Value-Based Payment Reform Academy:
State Strategies to Calculate and Analyze Total Cost of Care as part of FQHC Value-based Purchasing Initiatives

For audio, please dial:
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Access Code: 5077594

June 25th, 2018
3:00-4:00pm ET

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Logistics

- Phone lines will be unmuted during the Q&A period. During that time please mute your own lines except when speaking.
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1. Introduction

2. *Presentation*: Overview of Calculating and Analyzing TCoC

3. *Presentation*: FQHCs and Value-Based Payments: Connecticut Medicaid’s HUSKY Health PCMH+ Program

4. Question & Answer

5. Wrap up and evaluation reminder
Today’s Speakers

**Kevin Quinn**
Senior Health Economist, Clinical and Economic Research, 3M Health Information Systems Inc.

**Dr. Robert Zavoski**
Medical Director, Connecticut Department of Social Services

**Nicole Godburn**
Fiscal Administrative Officer, Connecticut Department of Social Services
State Strategies to Calculate and Analyze Total Cost of Care as Part of FQHC Value-based Purchasing Initiatives

Discussion with National Academy for State Health Policy
June 25, 2018
Total Cost of Care vs *Avoidable* Cost of Care

Key prerequisites:
- A feasible method exists to assign patients to specific FQHCs
- Eligibility and utilization data are accurate, reasonably timely, and available
- Medicaid agency has or can obtain flexibility in payment arrangements to FQHCs

Key assumption: Good primary care can reduce improve patient population health status and reduce avoidable cost of care

Key goal: Create a virtuous circle by redeploying savings from reduced utilization into higher FQHC payments and better primary care

Key implications for focus:
- Initiatives that save money
- Initiatives that improve health
- Utilization that is potentially avoidable
- Utilization that FQHCs can influence
- Enabling actionable data to plans and providers
## Paying for Outcomes: 8 Principles for Success

1. Focus initially on outcomes where quality failure results in increased payment
2. Financial incentives must be substantial enough to motivate change
3. Efforts should focus on outcomes that are amenable to improvement
4. P4O outcome standards should be empirically derived, reflecting performance levels achieved by the best providers
5. P4O should not mandate specific processes. Providers are better judges.
6. Financial incentives should reflect outcome performance for a provider’s patient population overall, not individual cases
7. Risk adjustment is almost always essential for fairness
8. P4O methods must be transparent, clinically precise, and comprehensive

Implications for Focus

Potential Areas for FQHC Focus

- Many hospital admissions
- Many ER visits
- Many hospital readmissions
- Certain outpatient services
- Specialist services??

Costly, with significant potential savings
Primary care has impact
Measurement methods exist
Evidence and models from Medicaid
Significant benefit for patients

Not Potential Areas for FQHC Focus

- Many hospital admissions (90%?)
- Many ER visits
- Many hospital readmissions (30%)
- Admissions to long-term care
- Prescription drug cost
- Primary care visits

Use is appropriate -- and/or --
Hard to measure avoidable use in defensible way -- and/or --
Not a lot of potential savings -- and/or --
Primary care has minimal influence
Potentially Avoidable Hospital Admissions

- Amenable to reduction with better primary care, medication adherence, patient education, remote monitoring, etc.
- Measures:
  - AHRQ Patient Quality Indicators (aka ambulatory care sensitive conditions)
  - 3M Potentially Preventable Admissions
  - State-defined lists
- In an all-payer analysis of 502,238 inpatient stays, Minnesota found 49,498 stays (11%) were potentially preventable*
- Reduction efforts in Texas Medicaid likely contributed to 9,800 fewer PPA visits than expected in 2015**

Top 10 Reasons for Potentially Preventable Admissions in Florida Medicaid

**Millwee B, Goldfield N, Turnipseed J. Achieving improved outcomes through value-based purchasing in one state. American Journal of Medical Quality. 2017;33(2)
Potentially Avoidable ER Visits

- Amenable to reduction with nurse call lines, expanded primary care hours, post-visit follow-up calls, better primary care, medication adherence, etc.
- Measures:
  - NYU ED algorithm
  - 3M Potentially Preventable (ER) Visits
  - State-specific lists
- In an all-payer analysis of 1.8 million ER visits, Minnesota found 1.2 million (66%) were potentially preventable*
- Reduction efforts in Texas Medicaid likely contributed to 33,000 fewer ER visits than expected in 2015*


