Connecticut Medical Assistance Initiative
Policy Transmittal 20XX-XX

PB20XX-XX
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Contact: XXX @ 860-424-XXXX

Roderick L. Bremby, Commissioner

TO: Physicians, APRNs, Hospitals, and Federally Qualified Health Centers

RE: New Person-Centered Medical Home Initiative

Person-Centered Medical Home (PCMH) Initiative

Introduction

The purpose of this practitioner bulletin is to announce and describe the Department of Social Service's ("Department") new PCMH initiative. Under this new initiative, practices or clinics that demonstrate a higher standard of person-centered primary care service delivery will qualify for a higher level of reimbursement for primary care services as compared to non-PCMH practices or clinics. Practices or clinics are also eligible for additional financial incentives based on performance.

The PCMH initiative is one of several reforms that the Department is introducing under the new HUSKY Health program, which has been expanded to include the Medicaid Aged, Blind and Disabled (ABD) and Low Income Adult (LIA) populations in their entirety. The portion of HUSKY Health that serves individual segments of the population is as follows:

Population	HUSKY Nomenclature
Low income families	HUSKY A
Children's Health Insurance Program (CHIP)	HUSKY B
Aged Blind or Disabled (ABD)	HUSKY C
Low Income Adults (LIA)	HUSKY D

For the purpose of this transmittal, the Department will use the term HUSKY or HUSKY Health to refer to all Medicaid and CHIP populations including HUSKY A, B, C and D. The HUSKY Health program restructuring is further described in PB-2011-77. Charter Oak Health Plan recipients are also included in this initiative.

This practitioner bulletin includes information about the PCMH initiative including:

1. Participation Requirements
2. PCMH Application Process
3. Glide Path
4. Prospective Attribution
5. Reimbursement

The Department will arrange for administrative services to support the PCMH initiative. These services will be provided by the Department's Medical Administrative Services Organization (ASO), Community Health Network of Connecticut (CHNCT). The Medical ASO's services will be described in a future practitioner bulletin.

1. Participation Requirements

To be eligible to apply and qualify for PCMH status a practice or clinic must be enrolled in the Connecticut Medical Assistance Program (CMAP) under one of the following designations:

- Independent physician group or solo practice,
- Federally Qualified Health Center, or
- Hospital outpatient clinic.

The Department anticipates that any nurse practitioner groups that are separately enrolled in CMAP will be included in the application filed by the physician directed

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practice or clinic with which they are affiliated.

Practices or clinics that also function as a school-based health center may apply for PCMH qualification if they meet all of the requirements described herein, including year-round access to primary care services.

In order to qualify as a PCMH, a practice or clinic must be recognized by the National Committee for Quality Assurance (NCQA) as a "Level 2" or "Level 3" PCMH. Recognition is based on either NCQA's 2008 or 2011 PCMH standards. Practices that are recognized based on 2008 NCQA standards will need to update their NCQA status based on the most current NCQA requirements or 2011 standards.

In addition, to qualify as a PCMH, medical records for all patients treated within the primary care practice or clinic must be available to and shared by all clinicians, as appropriate. The same systems must support both clinical and administrative functions (e.g., scheduling, treating patients, ordering services, prescribing, maintaining medical records and follow-up).

Finally, qualified practices or clinics are required to meet the following special requirements:

Requirement Type	Requirements/Expectations
Federal EPSDT Screening	Meet federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program requirements including, but not limited to: timely comprehensive well-child visits, including hearing and vision screening; timely developmental screening; referral for preventive dental care beginning at age X; and referral with follow-up care based on conditions identified in well-child and Interperiodic visits and screenings.
Smoking cessation	Participate in activities related to Department's iQUIT Smoking Cessation Incentive Grant as follows: • conduct patient screening to determine whether patients smoke; • offer smoking cessation services such as counseling and pharmacotherapy; • inform patients who smoke of the Medicaid smoking cessation incentive program; • facilitate on-line registration in the Department's smoking cessation study through a data portal; • dispense incentives to patients; and, • test patients' smoking cessation using a breathalyzer provided within available resources by the Department.
Decreasing racial and ethnic disparities	Participate in initiatives to decrease racial and ethnic disparities including, but not limited to: educational forums; and data collection activities designed to analyze outcomes by race and ethnicity.
Consumer Protections	Adhere to consumer protections as determined by the Department.

