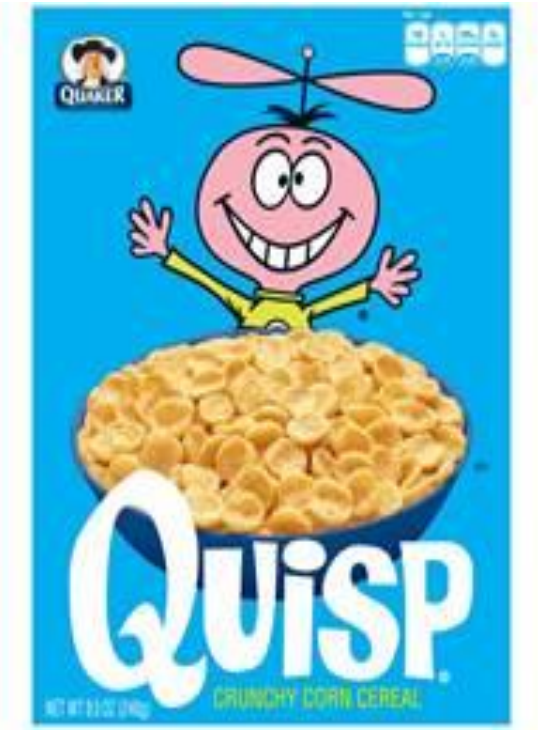
Update

Presentation to the SIM Steering Committee

March 9, 2017

Person-Centered Medical Home +
(PCMH+)
Overview

Formerly known as the **Medicaid Quality Improvement and Shared Savings Program (MQISSP)**, DSS re-named the initiative "**PCMH+**", to make things easier for consumers to understand, and also to avoid endorsing sugary breakfast cereals . . .



PCMH+ . . .

- is a Connecticut Medicaid initiative whose aim is to build on the success of the current Medicaid PCMH program by enabling practice transformation, care coordination capacity, and further improved health and satisfaction outcomes for Medicaid members who are served by Federally Qualified Health Centers (FQHCs) and “advanced networks”

- launched, as planned, on January 1, 2017

- is using the existing Connecticut Medicaid Person-Centered Medical Home (PCMH) initiative, under which 43% of Medicaid members are being served, as an essential building block to expand upon current practice transformation work

- builds on existing supports for members (ASO-based member services and Intensive Care Management, ICM) and providers (primary care rate increase, PCMH payments, Electronic Health Record payments, ICM)

- is using the Department's current PCMH attribution model to identify where members have sought care, and then to prospectively assign beneficiaries to PCMH+ Participating Entities for the performance year

- will continue to ensure that Medicaid members have the right to seek care from any Medicaid provider, and afford them the option to opt-out of participation in PCMH+ at any time

PCMH+ Building Blocks

PCMH+

- Enhanced care coordination activities
- Upside-only shared savings arrangements
- Use of Medicaid claims data to perform predictive modeling
- Administrative Services Organization-Based Intensive Care Management
- Person-Centered Medical Home practice transformation

- furthers the Department's interests in preventative health and advances care coordination to better support population health goals for individuals who face the challenges of substance abuse and behavioral health, limited educational attainment, poverty, homelessness, and exposure to neighborhood violence

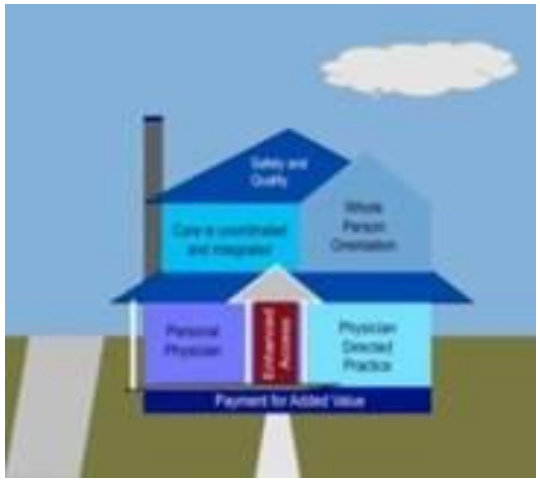
- include a package of strategies designed to prevent, detect and remedy under-service