Source: Rhode Island Department of Health, Potentially Preventable Emergency Room Visits. http://health.ri.gov/data/potentiallypreventableemergencyroomvisits/. Visits that result in inpatient admission are not considered potentially preventable.
Potentially Avoidable Readmissions

- Amenable to improvement by scheduling post-discharge primary care visits, follow-up calls 2-3 days after discharge, advising FQHC of admission and discharge, etc.
- Reductions of approx. 20% are possible with sustained effort over several years
- Measures:
  - Medicare readmission measure
  - Other all-cause measures
  - 3M Potentially Preventable Readmissions

Reduced Rates of Potentially Preventable Readmissions in Minnesota (All Payer)

Top 10 DRGs in Terms of Total PRRs, Texas Medicaid

- 753 Bipolar Disorders
- 750 Schizophrenia
- 751 Maj Depression
- 540 Cesarean Delivery
- 560 Vaginal Delivery
- 194 Heart Failure
- 140 COPD
- 662 Sickle Cell Anemia Crisis
- 720 Septicemia & Disseminated Infections
- 420 Diabetes

Sources:
Risk Adjustment Is Essential

- The incidence of potentially preventable events varies a lot by baseline health status

- In Mississippi Medicaid, people in CRG health status 7 had almost 20 times more potentially preventable admissions than people in CRG health status 2
  - CRG = 3M Clinical Risk Group

- For fairness and accuracy, measurement must take into account differences in casemix across FQHC populations

Risk Adjustment and Shared Savings in FQHCs

1. Measure actual rates of a PPE by FQHC
2. Measure average casemix of each FQHC’s patient population using a population risk adjustor
3. Calculate expected rates of PPEs for the FQHC after casemix adjustment
4. Calculate actual/expected ratios for the FQHC
5. Set a target. Examples:
   1. Performance year to year
   2. Performance relative to peers
   3. Performance relative to a standard
6. Determine shared savings formula
7. Provide actionable data to FQHCs

Appendix
3M Health Information Systems

1. Over $200 billion a year
   Clinical classification methods developed by 3M are used to pay more than $200 billion/yr to providers by Medicare, Medicaid, and commercial payers.

2. Widely used by payers
   APR DRGs used for inpatient payment in 33 states; EAPGs used for outpatient payment in 16 states (Medicaid and/or Blue Cross Blue Shield).

3. Leader in health care information
   Industry leader for coding, classification and payment systems used by CMS, MedPAC, 38 states, 200 payers, 80% of U.S. hospitals.

4. Quality measures used in 16 states
   - Public reporting and value based purchasing
   - Reductions in potentially preventable ER visits, admissions, readmissions, complications

5. Primary ICD-10 contractor
   - Developed ICD-10 Procedure Coding System
   - Primary CMS contractor for payment aspects of ICD-10 conversion for most provider types

6. Population and Payment Solutions
   - Process payer claims through 3M methodologies for 45 million lives a month
   - Deep consulting expertise in 3M methodologies

7. 4,000+ customers in 25 countries
   - 3M groupers used in Belgium, Spain, 6 others
   - 3M provides grouping and coding tools to 4,000+ payers and providers in 25 countries (outside U.S.)

3M Confidential.
## Methodologies to Define the Products of Health Care for Insight, Risk Adjustment, and Payment

<table>
<thead>
<tr>
<th>Methodology</th>
<th>Unit of Analysis</th>
<th>Can Be Used To Pay</th>
<th>Incorporates</th>
</tr>
</thead>
<tbody>
<tr>
<td>APR DRG</td>
<td>All Patient Refined Diagnosis Related Groups</td>
<td>Inpatient admission</td>
<td>Inpatient hospital</td>
</tr>
<tr>
<td>EAPG</td>
<td>Enhanced Ambulatory Patient Groups</td>
<td>Outpatient visit (physician, hospital, etc.)</td>
<td>Outpatient hospital, ASC</td>
</tr>
<tr>
<td>FSG</td>
<td>Functional Status Groups</td>
<td>Eligible person</td>
<td>MCOs, LTSS providers*</td>
</tr>
<tr>
<td>CRG</td>
<td>Clinical Risk Groups</td>
<td>Eligible person</td>
<td>MCOs, ACOs</td>
</tr>
<tr>
<td>PFE</td>
<td>Patient Focused Episodes</td>
<td>Episode of care</td>
<td>MCOs, ACOs, hospitals, physician groups</td>
</tr>
</tbody>
</table>