All practices or clinics that apply for PCMH qualification will be reviewed and evaluated against the same PCMH standards and requirements.

Eligible Practitioners

Practitioners within the PCMH practice or clinic must meet eligibility requirements in order for the practice or clinic to receive enhanced reimbursement for the services rendered by the practitioner.

To be eligible, practitioners must have an active unrestricted license as a doctor of medicine or osteopathy or be licensed as a nurse practitioner or physician assistant. Physicians must specialize in general internal medicine, geriatrics, family medicine or general pediatrics.

DRAFT

Eligible practitioners must function as PCPs and have their own panel of primary care patients. Primary care services must account for at least 60% of the practitioner's allowed charges. Services rendered by specialists or practitioners who do not have their own patient panel or cannot be selected as a PCP do not qualify for PCMH reimbursement.

All eligible primary care practitioners in the practice or clinic who see HUSKY Health recipients or Charter Oak Health Plan recipients must be included in the PCMH application to the Department. Practitioners who do not currently participate in CMAP, but wish to enroll can apply to participate in CMAP concurrently with their practice's or clinic's application for the Department's PCMH program.

2. PCMH Application Process

Beginning December 1, 2011, the Department will accept applications from CMAP enrolled practices or clinics to participate in the PCMH initiative.

Practices or clinics that wish to participate as a PCMH are required to submit a PCMH application to the Department of Social Services, 25 Sigourney Street, Hartford, CT. 06106. PCMH application materials will be available on-line from the Department beginning on December 1, 2011. Practices or clinics must submit proof of NCQA Recognition status with their application to the Department.

Full PCMH qualification allows practices or clinics to participate as a PCMH as of the first of the month following approval. To maintain ongoing participation as a PCMH, practices or clinics must maintain NCQA Recognition and meet the Department's special requirements as identified in Section 1, Participation Requirements.

3. Glide Path

The Department's PCMH Glide Path option provides financial and technical support for practices or clinics that are preparing to seek PCMH qualification. To qualify for Glide Path status, practices or clinics must demonstrate to the Department that they have initiated significant activities toward meeting the Department's PCMH standards.

Applicants seeking Glide Path status must submit the following documentation:

Submission Requirement	Description
Complete PCMH application	Available from the Department on December 1, 2011.
Glide Path Gap Analysis	Documentation that illustrates the steps that the practice or clinic must take to achieve a minimum of NCQA Level 2 PCMH Recognition based on its current capabilities at the time the gap analysis is complete in a format provided by the Department.
Glide Path work plan	Documentation that identifies the steps the practice or clinic will take to fully comply with all NCQA Level 2 Standards at a minimum and additional Department participation requirements as described herein.
Ongoing documentation for each Glide Path phase	Described herein based on the tasks that practices or clinics select within the Glide Path options.

Practices or clinics are required to select Glide Path milestones as described below. Practices or clinics must mutually agree upon Glide Path milestones with the Department. Such milestones and timelines must be documented in Glide Path documentation for submission to the Department and will form the basis of payments described herein. In the event that a practice or clinic does not achieve Glide Path milestones in the agreed upon timeframes, the practice or clinic may request an extension of up to six (6) months in total, across all Glide Path phases. Practices or clinics must complete the entire Glide Path in no more than 24 months, including any requested extensions. In the event that a practice or clinic does not complete the Glide Path within a 24 month period in total, the

DRAFT

practice or clinic will no longer qualify for Glide Path status and associated enhanced reimbursement, including repayment of any Start-up payments received from the Department.