- in addition to enabling shared savings arrangements with all Participating Entities, is making supplemental payments to participating Federally Qualified Health Centers (FQHCs) in support of enhanced care coordination activities focused upon:
  - behavioral health integration
  - cultural competency, including use of CLAS standards
  - children and youth with special health care needs
  - disability competency

See this link for more detail:
http://www.ct.gov/dss/lib/dss/pdfs/ratesetting/pcmhplus/enhanced_care_coordination_guide_11_30_16.pdf

- will make shared savings payments to all Participating Entities (both FQHCs and "advanced networks") that exceed benchmarks on a core set of measures of quality and care experience, within each Entity's savings for the performance year, if any, when evaluated against the comparison group (the **individual pool**)

- in addition to the individual pool shared savings payments described above, if the PCMH+ program overall generates savings for the performance year, DSS will make payments to entities that meet additional quality metrics (the **challenge pool**)



Person-Centered
Medical Homes

Community-based
care coordination through
expanded care team

SHARED SAVINGS

"Upside-only" arrangements in which providers that meet health and satisfaction measures and produce savings share in a portion of those savings, but do not absorb losses

PCMH+ Operational Update

PCMH+ Operational Update

All PCMH+ activities are tracking timely:

- **Model design:** In consultation with the Care Management Committee of the MAPOC, DSS has developed all major aspects of PCMH+ model design, including, but not limited to: provider qualifications, care coordination standards, quality measures, shared savings methodology, and a range of strategies designed to prevent, as well as to identify and remedy, under-service to Medicaid members

PCMH+ model design was guided by a number of important values:

1) protecting the interests of Medicaid members
2) improving overall health and wellness for Medicaid members
3) creating high performance primary care practices with integrated support for both physical and behavioral health conditions
4) building on the platform of the Department's Person-Centered Medical Home (PCMH) program, as well as the strengths and analytic capability of the Medicaid program's medical Administrative Services Organization (ASO)
5) enhancing capacity at practices where Medicaid members are seeking care, to improve health outcomes and care experience
6) encouraging the use of effective care coordination to address the social determinants of health

- All source documents are available on the face page of the MAPOC website at: https://www.cga.ct.gov/med/

- Please also see this link for the PCMH+ Request for Proposals, which includes extensive detail about PCMH+ requirements: http://www.biznet.ct.gov/SCP_Search/BidDetail.aspx?CID=40026

- **Stakeholder process:** DSS developed PCMH+ model design through monthly meetings and work group sessions, as well as subject specific webinars, with the Care Management Committee of the Medical Assistance Program Oversight Council (MAPOC)

- Materials memorializing the work of the Care Management Committee are posted monthly on the MAPOC web site at this link: https://www.cga.ct.gov/med/comm1.asp?sYear=2016

- **Issuance of procurement:** DSS' Request for Proposals for PCMH+ Participating Entities was released timely on June 6, 2016

- **Procurement results:** On October 4th, DSS extended invitations to negotiate contracts to the following entities:

  Advanced Networks: Northeast Medical Group, St. Vincent's Medical Group

  Federally Qualified Health Centers (FQHCs): Community Health Center, Inc., Cornell Scott-Hill Health Corporation, Fair Haven Community Health Clinic, Inc., Southwest Community Health Center, Generations Family Health Center, Inc., OPTIMUS Health Care, Inc., Charter Oak Health Center, Inc.