## Methodologies to Measure Quality for Public Reporting, Payment Adjustment, and Quality Improvement

<table>
<thead>
<tr>
<th>Methodology</th>
<th>Unit of Analysis</th>
<th>Measures Quality Of</th>
<th>Clinical Risk Adjustor</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPC</td>
<td>Potentially Preventable (Inpatient) Complications</td>
<td>Inpatient admission by APR DRG</td>
<td>Inpatient care</td>
</tr>
<tr>
<td>PPR</td>
<td>Potentially Preventable Readmissions</td>
<td>Inpatient admissions by APR DRG</td>
<td>Inpatient care, MCO, primary care providers</td>
</tr>
<tr>
<td>PPA</td>
<td>Potentially Preventable (Hospital) Admissions</td>
<td>Inpatient admission by APR DRG</td>
<td>MCO, primary care providers, LTSS providers</td>
</tr>
<tr>
<td>PPV</td>
<td>Potentially Preventable (ER) Visits</td>
<td>Emergency room visit by EAPG</td>
<td>MCO, primary care providers, LTSS providers</td>
</tr>
<tr>
<td>PPS</td>
<td>Potentially Preventable (Outpatient) Services</td>
<td>Tests and procedures by EAPG</td>
<td>MCO, physicians, other professionals</td>
</tr>
<tr>
<td>ROM</td>
<td>Risk of Mortality</td>
<td>Inpatient admission by APR DRG</td>
<td>Inpatient care</td>
</tr>
</tbody>
</table>

MCO=managed care organization. LTSS=long term services and supports, such as nursing facility and home and community based care. ASC=ambulatory surgical center. ACO=accountable care organizations and similar entities.

"Potentially Preventable Events (PPEs)" comprise PPRs, PPCs, PPA, PPVs, PPSs

"Population Focused Preventables" comprise PPAs, PPVs, PPSs

* Functional status groups must be combined with Clinical Risk Groups to analyze or pay MCOs and LTSS providers
Suggested References

Copies available from kquinn@mmm.com


Acronyms

- A / E: Actual rate divided by expected rate, e.g., 20 actual events divided by 16 expected events => A / E = 1.25
- CMS: Centers for Medicare and Medicaid Services
- CRG: 3M Clinical Risk Group
- ER: Emergency room
- HEDIS: Healthcare Effectiveness Data and Information Set
- LTSS: Long-term services and supports
- MCO: managed care organization
- PMPM: per member per month
- PPA: 3M Potentially Preventable (Inpatient) Admission
- PPE: 3M Potentially Preventable Events
- PPR: 3M Potentially Preventable Readmission
- PPV: 3M Potentially Preventable ER Visit
For More Information

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FQHCs and Value-Based Payments
Connecticut Medicaid’s HUSKY Health PCMH+ Program

National Academy for State Health Policy

Robert Zavoski, MD, MPH - Medical Director
Nicole Godburn, MBA – Fiscal Administrative Officer
Connecticut Department of Social Services
June 25, 2018
Connecticut Medicaid/HUSKY Health – Context:
  • Program structure
  • Platform of success in primary and preventive care

How/why we arrived here:
  • PCMH Program
  • Intensive care management
  • Data/analytics

PCMH+
  • Program structure
  • Evaluation
By contrast to most other states, Connecticut is not using capitated managed care arrangements for its medical, behavioral health and dental services.

Like most large employers (and for the same reasons), HUSKY Health is self-insured and contracts with Administrative Services Organizations (ASOs) to administer parts of our program.

A simplified, streamlined, statewide structure, rates, and policies enable a “one call does it all” approach and ensures lean administrative costs of only 3.2%.
HUSKY Health . . .

is continuously improving health and care experience outcomes and effectively controlling costs through a range of strategies (Person-Centered Medical Homes, Intensive Care Management, behavioral health community care teams), emphasizing:

*the right care at the right time in the right setting . . .*
HUSKY Health touches everyone.

