Connecticut Medical Assistance Initiative PB 2011-84
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Roderick L. Bremby, Commissioner Contact: Erica Garcia @ 860-424-5670

TO: Physicians, Physician Groups, APRNs, APRN Groups, Hospitals, and Federally Qualified Health Centers

RE: New Person-Centered Medical Home Initiative

Person-Centered Medical Home (PCMH) Initiative

Introduction

The purpose of this provider bulletin is to announce and describe the Department of Social Services' (the "Department" or "DSS") new PCMH initiative. The information contained within this provider bulletin is pending final approval by the Centers for Medicare and Medicaid Services.

Under this new initiative, practices and clinics ("practices") that demonstrate a higher standard of person-centered primary care service delivery will qualify for a higher level of reimbursement for primary care services from the Department. Practices will also be eligible for additional financial incentives based on performance measures.

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. HUSKY Health serves individual segments of the population 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 policy transmittal, the Department will use the term HUSKY or HUSKY Health to refer to all Medicaid and Children's Health Insurance Program (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 will also be included in this initiative.

This provider bulletin includes important information about the PCMH initiative, including the following:

1. Participation Requirements
2. PCMH Application Process
3. Glide Path Option
4. Recipient assignment
5. Reimbursement

Administrative services to support PCMHs shall be provided by Community Health Network of Connecticut (CHNCT), the Department's medical Administrative Services Organization (ASO). The medical ASO's services will be described fully in a future provider bulletin.

1. <u>Participation Requirements</u>

To be eligible to apply and qualify for PCMH status, a practice 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 nurse practitioner groups that are separately enrolled in CMAP will be included in the application filed by the physician-directed practices with which they are affiliated.

In order to qualify as a PCMH, a practice must be recognized by the National Committee for Quality Assurance (NCQA) as a "Level 2" or "Level 3" PCMH. NCQA recognition is based on the NCQA standards in place at the time of its most recent recognition. Accordingly, the Department will accept recognition in accordance with NCQA's 2008 or 2011 PCMH standards.

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

Qualified practices must also meet the following additional requirements:

Category	Department Requirements
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 for appropriate age groups; and referral with follow-up care based on conditions identified in well-child and inter-periodic visits and screenings.
Smoking cessation	Participate in activities related to the Department's iQUIT Smoking Cessation Incentive Program as follows: • conduct patient screening to determine whether patients smoke; • offer evidence-based smoking cessation counseling services and pharmacotherapy; • inform patients who smoke of the iQUIT program; • facilitate on-line registration in the iQUIT program; • dispense incentives to patients; and, • test patients' smoking cessation using a breathalyzer provided, within available resources, by the Department.
Decrease racial and ethnic disparities	Participate in initiatives to decrease racial and ethnic health disparities, including, but not limited to: participating in educational forums; collecting and analyzing data to review disparities related to race and ethnicity; and engaging in efforts to act on data-driven opportunities for improvement that reduce disparities.
Consumer Protection	Adhere to consumer protections, which will include ensuring recipients' rights to confidentiality, nondiscrimination, timely access, informed choice, participation in treatment decisions and access to a grievance process. Consumer protections will be formulated by the Department with input from providers and advocates within six months of the effective date of the PCMH initiative. Such protections will be in addition to existing protections for Medicaid consumers established under state and federal law.

Practices that function as school-based health centers may apply for PCMH status. They must meet all of the requirements described herein, including the requirement to provide year-round access to primary care services.

Eligible Practitioners

In order to receive enhanced reimbursement for PCMH services, the performing practitioners within the PCMH practice must meet all eligibility requirements described herein.

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

geriatrics, family medicine or general pediatrics.

An eligible practitioner must function as Primary Care Practitioner (PCP) and have a "panel of primary care patients" or "patient panel," which is a set of patients for whom the practitioner is responsible for providing primary care services, where primary care services account for at least 60% of the practitioner's time across all payers. Specialists or other practitioners who do not have their own patient panels are not eligible for PCMH participation.