- **Contract status update:** DSS has executed contracts with **all nine** of the above-referenced entities

- **Medicaid authority:**

  - **Advance advisory process:** In early 2016, DSS launched an informal consultative process with CMS and other relevant federal agencies by circulating a detailed concept paper on PCMH+

  - **Drafting and notice of State Plan Amendment:** DSS with Mercer drafted, noticed for public comment, revised and formally submitted to CMS the required (SPA) needed to make supplemental payments (to FQHCs) and shared savings payments to eligible FQHCs and "advanced networks"

  - **Underlying authority:** The SPA relies upon primary care case management (PCCM) authority under section 1905(a)(25) of the Social Security Act

  - **CMS approval:** DSS received approval of the SPA from CMS on 2/2/17, retroactive to 1/1/17

- **Regulation:** On 1/17/17, the Department posted public notice for a proposed regulation to govern the PCMH+ program - the public comment period for the regulation is open and ends 2/17/17

- **Operational Policy:** As authorized by Conn. Gen. Stat. 17b-263, effective 1/1/17, the Department is implementing an operational policy, with the force of regulation, while the regulation is being adopted

- **Stakeholder process:**

  - **Member engagement:** In consultation with stakeholders, DSS developed a member communication that was issued in late November, 2016; a supported process for member opt-out; and member materials and information sessions

  - **Member opt-out:** Note that fewer than 2,000 individuals opted out of participation in prior to PCMH+ launch on January 1

  - **Dedicated web page:** DSS launched a PCMH+ web page: http://www.ct.gov/dss/pcmh+

- **Provider engagement:** In partnership with Mercer, DSS also developed provider materials and information sessions, which were held in December, 2016

PCMH+ overview for providers:

http://www.ct.gov/dss/lib/dss/pdfs/ratesetting/pcmhplus/pcmh_informationsession_providers_finaldraft_12_9_16update.pdf

Guide to enhanced care coordination activities:

http://www.ct.gov/dss/lib/dss/pdfs/ratesetting/pcmhplus/enhanced_care_coordination_guide_11_30_16.pdf

- **Member attribution:** CHN worked with DSS and Mercer to update Medicaid member attribution, remove individuals in excluded groups (e.g. those participating receiving long-term services and supports), and produce member attribution lists, which have been forwarded to all Participating Entities

- As of January 1, 2017, a total of **137,037 Medicaid members** were attributed to PCMH+

- **Provider portal:** attribution lists, and PCMH data, are being made available to providers through CHN's existing PCMH provider portal, available at this link: http://www.huskyhealthct.org/providers/providers_login.html

PCMH Attribution Process

Unassigned Members to a PCP/PCMH

[2] PCP Attribution Logic:

- Members new to the program or existing members not previously attributed have their claim data criteria run retro to 15 months prior to the date of the current attribution month.
- If the claim data criteria identifies a usual source of care during that time period, the member will be attributed to that PCP.
- If during this timeframe the member has seen multiple PCP's, they will be attributed to one of the PCP's using the plurality logic. The plurality logic is based on who has billed the most codes based on established claims data criteria.
- In the instance of a tie regarding the number of visits to a PCP, the PCP who has the latest preventative visit, based on date of service, will be the PCP the member is attributed to.
- If there have been no preventative visits billed by either provider, the PCP with the most recent claim (based on the claim DOS and claims data criteria[1]) would be the PCP the member is attributed to.
- If a PCP is no longer affiliated with a group, this provider is considered to be invalid by DSS and members cannot remain attributed to this PCP.
- All members attributed to this invalid PCP will be re-attributed to the group or the claims logic will look to see if a claim from another PCP has been received.
- If a claim from another PCP has been identified, the claim must have a later date of service then the previously attributed provider.

[3] Please note:
CHNCT will work directly with unassigned members to connect them with a PCP/PCMH if they come to CHNCT's attention through members services, utilization management or intensive care management.