All practices or clinics that apply for Glide Path status will be categorized as being in one of three phases:

Glide Path – Phase 1: Practices or clinics must demonstrate fulfillment of three or more of the following tasks within a six month timeframe to successfully complete PCMH Phase 1 of the Glide Path including:

- Documented evidence of PCMH staff orientation within the practice or clinic;
- Documented evidence of monthly ongoing self-learning or guided learning activities at a minimum;
- Documented evidence of plans to adopt and implement an Advanced (ONC certified?) Electronic Health Record (EHR). Such documentation must include materials that demonstrate plans to purchase a qualified EHR for Meaningful Use Certification within twelve months or the completion of the PCMH Glide Path Phase 2; and,
- Practices or clinics that already own an EHR must provide documented evidence of necessary planned upgrades of the existing EHR to achieve Meaningful Use Certification within the same timeframe.

For practices or clinics that are recognized by NCQA as a Level 1 PCMH, submission of NCQA proof of that status can substitute for one of the three tasks required to satisfy the Glide Path phase 1 requirements for the practice or clinic.

For practices or clinics that qualify for the Medicaid EHR Incentive payment program documentation of Medicaid Meaningful Use status is required. An approved attestation by the Department qualifies as one of the three tasks that a practice or clinic must achieve toward completion of Phase 1 of the Glide Path. Proof of the practices' or clinics' ability to meet this requirement further includes: medication lists, allergies, advanced directives for all patients and disease and wellness registries to monitor and plan for patient care.

The maximum anticipated timeframe for completing Phase 1 of the Glide Path is six months.

Glide Path – Phase 2: To qualify for Phase 2 status, practices or clinics must have completed Phase 1 of the Glide Path (defined as three or more of the tasks listed under Phase 1) and further meet at least three of the following requirements:

- Use an Advanced EHR for e-prescribing, problem list generation, medication management, and progress note generation. The PCMH must demonstrate successful use of these tools to the Department;
- Provide evidence of a formal contract with the eHealth Connecticut Regional Extension Center with the goal of becoming a Meaningful User of an EHR;
- Submit evidence that the practice or clinic has either employed or contracted with care coordination and disease education resources. Evidence shall include job descriptions and resumes of the care coordinator and disease educator within the practice or clinic or a contract that demonstrates the purchase of care coordination and disease education services;
- Use of an EHR or Disease and Wellness registry to identify and serve patients with chronic conditions (e.g., asthma, diabetes, etc.). Documentation must include EHR formats and data to track patients by chronic care diagnosis including a prioritization of risk level across all

DRAFT

recipients with chronic needs identified; and,
- Enhanced access to clinical sites including after-hours services and or email/web-portal access for patients to communicate with the practice or clinic.

Documentation must include a complete listing of e-mail policies, processes and procedures and a link to a secure web site (to which the Department can gain access in accordance with HIPAA). The practice or clinic must further provide evidence of such communications.

The maximum anticipated timeframe for completing Phase 2 of the Glide Path is six months.

Glide Path - Phase 3: To qualify for Phase 3 status, practices or clinics will be required to meet Glide Path requirements for both Phase 1 and Phase 2 and will be required to:
- Submit the documentation required to complete Phases 1 and 2 of the Glide Path; and
- Be in the data gathering stage of the PCMH recognition process, just prior to NCQA submission. NCQA submission must be made within two months of reaching Glide Path Phase 3.

The practice will also be required to meet one of the following to complete Phase 3 and achieve full PCMH status:
- Documented achievement of all of the NCQA PCMH "Must Pass" elements;
- Documented proof that the practice or clinic completed and submitted an application to NCQA;
- Evidence that the practice or clinic is in the data-gathering phase of the NCQA PCMH approval process including data formats; specifications for data collection; and,
- Evidence that the practice or clinic site has achieved Meaningful Use of a (ONC?) Certified Advanced EHR.

The maximum anticipated timeframe for Phase 3 of the Glide Path is six months.

The Department will require Glide Path Applicants to submit all required documentation to the Department. The Department will review Glide Path submissions and may request, at its sole discretion, a meeting with a practice or clinic prior to awarding Glide Path status to review progress along the Glide Path at the conclusion of each phase.

4. PCMH Patient Assignments

A prospective attribution methodology will be used to make PCP and PCMH assignments for all HUSKY Health and Charter Oak recipients. Assignment will be based on a recipient's history of using a Usual Source of Care (USC) or choice of USC. Assignments will be made to the practice or clinic rather than the individual practitioner. The practice or clinic will be responsible for establishing and fostering a personal relationship between the assigned recipient and an individual practitioner. The attribution process will help ensure that recipients who go to a new primary care clinic or practice will eventually be assigned to that practice.