The practice's PCMH application must include the names of all eligible practitioners in the practice who will treat HUSKY Health or Charter Oak Health Plan recipients. All practitioners within the practice who will provide care to HUSKY Health and Charter Oak Health Plan recipients must enroll individually in CMAP. Practitioners who do not currently participate, but wish to enroll in CMAP, may initiate an enrollment application by going to www.ctdssmap.com, then clicking on "Provider Enrollment" under the "Provider" heading.

2. PCMH Application Process

Beginning on or after December 1, 2011, PCMH application materials, including instructions on how to submit the applications, will be available on-line from the Department at www.HUSKYHealth.com.

If the Department approves a PCMH application, the designation is effective the first of the month following the date of application or NCQA recognition, whichever is later.

3. Glide Path Option

The Department's PCMH Glide Path option provides financial and technical support for practices that are preparing to seek PCMH qualification to serve HUSKY Health and Charter Oak Health Plan recipients. To qualify for Glide Path status, a practice must demonstrate in its application that it has initiated activities to achieve NCQA PCMH recognition.

Applicants seeking Glide Path status must submit the following:

Submission Requirement	Description
Complete PCMH application and Glide Path application	Available from the Department in mid-December, 2011.
Complete Glide Path Gap Analysis	Documentation that illustrates the steps that the practice must take to achieve a minimum of NCQA Level 2 PCMH Recognition based on its current capabilities at the time the gap analysis is completed. A practice shall submit a Gap Analysis based on its ability to perform all standards, elements and factors contained in the NCQA PCMH application at the time of Glide Path submission.
Complete Glide Path Work Plan documentation	Documentation that identifies the steps the practice will take to fully comply with all NCQA Level 2 Standards and additional Department participation requirements described herein, including a work plan that shows how the practice will complete all Glide Path requirements in the timeframes allotted by the Department.
Provide ongoing documentation for each Glide Path phase	Documentation that demonstrates ongoing achievement of the tasks that a practice selects within the Glide Path phases as described herein.

Glide Path applicants must submit all required documentation to the Department. The Department will review the submission and may, at its sole discretion, meet with a practice to address issues identified prior to awarding Glide Path status or to review progress along the Glide Path at the conclusion of each phase. Practices must select Glide Path milestones and timeframes

for each Glide Path phase as part of the initial Glide Path application.

The Department will review the NCQA gap analysis when deciding whether to grant Glide Path status and will review updates to the NCQA application at the end of each Glide Path phase to assess progress on Glide Path tasks. The Department will require Glide Path applicants to grant the Department read-only access to the practice's NCQA PCMH application under its NCQA licensure agreement when applying for and at the end of each Glide Path phase.

Each practice that qualifies for the Glide Path will be categorized by the Department into one of the following three phases based on its status at the time of application. The practice will be required to submit updates to keep the Department informed of its progress toward completion of each phase. Demonstrated progress will be required to continue to qualify for Glide Path reimbursement.

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

- Orientation of all clinical and non-clinical staff within the practice to PCMH requirements and development of strategies to meet such requirements;
- Monthly, ongoing self-learning or guided training by clinical and non-clinical staff about PCMHs;
- Plans to adopt or implement a Meaningful Use Certified Electronic Health Record (EHR), as designated on the website of the Office of the National Coordinator for Health IT (ONC);
- For practices that already own an EHR, planned upgrades of the existing EHR to achieve Meaningful Use Certification.

For practices that are recognized by NCQA as Level 1 PCMHs, submission of NCQA proof of Level 1 status may substitute for one of the three tasks to satisfy the Phase 1 requirements.

Similarly, for practices that qualify for a Medicaid or Medicare Electronic Health Records (EHR) Incentive Payment, documentation of such payment may substitute for one of the three tasks to satisfy the Phase 1 requirements.

Once qualified for the Glide Path, all practices will receive a portion of the PCMH Participation Fee Differential Payment described below. In addition, for those practices on the Glide Path that have five or fewer eligible practitioners (as measured on a full-time equivalent basis), and whose patient panels consist of at least 25% HUSKY Health and/or Charter Oak Health Plan recipients at the time of acceptance to Glide Path status, the Department proposes to offer Start-up Payments as described below.