On a monthly basis, PCP attribution reports are run by CHNCT that includes all members (new, unattributed and assigned) based on the established claims data criteria[1]

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If claims history shows claim data for a PCP/PCMH, the member will be attributed based on the PCP Attribution Logic[2]

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If a member does not have claims data matching the established criteria during the attribution run they will remain unattributed [3]

↓

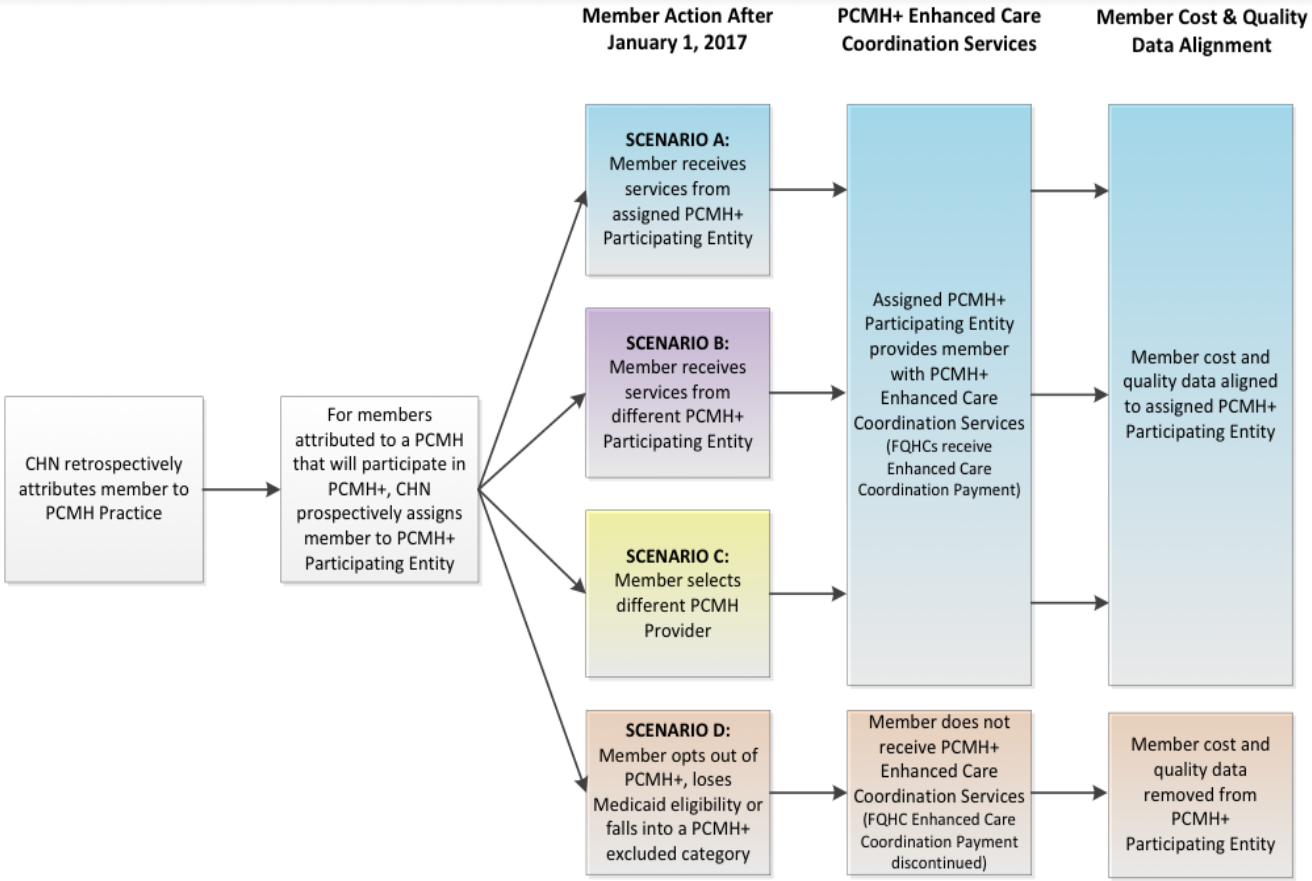
For Members who are attributed and access the secure web portal:

- Members can view their assigned PCP/ PCMH
- Providers can view their member rosters.