The Department's Medical ASO will provide all participating practices or clinics with a quarterly or monthly list of assigned recipients beginning in calendar year 2012. The ASO will further provide PCMH data for the purpose of reporting to practices and clinics and their practitioners. The Department and the ASO will monitor the PCMH initiative using such reporting data.

5. Reimbursement

The Department intends to provide enhanced reimbursement to practices or clinics that qualify for PCMH status to help offset the costs of becoming, maintaining, and operating

DRAFT

as a PCMH for HUSKY Health and Charter Oak recipients. The Department's reimbursement is designed to cover up to 125% of the estimated annual incremental PCMH costs associated with providing PCMH services to HUSKY Health and Charter Oak recipients using a hybrid reimbursement approach. The Department's hybrid approach includes the following four components:

- Start-up Supplemental Payment (small independent practices only);
- Participation Fee Differential;
- PMPM Performance Incentive Payments; and
- PMPM Performance Improvement Payments.

Start-up Supplemental Payment

The Start-up Supplemental Payment is a prospective payment available to independent practices participating in the Glide Path option. The Supplemental Payment exists to assist Glide Path practices in offsetting a portion of the costs associated with developing and implementing a PCMH that serves HUSKY Health and Charter Oak recipients. The Start-up funds are only available to independent practices of five primary care practitioners or less.

The Start-up Supplemental Payment is divided into three equal payments that correspond to progress along the Glide Path phases. If a practice does not complete the Glide Path and achieve qualified PCMH status from the Department, the practice must return any Start-Up payments received to the Department.

PCMH Participation Fee Differential Payments

PCMH Participation Fee Differential Payments will be paid as an adjustment to the existing fee schedule, encounter rate, or visit rate. The PCMH Participation Fee Differential Payments are made only to qualified PCMH practices or clinics for services rendered by eligible practitioners. The PCMH Participation Fee Differential does not require changes to current billing practices.

In the case of independent practices, the PCMH Participation Fee Differential Payments will be applied to the current "default" Medicaid fee schedule. The differential will be limited to primary care services including the following procedure codes:
INSERT CODES

The Department intends to review and revise its PCMH rates and fees effective January 1, 2013 at such time that Medicaid fees for primary care physician services increase to a level equal to 100% of the Medicare FFS fees pursuant to Section 1202 of the Affordable Care Act. The Department also intends to review and revise the fee differential amounts at such time that there are adjustments to the default Medicaid rates or fees applicable to physicians, FQHCs, and hospitals.

In addition, the Department also intends to review alternative methods for providing enhanced reimbursement to practices or clinics for PCMH participation including monthly per member per month (PMPM) payments. The Department reserves the right to substitute Participation Fee Differential Payments with a monthly PMPM for PCMH qualified practitioners and/or Glide Path practitioners. In such event, providers will be notified and afforded the opportunity to comment.

For practitioners with Glide Path status, PCMH Participation Fee Differential Payments equal fifty-percent of the PCMH Participation Fee Differential Payments associated with payment for practices or clinics with NCQA Level 2 status.

PMPM Performance Incentive and Performance Improvement Payments

The Performance Payments will be based on the aggregate performance of practitioners in

DRAFT

fully qualified practices or clinics. Payment will be calculated based on actual performance measured against adult and pediatric measurement set as outlined below under "Pediatric and Adult Performance Measures for Performance Payments." Glide Path practices and clinics will not qualify for Performance Payments.

Performance Payments will be based on recipients who were retrospectively attributed to the practice or clinic based on service history and for those recipients who chose the practice or clinic as their USC. If a recipient chose a practice or clinic, but was attributed to a different practice or clinic based on service history, the recipient will be attributed to the latter for the purpose of performance payments.

Performance Payments will be calculated and paid to a practice or clinic based on the number of HUSKY Health and Charter Oak recipients who are retrospectively attributed to practitioners in the practice or clinic based on their use of a USC or choice of USC for all practitioners who are associated with that practice or clinic.