1 in 4 Connecticut children. 1 in 2 Connecticut births.
Working families and individuals.
Older adults. People with disabilities.
Your neighbor. Your cousin. Your friend.
Connecticut’s past and present. And most important, its future.
How/Why Did We Arrive Here?
On a foundation of Person-Centered Medical Homes, ASO-Based Intensive Care Management (ICM), Pay-for-Performance (PCMH, OB), and Data Analytics/Risk Stratification, we are building in Community-based care coordination through expanded care team (health homes, PCMH+) and Supports for social determinants (ICM, transition/tenancy sustaining services, interventions for childhood trauma). With the desired result of creating Multi-disciplinary (medical, behavioral health, dental services; social supports) health neighborhoods.
PCMH+

- Shared Savings arrangement involving “participating entities” selected via a public procurement:
  - FQHCs
  - ‘Advanced Networks’
- Advanced payments are provided to FQHCs
- PEs are expected to
  - Provide enhanced care coordination
  - Provide enhanced services to special populations
  - Improve their performance on selected quality measures

In order to be eligible to share in potential savings.
Relationship to PCMH Initiative
PCMH+ is using the existing Connecticut Medicaid Person-Centered Medical Home (PCMH) initiative, under which 45% of Medicaid members are being served, as an essential building block to expand upon current practice transformation work.
From a practical standpoint:

- Community Health Network of Connecticut (CHNCT) provides practice transformation support to practices that are participating in the Connecticut Medicaid PCMH program

- See this link for detailed information on the PCMH program:

  http://www.huskyhealthct.org/providers/pcmh.html#
Connecticut Medicaid PCMH program non-FQHC practices are continuing to receive enhanced fee-for-service payments and also are eligible for performance and year-over-year improvement payments on a range of established quality measures.

See this link for 2016 quality measures:

PCMH has also illustrated where PEs have opportunities to improve quality.
### PCMH Practice Setting Results Comparison

**CY 2014 vs. CY 2015**

<table>
<thead>
<tr>
<th>Health Quality Measures - Higher Rate Indicates a Better Result</th>
<th>CY 2014 Admin Rate</th>
<th>CY 2015 Admin Rate</th>
<th>Rate Difference</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma Medication Ratio</td>
<td>63.3%</td>
<td>67.8%</td>
<td>4.5%</td>
<td>7.1%</td>
</tr>
<tr>
<td>Adolescent Well Care Visits&lt;sup&gt;1&lt;/sup&gt;</td>
<td>70.9%</td>
<td>70.8%</td>
<td>-0.1%</td>
<td>-0.2%</td>
</tr>
<tr>
<td>Behavioral Health Screening (Ages 1-17)&lt;sup&gt;2,3&lt;/sup&gt;</td>
<td>N/A</td>
<td>23.9%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - Eye Exam&lt;sup&gt;1&lt;/sup&gt;</td>
<td>54.6%</td>
<td>54.2%</td>
<td>-0.4%</td>
<td>-0.8%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - Hemoglobin A1c (HbA1c) Testing&lt;sup&gt;1&lt;/sup&gt;</td>
<td>87.9%</td>
<td>87.0%</td>
<td>-0.9%</td>
<td>-1.0%</td>
</tr>
<tr>
<td>Medication Management for People with Asthma</td>
<td>44.9%</td>
<td>43.6%</td>
<td>-1.3%</td>
<td>-2.9%</td>
</tr>
<tr>
<td>Post-Admission Follow-Up within Seven Days of an Inpatient Discharge (Physical Health and Behavioral Health)</td>
<td>44.7%</td>
<td>47.3%</td>
<td>2.5%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Well-Child Visits in the First 15 Months of Life - 6 or More Visits&lt;sup&gt;1&lt;/sup&gt;</td>
<td>80.7%</td>
<td>82.8%</td>
<td>2.1%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life&lt;sup&gt;1&lt;/sup&gt;</td>
<td>85.9%</td>
<td>86.4%</td>
<td>0.4%</td>
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<tr>
<td>Ambulatory Care - ED Visits per 1000 MM</td>
<td>63.70</td>
<td>60.88</td>
<td>-2.8</td>
<td>-4.4%</td>
</tr>
<tr>
<td>Asthma Patients with One or More Asthma-Related Emergency Room Visits (Ages 2-20)</td>
<td>7.8%</td>
<td>7.0%</td>
<td>-0.8%</td>
<td>-10.2%</td>
</tr>
<tr>
<td>Readmissions within 30 Days - Physical Health Only</td>
<td>9.90%</td>
<td>9.91%</td>
<td>0.0%</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

<sup>1</sup> Hybrid measure reported using only administrative data.