[1] Claims Data Criteria:
Preventative code ranges: 99381-99387 & 99391-99397
E&M code ranges: 99201-99215 & 99401-99409
Revenue codes: 510, 514, 515, 517, and 519

PCMH+ Assignment Scenarios

ctmail.ct.gov



PCMH+ Member Attribution by Participating Entity

Participating Entity Name	TIN Name	Attributed Members
Northeast Medical Group AN	NORTHEAST MEDICAL GROUP	7,509
St. Vincent's AN	FAMILY PRACTICE GROUP OF MIDDLESEX HOSPITAL	1,627
St. Vincent's AN	MILFORD PEDIATRIC GROUP	4,465
St. Vincent's AN	WESTERN CONNECTICUT MEDICAL GROUP	4,155
St. Vincent's AN	PULMONARY & INTERNAL MEDICINE OF FAIRFIELD COUNTY PC	59
St. Vincent's AN	GRIFFIN FACULTY PRACTICE	2,087
St. Vincent's AN	MHS PC INC	3,300
St. Vincent's AN	DRS GOLDFARB, RANNO AND ASSOCIATES LLC	280
St. Vincent's AN	ST. VINCENT'S MULTISPECIALTY GROUP INC	2,113
Fair Haven Community Health Center	FAIR HAVEN COMMUNITY HEALTH CENTER	7,811
Cornell Scott-Hill Health Center	CORNELL SCOTT- HILL HEALTH CENTER	13,781
Generations Family Health Center	GENERATIONS FAMILY HEALTH CENTER INC	8,000
Southwest Community Health Center, Inc.	SOUTHWEST COMMUNITY HEALTH CENTER INC	8,299
Community Health Center, Inc.	COMMUNITY HEALTH CENTER INC	44,917
Optimus Health Care, Inc.	OPTIMUS HEALTH CARE INC	21,304
Charter Oak Health Center	CHARTER OAK FAMILY HEALTH CENTER	7,330
	TOTAL	**137,037**

Please note that members served under the following are not eligible for PCMH+ and were excluded from attribution: 1915(c), 1915(k),1915(i); Money Follows the Person, HUSKY B, dual eligible Members, nursing facility, limited benefit, state-funded, hospice, behavioral health home

PCMH+ Next Steps

- Continued development of **under-service strategies**

- **PCMH+ Wave 1 assessment**:
  - Desk reviews
  - Quantitative data review
    - Member complaints
    - Member opt-outs
    - PCMH provider performance reports
    - LexisNexis health disparity reports
  - Input from key stakeholders

PCMH+ Next Steps

- For detail on evaluation, please see these documents:

PCMH+ Underservice Strategy Summary (February, 2017)

https://www.cga.ct.gov/med/committees/med1/2017/0223/20170223ATTACH_PCMH%20Plus%20Underservice%20Strategy%20Summary%20.pdf

HUSKY Health Quality Measures and Performance Results (February, 2017)

https://www.cga.ct.gov/med/council/2017/0210/20170210ATTACH_Health%20Quality%20Measures%20and%20Performance%20Results%20Presentation.pdf

Questions or comments?