Glide Path – Phase 2: To qualify for Phase 2 status, practices must have completed Phase 1 of the Glide Path, i.e., they must have completed three or more of the tasks listed under Phase 1. Completion of Phase 2 entails documenting three or more of the following within a six-month timeframe:

- Use of a ONC-certified EHR for e-prescribing, problem list generation, medication management and progress note generation. The PCMH must demonstrate successful use of these tools through the submission of documentation or a live EHR demonstration;
- A contract with the eHealth Connecticut Regional Extension Center with the goal of becoming a Meaningful User of an EHR;
- The use of employed or contracted care coordination and disease education resources within the practice.
- Use of an EHR or Disease and Wellness registry to identify and serve patients with

chronic conditions (e.g., asthma, diabetes, etc.); and,
- Enhanced access to clinical sites, including after-hours services and or email/web-portal access for patients to communicate with the practice.

Glide Path - Phase 3: To qualify for Phase 3 Glide Path status, practices must demonstrate that they have met Glide Path requirements for both Phase 1 and Phase 2. In order to complete Phase 3, practices must obtain NCQA recognition of Level 2 or Level 3 PCMH status within six months of starting Phase 3. Key elements of Phase 3 are the following:
- Achievement of Meaningful Use of an ONC approved Certified HER;
- Data gathering for NCQA submission;
- Achievement of all of the NCQA PCMH "Must Pass" elements; and
- Completion and submission of an application to NCQA.

If a practice does not complete each Glide Path phase within the allotted six-month timeframe, the practice may request an extension. The practice may request one or more extensions; the combined duration of such extensions, however, may not exceed six months.

Practices must complete the entire Glide Path in no more than 24 months, including any requested extensions. In the event that a practice does not complete the Glide Path within a 24-month period in total, the practice will no longer qualify for Glide Path status and associated enhanced reimbursements. All practices that apply for Glide Path status will be categorized into one of three phases at the time of application and on an ongoing basis as the practice completes and obtains approval for each phase.

4. Recipient Assignments

Beginning sometime during the first quarter of calendar year 2012, the Department will provide all primary care practices (PCMH and traditional) with a monthly roster identifying assigned recipients. The purpose of the roster is to support practices' outreach, engagement and care management. It is anticipated that assignments will be based on two methods. Where claims history for primary care services exists, a recipient will be assigned to a practice based on the recipient's history of using the practice for primary care. If a recipient received primary care services at more than one practice, the Department will assign the recipient to the practice where the recipient received the majority of his or her primary care services. Assignment will be based on recipient choice where no service history exists and when a change in primary care practice is requested. If there is no service history and the recipient does not make a choice, there will be no default assignments to a PCMH or other primary care practice.

The Department will provide additional information regarding the assignment process prior to implementation.

PCMH practices are responsible for establishing and fostering a personal relationship between the recipient and a primary care practitioner.

5. Enhanced Reimbursement

The Department will provide enhanced reimbursement to practices that qualify for PCMH status to help offset the costs of becoming, maintaining and operating as a PCMH for HUSKY Health and Charter Oak Health Plan recipients. The Department's reimbursement provides up to 125% of the estimated annual incremental PCMH costs using a hybrid reimbursement approach. The hybrid approach includes the following three components:

A. Start-up Supplemental Payment (small independent practices only);

B. PCMH Participation Fee Differential Payment;
C. Per Member Per Month ("PMPM") Performance Payments.

A. Start-up Supplemental Payment

The Department proposes to pay prospective, Start-up Supplemental Payments to independent Glide Path practices for the purpose of offsetting a portion of the costs associated with developing and implementing a PCMH.

The Department will make start-up funds available only to independent practices of five full time equivalent ("FTE") practitioners or fewer, whose primary care panels consist of at least 25% HUSKY Health and/or Charter Oak Health Plan recipients at the time of acceptance to Glide Path status.

The Department will divide the Start-up Supplemental Payment into three equal payments. The first payment will be made upon acceptance into the Glide Path; the second payment will be made after completion of Phase 1; and the third payment will be made after completion of Phase 2.

If a practice does not complete the Glide Path and achieve full PCMH status, the practice must return to the Department any Start-Up Supplemental Payments it received.