The Department will distribute Performance Payments annually but retains the option to adjust the payment cycle to be more frequent than annually. In the first year of the PCMH initiative, the Department intends to pay practices and clinics for the Performance Measurement Period 1/1/12 to 12/31/12. The Performance Measurement Period may be adjusted depending on the number of practices or clinics that qualify January 1st.

The PMPMs for Performance Payments may be risk adjusted. Performance Payments will be calculated and paid by the Department within six months of the close of the Performance Measurement period. This will allow for 120 days of claims run out, performance analyses, and calculation of the practice or clinic specific performance payments.

There will be two Performance Payment components: an Incentive Payment and an Improvement Payment. Each of these payments will represent approximately 50% of the total dollars set-aside by Department for the Performance Payments in total.

a. Incentive Payment

To receive an Incentive Payment for the first full year of a practice's or clinic's achievement of full qualification at NCQA Level 2 or 3, the practice or clinic will be required to submit documentation and/or demonstrate that the practice or clinic is using its EHR to coordinate care, track recipient services, provide education to support disease self-management and follow-up and outreach for high-risk individuals. The practice or clinic will also be required to submit complete and reliable performance reporting data that cannot be derived from claims or other administrative data.

For the second and subsequent years of full qualification, the Department will pay practices or clinics that meet Incentive Payment requirements an annual Incentive Payment based on its performance. The Incentive Payment will be awarded proportionate to the practice's or clinic's performance relative to other qualified PCMH practices and clinics. Only practices or clinics in the top three performance quartiles will qualify for an Incentive Payment.

The Incentive Payment will be based on relative performance of eligible adult and pediatric practitioners in the top three performance quartiles only relative to all qualified PCMH practices or clinics.

b. Improvement Payments

DSS will pay practices or clinics Improvement Payments based on their

DRAFT

improvement over their previous year's performance. Payment will be based on the aggregate performance of each practice or clinic, without regard to the individual performance of their eligible practitioners. Although payment will be based on aggregate performance, the Department will provide each practice or clinic with performance data broken out by eligible practitioner.

For the first full year of a practice's or clinic's achievement of full qualification at NCQA Level 2 or 3, the improvement payment will be combined with the incentive payment. For the second and subsequent years of a practice's or clinic's achievement of full qualification, the practice or clinic must demonstrate improvement over the practices' or clinics' performance the previous year.

Once one year of baseline data has been compiled, Improvement Payments will be distributed as follows:

% Improvement Over the Prior Year	**Level of Performance Incentive Payment**
5% improvement over prior year results	50% of the possible Improvement Payment
10% improvement over prior year results	75% of the possible Improvement Payment
90th – 100th percentile relative to all Qualified PCMH practices and clinics	100% of the possible Improvement Payment

Reimbursement Summary

Start-up, Participation, Performance Incentive Payment, and Performance Improvement Payment Summary

Start-up Supplemental Payments

Practice Size	Installments	Total
1	3 Equal Payments based on Glide Path Milestones	$13,000
2		$16,000
3		$19,000
4		$22,000
5		$25,000
5+		N/A

Glide Path Participation Fee Differential

Provider Type	Payment Type	Glide Path
Adult	% increase	
Pediatric	% increase	
FQHC	Fixed add-on	
Hospital Outpatient	Fixed add-on	

NCQA Level 2 Participation Fee Differential and Performance Payments

Provider Type	Payment Type	NCQA Level 2
Adult	% increase	
Pediatric	% increase	
FQHC	Fixed add-on	
Hospital Outpatient	Fixed add-on	
All	Performance Incentive PMPM	
All	Performance Improvement PMPM	

NCQA Level 3 Participation Fee Differential and Performance Payments

Provider Type	Payment Type	NCQA Level 3
Adult	% increase	
Pediatric	% increase	
FQHC	Fixed add-on	
Hospital Outpatient	Fixed add-on	
All	Performance Incentive	

DRAFT

	PMPM	
All	Performance Improvement PMPM	

Pediatric and Adult Performance Measures for Performance Payments

The following measures will be used to calculate Performance Payments for the PCMH initiative.