Appendix
HUSKY Health:
Context
Past, Present and Future At A Glance

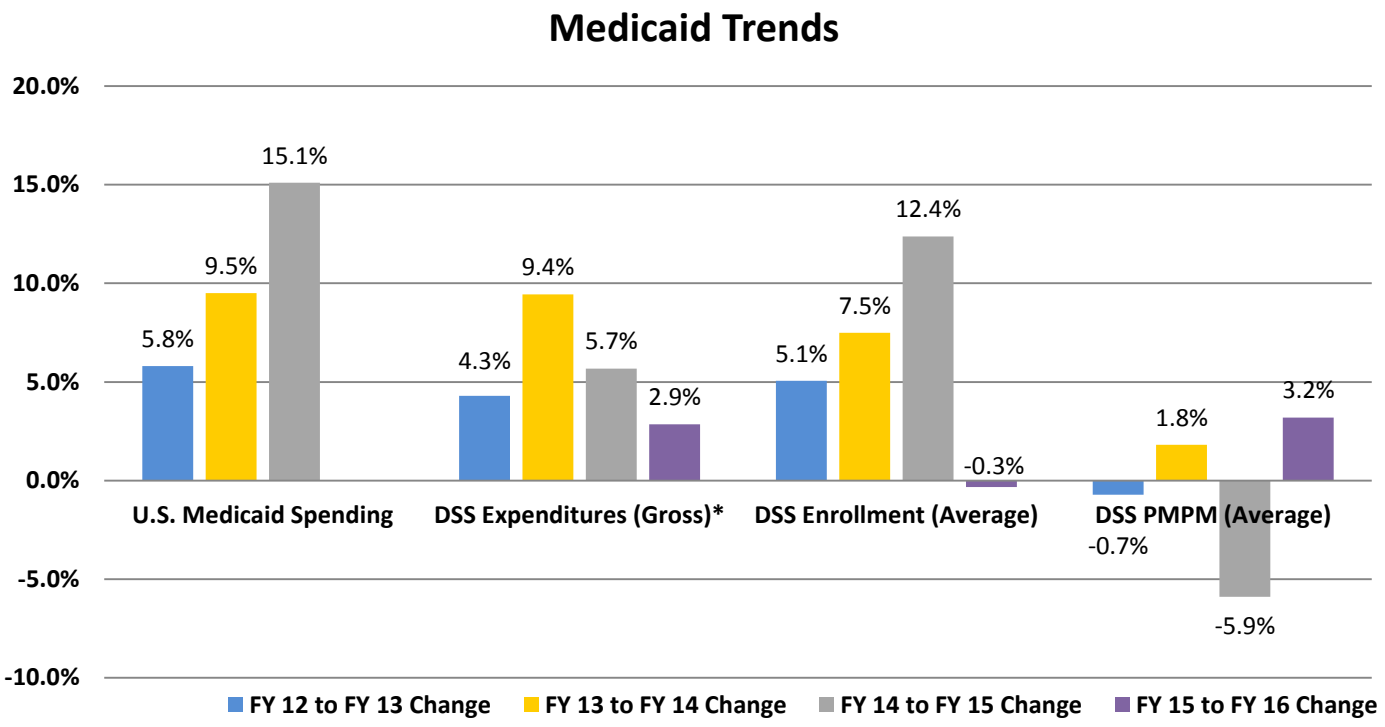
Context

Person-Centered Medical Home Initiative:

- As of February, 2017, **112 practices** (representing **464 sites** and **1,620 providers**) were participating

