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PARTICIPATION OF NON-DSS PCMH PRIMARY CARE PRACTICES IN MQISSP ADVANCED NETWORKS

January 13, 2016

Section 1: Introduction

The State of Connecticut Department of Social Services (DSS) is developing a new, upside-only shared savings initiative titled the Medicaid Quality Improvement and Shared Savings Program (MQISSP). Through MQISSP, DSS will procure qualified Participating Entities, Advanced Networks, and Federally Qualified Health Centers (FQHCs) to improve the quality, efficiency, and effectiveness of care, with an opportunity to share in Medicaid savings. MQISSP builds on the existing successful DSS Person-Centered Medical Home (PCMH) program.

DSS, with input from the Council on Medical Assistance Program Oversight Care Management Committee (the Committee), has developed requirements for FQHCs and Advanced Networks to participate in MQISSP, including requirements for Advanced Network composition. At its December 2015 meeting, the Committee continued discussion of this design element, particularly regarding the participation of primary care practices in Advanced Networks. The purpose of this paper is to provide additional information and analysis to support continued discussion of this issue.

Section 2: Background and Issue

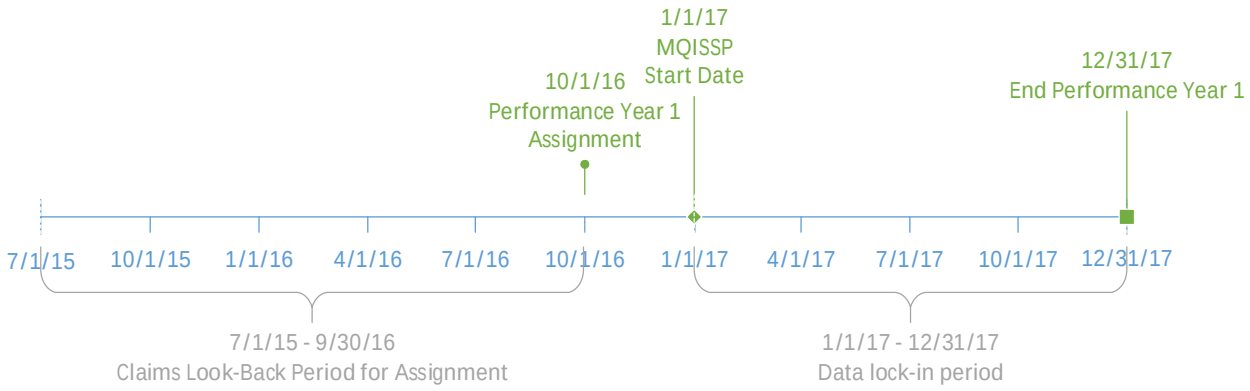
To participate in MQISSP, Advanced Networks must include a practice that is currently participating in the DSS PCMH program and holds PCMH certification/recognition by the National Committee for Quality Assurance (NCQA) or The Joint Commission. In addition to a DSS PCMH practice, Advanced Networks are encouraged to include additional providers (primary care practices, behavioral health providers, specialists, hospitals, etc.).

Beneficiaries will be prospectively assigned to the DSS PCMH practice(s) in Advanced Networks on the basis of DSS' existing PCMH retrospective attribution methodology, which may be adapted for MQISSP. While Advanced Networks are encouraged to include other providers, only beneficiaries assigned to the DSS PCMH practice(s) will be included for the purpose of MQISSP quality measure reporting and shared savings calculations.

Beneficiary assignment will occur once a year prior to the start of the next MQISSP performance year. There will be no reassignment of MQISSP Members (Members) during performance years, with the exception of Members who opt out of the MQISSP program. Beneficiaries will be assigned to DSS PCMHs based on their active choice of provider (i.e., usual source of care), as determined by a 15 month look-back of the beneficiary's claims history. For the MQISSP performance year starting January 1, 2017, the assignment will occur on October 1, 2016, and will be based on the beneficiary's usual source of care between July 1, 2015 and September 30, 2016. For the second MQISSP performance year starting January 1, 2018, the

assignment will occur on October 1, 2017, and will be based on the beneficiary's usual source of care between July 1, 2016 and September 30, 2017.

Figure 1. MQISSP Assignment Timeline for Performance Year 1



MQISSP Members will retain the ability to choose to see any qualified Medicaid provider. However, if a Member leaves a DSS PCMH practice to receive care at another primary care practice, the member's quality and cost data will still be included in the Participating Entity's shared savings calculations until the next year's assignments are made. The purpose of this design is to encourage practices to retain Members. However, if a Member chooses to opt-out of the MQISSP program entirely, the Member's cost and quality data will be removed from the Participating Entity's data.

The primary issue voiced by advocates is that the opportunity of shared savings may encourage DSS PCMH providers to shift high cost or clinically complex Members out of the Participating Entity or to a non-DSS PCMH primary care practice within the Participating Entity in an effort to drive additional savings.

