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PCMH+ UNDERSERVICE STRATEGY SUMMARY

February 23, 2017
Draft and Subject to Revision

Background Information

The Connecticut Department of Social Services (DSS) has developed a multi-faceted strategy that represents the Department's best efforts to identify, remediate, and mitigate the potential for underservice of members within the Person Centered Medical Home (PCMH+) program. DSS, in partnership with Mercer and the Community Health Network of Connecticut (CHN), conducted an extensive environmental scan of underservice strategies research which demonstrated limited results. The environmental scan evaluated national delivery models, MassHealth's ACO design[1], MAPOC Complex Care Committee's Underservice Workgroup recommendations[2], and input from program stakeholders[3] to support a methodology to monitor and identify instances of systematic underservice of members by PCMH+ participating entities (PEs) regardless of intentionality.

DSS also recognizes that the best evaluation of the PCMH+ program will come from the members it serves. Members' voices, experiences, and outcomes will showcase the successes of PCMH+ as well as areas needing improvement. The researched delivery models identified target areas for monitoring including service utilization, robust appeals and grievances processes, members' choice of provider, member engagement, and patient centered quality measures which provided a foundation from which to build. PCMH+ seeks to expand these protections to ensure member experiences and outcomes are protected.

In addition to the Connecticut Medicaid program's fee-for-service payment structure that offers disincentives for providers to underserve members, this document summarizes the various initiatives that DSS is utilizing to ensure that Medicaid member quality of care and access to medical care is not adversely affected as a result of the PCMH+ program.

PE-driven Member Protections

- DSS conducted two PE-driven information sessions informing PEs of DSS' oversight activities and the consequences of systematic underservice.
- PEs will host community information session as well as participate in PE learning collaboratives.
- PE oversight bodies must include substantial representation by PCMH+ Members assigned to the PCMH+ Participating Entity.
- PE oversight bodies will monitor PE activity throughout the program.
- PEs found to have systematically underserved members will be disqualified from receiving shared savings if they demonstrate repeated or systematic failure to offer medically necessary services or manipulate their member panel, whether or not there is evidence of intentionality.
- All PE savings will be distributed based on meeting and exceeding quality thresholds.
- Shared savings distribution plans cannot award individual providers for cost savings.

[1] https://www.hcfama.org/sites/default/files/hcfa_comments_to_masshealth_on_aco_design_12.16.15.pdf.
[2] https://www.cga.ct.gov/med/committees/med2/2014/0725/20170725ATTACH_Underservice%20monitoring%20reccomendations%207.20.14%20final.docx.
[3] https://www.cga.ct.gov/med/committees/med2/2014/1024/20141024ATTACH_under%20service%20priority%20survey%20results.pdf.

DSS Utilization Report Monitoring

DSS has worked with CHN to develop a series of targeted utilization reports to monitor trends for specific services and benefits within the program to identify shifts in service utilization within the population. PCMH+ utilization monitoring reporting includes high cost medications and implantable devices or other equipment. The following represents some of the areas being developed:

- Hepatitis C
- HIV
- Depression
- Multiple Sclerosis or Rheumatoid Arthritis
- Opioid dependence
- Sleep apnea

In addition, Mercer will also monitor and analyze the following:

- Member movement across and out of the program.
- Changes in PEs' aggregate risk scores.
- Identification of patterns of variation (e.g., aggregate member cost analysis, cost of care by service type, etc.).

Member-specific Protections

- Members elect their PCMH+ PE via the PCMH attribution process.
- Members' freedom of provider choice remains, regardless of their assigned PE.
- DSS held member education opportunities via welcome letters and information sessions.
- Members are not locked into the program and can withdraw at any time.
- The Wave I program review will gather feedback directly from members.
- The program will not add any layer to the grievance reporting process.
- Members are able to openly file complaints to CHN, DSS, and/or Xerox.
- The program includes specific policies for ensuring continuity of care among the existing Intensive Care Management and PCMH programs.

Quality Measure Protections

Of the 27 quality measures included in the PCMH+ program, 21 are considered underservice monitoring measures. In particular, the PCMH CAHPS measure should provide member-centric data points on members' access to care and satisfaction with providers.

Actuarial Protections in the Shared Savings Calculation Methodology

- The program is an upside risk only model with a 10% savings cap.
- Every dollar saved must go through a quality gate to be captured by a PE.
- The sliding scale scoring system for two of the three quality scoring components decreases the risk of "all or nothing" savings targets.
- PEs are rewarded for improving cost performance year over year compared to the comparison group trend instead of a fixed cost target.
- PEs are allowed to participate in the Challenge Pool regardless of their saved amounts.
- Risk adjustment deters targeted utilization changes of the more acute populations.
- High-cost claims truncation provides protection against outlier and high-cost members.
- Comparison group analysis provides identification of abhorrent cost or utilization changes.