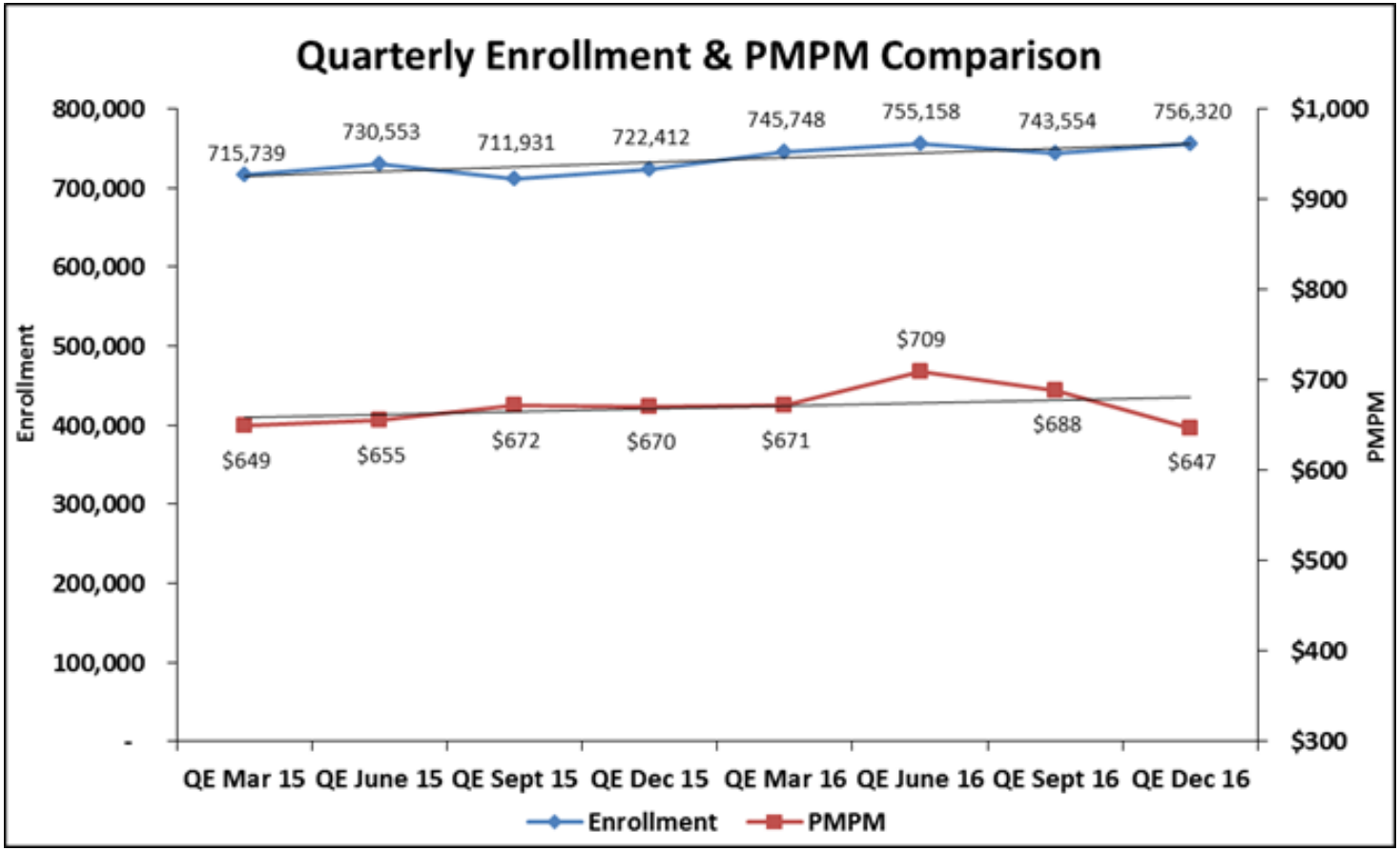
- These practices are serving **327,916 Medicaid members** – **over 43%** of all members

Comparison with National Trends



** Expenditures are net of drug rebates and include DMHAS' behavioral health costs claimable under Medicaid. This depiction **includes** all hospital supplemental and retro payments.*

Enrollment and PMPM



Expenditures have increased proportionate to the increase in enrollment, but per member per month costs have remained remarkably steady.

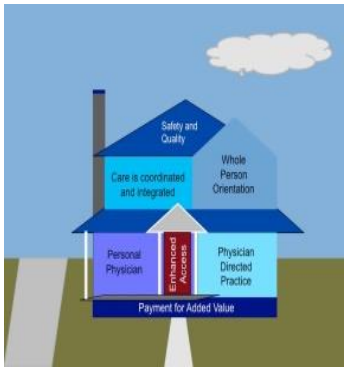
Past, Present and Future at a Glance

Past, Present and Future

	Past	Present	Future
Administrative/ financial model	A mix of risk-based managed care contracts and central oversight	Self-insured, managed fee-for service model; contracts with four Administrative Services Organizations (ASOs)	Self-insured, managed fee-for-service model that incorporates health neighborhoods and Value-Based Payment (VBP) approaches
Financial trends	Double digit year-over-year increases were typical	Overall expenditures are increasing proportionate to enrollment; per member per month spending is trending down	Quality-premised VBP strategies will enable further progress on trends
Data	Limited encounter data from managed care organizations	Fully integrated set of claims data; program employs data analytics to risk stratify and to make policy decisions	Data match across human services and corrections data sets will enable more intelligent policy making