PCMH Pediatric Measures – Year 1

- Well care visit during the measurement period consistent with the EPSDT schedule and the AAP schedule including newborn visits at 3-5 days and by 1 month, visits at 2, 4, 6, 9, 12, 15, 18, 24, and 30 months and annual visits thereafter between 3 and 21 years of age.

- Successful connection of children under age 3 to dental services including any child with a dental claim during the measurement period.

- Children with asthma who utilize the Emergency Department during the measurement period.

- Children from birth to 21 years of age who utilized the Emergency Department three or more times in a six month period during the measurement year.

- The delivery of a developmental screening with a formal tool at 9, 18 and 30 month well child visits.

- The aggregate score for the PCMH Consumer Assessment of Healthcare Practitioners and System (CAHPS) data set for a 12 month period relative to all other participating PCMH practitioners.

PCMH Pediatric Measures - Year 2

- Children and adolescents age 2 to 21 years of age who had an outpatient PCP visit with a BMI percentile outside of the acceptable range with a documented follow-up plan that the patient and family agreed to during the measurement period.

- Children treated with psycho stimulant medication for an ADHD diagnosis whose medical record had documentation of at least two follow-up visits during a 12-month period.

- Children from birth to 21 years of age who utilize the Emergency Department three or more times in a six month period during the measurement year and have a person-centered follow-up plan to which the recipient and their family have agreed documented in the EHR.

PCMH Adult Measures – Year 1

- Adults age 21-75 with a diagnosis of diabetes who received two HbA1c tests at least three months apart during the measurement period.

- Adults with a diagnosis of diabetes whose practitioner measured their LDL-C during the measurement period.

- Adults age 21-75 with a diagnosis of diabetes who received an eye exam with an eye care professional during measurement year or, in the year prior to the measurement year.

- Adults age 21-75 with a diagnosis of cardiovascular disease (CVC) who were treated with a statin drug and received at least two LDL-C test during the measurement period.

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- Adults age 21-75 with inpatient admissions with a claim for post-admission follow-up within seven days and within 14 days of the admission during the measurement period.

- Adults age 21-75 who utilized the Emergency Department three or more times in a six month period during the measurement period.

- Adults 21 years and over who were identified as having persistent asthma and were appropriately prescribed medication for a prescription that was filled during the measurement period.

- Adults who screened positive for behavioral health symptoms who received medication (and/or) medication management services during the measurement period.

- Adults age 21-75 with a diagnosis of diabetes or CVC disease with a Blood Pressure of less than 140/90 where the consumer receives two blood pressure screenings during the measurement period.

- The aggregate score for the PCMH Consumer Assessment of Healthcare Practitioners and System (CAHPS) data set for a 12 month period relative to all other participating PCMH practitioners.

PCMH Adult Measures – Year 2

- The percent reduction in baseline in potentially avoidable re-admissions (based on ambulatory sensitive conditions) within a 30-day period among PCMH consumers age 21 years or older with an acute inpatient discharge during the measurement period excluding maternity, NICU, Pediatrics and Transplants.

- Individuals age 21-75 with a diagnosis of diabetes who exhibit an:
  - HbA1c level below seven within the measurement year
  - HbA1c level above nine within the measurement year
  - LDL-C level below 100 within the measurement year
  - LDL-C level above 130 within the measurement year

- Adults age 21-75 with a diagnosis of CVC disease who had an LDL level less than 100 with appropriate follow-up during the measurement period.

Incentive Payment measures will be paid as follows:

Performance Percentile	**Level of Performance Incentive Payment**
50th – 75th percentile	50% of possible incentive payment
75th – 90th percentile	75% of possible incentive
90th – 100th percentile	100% of possible incentive

<u>Posting Instructions</u>: Policy transmittals may be downloaded from the Connecticut Medical Assistance initiative Web site at www.ctdssmap.com.

<u>Distribution</u>: This policy transmittal is being distributed to holders of the Connecticut Medical Assistance Program Provider Manual by HP Enterprise Services, Managed Care Organizations and other Department of Social Services vendors.

<u>Responsible Unit</u>: Department, *(Unit, phone number).*

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