<sup>2</sup> New DSS custom measure starting in CY 2015.

<sup>3</sup> CY 2015 uses screening procedure codes 96110 and 96127. Prior to CY 2015 only procedure code 96110 was used. Therefore CY 2014 is not reported as it is not comparable.
## FQHC Results Comparison
### CY 2014 vs. CY 2015

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<td>N/A</td>
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<tr>
<td>Comprehensive Diabetes Care - Eye Exam †</td>
<td>50.4%</td>
<td>52.8%</td>
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<td>4.6%</td>
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<td>Medication Management for People with Asthma</td>
<td>41.3%</td>
<td>38.6%</td>
<td>-2.6%</td>
<td>-6.3%</td>
</tr>
<tr>
<td>Post-Admission Follow-Up within Seven Days of an Inpatient Discharge (Physical Health and Behavioral Health)</td>
<td>37.2%</td>
<td>38.6%</td>
<td>1.3%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Well-Child Visits in the First 15 Months of Life - 6 or More Visits †</td>
<td>70.1%</td>
<td>73.1%</td>
<td>3.0%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life †</td>
<td>82.9%</td>
<td>81.7%</td>
<td>-1.2%</td>
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<td>-1.9%</td>
<td>-13.9%</td>
</tr>
<tr>
<td>Readmissions within 30 Days - Physical Health Only</td>
<td>13.31%</td>
<td>13.38%</td>
<td>0.1%</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

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2 New DSS custom measure starting in CY 2015.
3 CY 2015 uses screening procedure codes 96110 and 96127. Prior to CY 2015 only procedure code 96110 was used. Therefore CY 2014 is not reported as it is not comparable.
PCMH+ Participating Entities (PEs) must include one or more practice(s) that are participating in the DSS PCMH program and hold Level 2 or 3 PCMH recognition from the National Committee for Quality Assurance (NCQA) or other equivalent accrediting body.

DSS regards PCMH recognition as an important prerequisite for PCMH+ since it indicates that practices already have an orientation to improving access and quality for 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
Care Management Activities
This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.

- Agency for Healthcare Quality and Research
PCMH+ requires PEs to build on the limited, embedded care coordination in PCMH with **enhanced care coordination activities** focused upon:

- behavioral health integration
- cultural competency, including use of the national Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) standards
- children and youth with special health care needs
- disability competency

See this link for more detail:

An extremely important initial task in PCMH+ was to develop protocols for and to achieve warm, person-centered transitions of members from CHNCT Intensive Care Management (ICM) to PEs.
Central themes in this effort included the following:

- DSS, CHNCT and the PEs want to ensure the most effective, possible coordination of care for PCMH+ members who need and want that support.

- CHNCT and the PEs have agreed upon protocols to prevent duplication of effort.

- For all PCMH+ attributed members, other than those indicated in a future slide, PE’s are the primary source of care coordination.

- CHNCT ICM will assist PEs in situations in which a higher level or intensity of clinical support is needed.
Please note that CHNCT ICM will continue to act as the lead for care management to PCMH+ members with the following needs:

- **Transplant needs** – in order to collaborate with the CHNCT prior authorization department and various providers to expedite the approvals needed for these members.

- **Transgender needs** – in order to knowledgeably and competently engage with members on covered services and requirements for gender affirming surgery.

- **Healthy Beginnings** – in order to engage with pregnant, post-partum and NICU members in support of the specialty services that are provided, including evidence-based coaching on the importance of attending perinatal appointments, breastfeeding support, interconception care, and newborn care and safety education.

- **Sickle Cell Disease** – in order to support members with this life-long condition, through specialized staff.
The PEs have also been actively participating in a bi-monthly provider collaborative meeting that has focused upon identifying lessons learned, challenges, barriers and opportunities. The latest collaborative meeting featured three break-out groups on the following topics:

- Wellness Recovery Action Plan (WRAP) & Behavioral Health Advanced Directives
- Assisting members with complex Behavioral Health & Substance Abuse care
- Children & Youth With Special Health Care Needs (CYSHCN)
Use of Data
One of the most important aspects of PCMH+ is that it is providing PEs with extensive data that equips them to better support attributed members.