Section 3 of this paper details design elements that seek to mitigate this concern.

Section 3: MQISSP Design Elements to Address Panel Manipulation

Several MQISSP design elements seek to reduce incentives for DSS PCMHs to negatively manipulate their panels to optimize their potential shared savings:

- The high cost claims truncation process removes costs above a threshold associated with an outlier or high cost claims from the shared savings calculation. This process ensures that Participating Entities are not disadvantaged by Members that may have outlier or high cost claims.
- The retrospective claims look-back process used for prospective assignment ensures that Members are allowed to "choose with their feet" before they are assigned to a DSS PCMH.

- If a DSS PCMH were to attempt to move a member out of the Participating Entity or to a non-PCMH primary care practice within the Participating Entity during the retrospective attribution period, it would have to do so early enough to ensure that the plurality of visits during the claims look-back period are with the new provider. Sophisticated claims analysis tools and processes at the practice level would be needed to perform this type of Member movement (which most providers do not have).
- Member quality and claims data stays with the assigned DSS PCMH, regardless of change in primary care provider during the performance year. Once a Member has been assigned, there would be no benefit for a DSS PCMH to shift the Member outside of the Participating Entity or to a non-DSS PCMH primary care provider as the cost and quality performance data associated with that Member would remain with the Participating Entity.
- DSS will monitor claims data for atypical Member movement.
- DSS will conduct secret shopper surveys targeting Members to identify negative experiences with the program, including involuntary movement to other providers.

DSS could deploy several additional strategies to further mitigate any negative panel manipulation impacting the second MQISSP performance year (starting January 1, 2018):

- The contract with MQISSP Participating Entities could include provisions related to prohibition of involuntary Member movement or encouraging members to change providers except as medically necessary.
- Prior to Member assignment for the second MQISSP performance year, DSS could review the data for any atypical Member movement.
- DSS could conduct a Member survey (in addition to the secret shopper surveys) to determine if any Member was involuntarily moved out of the Participating Entity or to a non-DSS PCMH primary care practice within the Participating Entity.

Section 4: Additional Design Options

If DSS seeks to restrict participation of non-DSS PCMH primary care practices in an Advanced Network, the following options have been considered:

1. All primary care practices in Advanced Networks must be DSS PCMHs at the time of the Advanced Network's response to the MQISSP request for proposal (RFP).

This option would require any non-DSS PCMH primary care practice in a proposed Advanced Network to be a participant in the DSS PCMH program. Under this option, all MQISSP Members would be served by DSS PCMHs (because only DSS PCMHs have attributed Members, and all primary care practices would be DSS PCMHs) with the requisite baseline coordination of care competencies to effectively provide the MQISSP enhanced care coordination activities. However, as noted above, Members would retain the ability to seek care from other primary care providers if they choose. Because this option has the potential to limit provider participation in the RFP, DSS is not considering this a viable option at this time.

2. All non-DSS PCMH primary care practices in Advanced Networks must become DSS PCMHs within 12–18 months of the RFP award.

Under this option, DSS would allow Advanced Networks to include non-DSS PCMH practices but would set a deadline (e.g., 12–18 months) by which all primary care practices in the Advanced Network must become DSS PCMHs. If all primary care practices in an Advanced Network do not become DSS PCMHs within the allotted timeframe, DSS could prohibit the Advanced Network from sharing in any savings achieved for that performance year. Or, DSS could require that the Advanced Network exit MQISSP and re-apply when all its primary care practices are DSS PCMHs.

However, Community Health Network of Connecticut has indicated that most practices need between six months and two years to reach a point where focused transformation can begin. The particular nature of ramp-up activities varies by practice, but could include gap analyses to implement changes to processes, policies, and documentation. An Advanced Network may need more than 12–18 months to meet the requirement that all primary care practices become DSS PCMHs. Furthermore, these timeframes may be extended based on recent updates to NCQA PCMH standards.

3. Non-DSS PCMH primary care practices can participate in Advanced Networks, but these practices cannot receive a portion of the savings achieved by the Advanced Network.

Under this option, all primary care practices would not be expected to become DSS PCMHs (although they would not be prevented from doing so if they choose). However, these practices could not receive any shared savings that the Advanced Network achieves.

4. Non-DSS PCMH primary care practices may participate in Advanced Networks, but DSS would expect these practices to be on the glide path or moving towards the glide path to PCMH certification/recognition.

Under this option, DSS would expect all non-DSS PCMH practices to move towards PCMH certification/recognition, but would not implement a deadline for achieving this milestone (as in option #2).

Section 5: Conclusion

The MQISSP design includes elements that mitigate any potential adverse panel manipulation to optimize potential shared savings. Several additional strategies are also available and could be deployed to prevent panel manipulation affecting the second performance year. Additional options are available if DSS chooses to restrict the participation of non-DSS PCMH primary care practices in Advanced Networks.