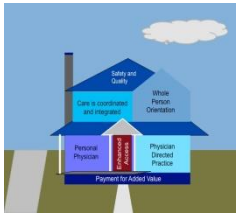
	Past	Present	Future
Member experience	Members had different experiences depending on which MCO oversaw their services; MCOs relied upon traditional chronic disease management strategies	ASOs provide streamlined, statewide access points and Intensive Care Management; PCMH practices enable coordination of primary and specialty care; health homes enable integration of medical, behavioral health and social services	Health neighborhoods will address both health needs and social determinants of health (e.g. housing stability)
Provider experience	Provider experience varied across MCOs; payment was often slow or incomplete	ASOs provide uniform, statewide utilization management and ICM; providers can bill on a bi-weekly basis	Consideration of migration to health neighborhood self-management of provider relationships

HUSKY Health 2017 and ongoing



Health neighborhoods composed of PCMH practices, specialties, CHWs and non-medical services and supports

Development of additional value-based payment strategies



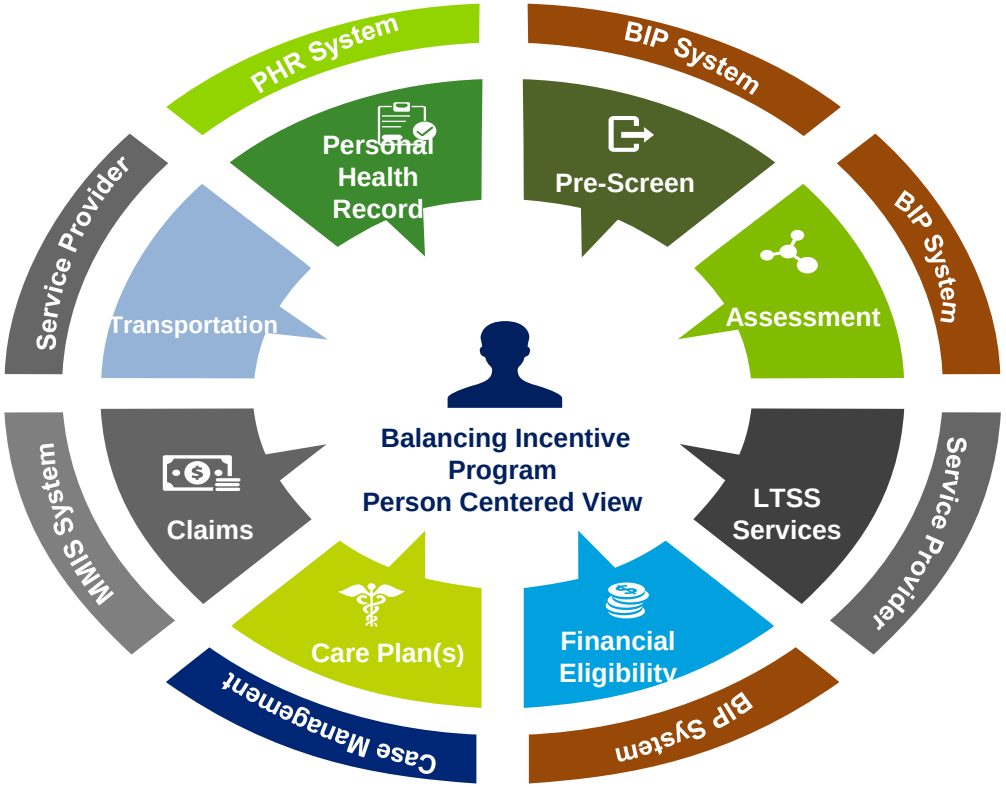
PCMH enhanced fees and performance payments

OB P4P

PCMH+

Shared savings arrangements

Episodes of care



Achievement of a person-centered, integrative, rebalanced system of long-term services and supports

HUSKY HEALTH CONNECTICUT