- **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](http://www.huskyhealthct.org/providers/providers_login.html)

- In the following slides, please see a refresher on what data is being provided
Overview of CareAnalyzer®. CareAnalyzer® is an analytic tool used by CHNCT for population health management and to monitor performance on a variety of quality measures.

The tool combines elements of patient risk, care opportunities, and provider performance, including the following:

- Current and predicted risk scores for each member using the Johns Hopkins ACG® (Adjusted Clinical Group) methodology
- Provider performance based on quality measures
- Utilization
- High risk member identification
- Gaps in care

The tool is available to primary care practices (PCPs):
- Practice level reports are available at both a summary and detail level, and are based on members attributed to the practice.
▪ Reports are loaded to the secure Provider Portal by the 20th of each month.

▪ Emails are sent each time a report is placed on the secure Provider Portal to notify providers that the report is available.

▪ Reports can be downloaded, saved, and filtered for use by office staff.

▪ All reports are generated at the practice’s Federal Tax Identification Number (TIN) level for members attributed to PE PCPs.
Panel Reports:
- Patient Panel Report
- PCMH+ Panel Report

Utilization Reports:
- ED Utilization Report
- Inpatient Claims Report
- Daily Admissions and Discharge Report

Gaps in Care Reports:
- Child Well-Care Visits
- Child Diabetes Screening Tests
- Adult Preventive Visits Age 50-64
- Adult Diabetes Screening Tests
Evaluation
All evaluation materials are posted on a rolling basis on the DSS PCMH+ web page at this link: [http://www.ct.gov/dss/pcmh+](http://www.ct.gov/dss/pcmh+)

<table>
<thead>
<tr>
<th>Evaluation Tool</th>
<th>Details</th>
<th>Means and Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCMH+ Monthly PE Compliance Reports</td>
<td>Report on PCMH+ contract compliance, including such elements as staffing, care coordination activities, and community partnerships</td>
<td>PEs submit reports to DSS by the mid-point of each month</td>
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<td>Reports are posted by the end of each month</td>
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<tr>
<td>PCMH+ Participation Detail Report</td>
<td>Report that tracks member participation</td>
<td>Conduent and CHNCT are tracking and producing monthly reports</td>
</tr>
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<tr>
<td>Opt-Out Survey Findings</td>
<td>Telephone survey of individuals who opt out of participation in PCMH+ after implementation on January 1, 2017</td>
<td>DSS conducts surveys on a rolling basis and is tracking to determine if any pattern that causes concern is detected</td>
</tr>
<tr>
<td>Grievances Report</td>
<td>Report that tracks grievances by HUSKY Health members</td>
<td>CHNCT is producing monthly reports using a marker to compile data for PCMH+ attributed members</td>
</tr>
<tr>
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<tr>
<td>Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey</td>
<td>Consumer satisfaction survey</td>
<td>Summary of baseline CAHPS will be published in July</td>
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<td>Note that a summary of 2015 data is posted</td>
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<tr>
<td>Mystery shopper</td>
<td>Exercise that tests availability of appointments and effect (if any) of HUSKY Health coverage on availability</td>
<td>2017 survey will be conducted in October</td>
</tr>
<tr>
<td></td>
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<td>Note that a summary of 2016 data is posted</td>
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<tr>
<td>Claims Data</td>
<td>Acknowledging that full claims run-out in support of calculating eligibility for shared savings will not be complete until July 1, 2018, the following claims data is available during the Wave 1 calendar year: point-of-sale pharmacy data; medical, behavioral health, dental and pharmacy claims detail that is pushed out to PEs through the CHNCT PCMH portal.</td>
<td>Full claims run-out by July 1, 2018. As indicated to left, data are available on a rolling basis.</td>
</tr>
</tbody>
</table>
Please also note that HUSKY Health is continuing to track diverse quality measures on behalf of all Medicaid members. See this report for a comprehensive overview:

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

Transparency
▪ **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)

▪ **Model design materials:** Materials memorializing the work of the Care Management Committee are posted on a rolling basis on the MAPOC web site at this link: https://www.cga.ct.gov/med/comm1.asp?sYear=2016
Questions or comments?
To ask a question, please use the ‘raise your hand’ feature or type it into the ‘chat’ box.
Thank You!

Thank you for joining this Value-Based Payment Reform Academy Group Technical Assistance Webinar!

Please complete the evaluation form following this presentation.