B. PCMH Participation Fee Differential Payments

The Department will pay PCMH Participation Fee Differential Payments as adjustments to the existing Medicaid fee schedule, encounter rate or visit rate to qualified PCMH practices for services rendered by eligible practitioners. Practices do not need to change their current billing processes in order to receive the PCMH Participation Fee Differential Payments.

In the case of *independent practices,* PCMH Participation Fee Differential Payments will be applied to the current Medicaid fee schedule and will be limited to primary care services. The Department will post the primary care codes for which the PCMH Participation Fee Differential will be paid at www.HUSKYHealth.com.

Glide Path practices will receive a portion of the PCMH Participation Fee Differential Payment. If the practice continues along the Glide Path and achieves full qualification as a PCMH, it will get the full PCMH participation fee differential payment. Payments will cease if the practice no longer meets the Department's requirements for continued Glide Path participation.

The Department will review and revise its PCMH rates and fees when Medicaid fees for primary care physician services increase to a level equal to 100% of the Medicare FFS fees, in accordance with Section 1202 of the Affordable Care Act. This fee increase is expected to be effective January 1, 2013. The Department also intends to review and revise the PCMH participation fee differential payment amounts at such time that there are adjustments to the default Medicaid rates or fees applicable to physicians.

The Department also intends to pursue alternative methods for providing enhanced reimbursement to practices for PCMH participation, including monthly per member per month ("PMPM") payments. Based largely upon the quality of administrative data, cost data, and increasing evidence of effectiveness, we intend to pursue a prospective PMPM payment for all qualified providers by 2014. Accordingly, if the Department decides to substitute Participation Fee Differential Payments with a monthly PMPM for PCMH qualified and/or Glide Path practices, it will notify practices and provide the opportunity for comment concerning this change prior to implementation.

C. PMPM Performance Payments

The Department intends to base PMPM Performance Payments on the aggregate performance of practitioners in fully qualified PCMH Practices; Glide Path Practices will not qualify for Performance Payments. The Department will calculate PMPM Performance Payments by measuring actual performance against the adult and pediatric measurement sets outlined below under "Pediatric and Adult Performance Measures for Performance Payments" for recipients attributed or assigned to the practice during the performance period. Recipients' assignments for the purpose of performance payments may differ somewhat from the assignments established in the monthly roster. The methodology for such assignments will be provided at a later date.

In the first year of the PCMH initiative, the Department intends to make PMPM performance payments to practices for the Performance Measurement period 1/1/12 to 12/31/12. The Department may adjust the Performance Measurement period depending on the number of practices that qualify on January 1, 2012. The Department intends to distribute Performance Payments annually, but may do so more frequently at its discretion.

The Department intends to calculate PMPM Performance Payments within six months of the close of the Performance Measurement period. This will allow for at least 120 days of claims run out, performance analyses and calculation of specific performance payments.

The Department may risk-adjust the PMPMs that are the basis for the PMPM Performance Payments.

There are two types of PMPM performance payments: (1) an Incentive Payment; and (2) an Improvement Payment.

(1) Incentive Payments

To receive an Incentive Payment for the first full year of a practice's achievement of full qualification at NCQA Level 2 or 3, the PCMH practice must submit documentation and/or demonstrate to the Department that the practice is using its EHR to coordinate care; track recipient services; provide education to support disease self-management and follow-up; and conduct outreach for high-risk individuals**.**

For that first year, while the Department will calculate administrative (i.e., claims-based) performance measures, it will not use such measures as the basis for awarding Incentive Payments.

For the second year in which a practice operates as a fully qualified PCMH, and annually thereafter, the practice must submit complete and reliable performance reporting data required by the Department that cannot be derived from claims or other administrative data, but are necessary to complete Performance Payment activities.

For the second and subsequent years of full qualification, the Department intends to make annual Incentive Payments to all practices in the top three performance quartiles based on their performance on the measures described below. Practices that fall within the bottom performance quartile will not be eligible for Incentive Payments.

Incentive Payment measures will be paid as follows:

Performance Percentile	**Level of Performance Incentive Payment**
25th - 50th percentile	25% of possible incentive payment
51st – 75th percentile	50% of possible incentive payment

76th – 90th percentile	75% of possible incentive
91st – 100th percentile	100% of possible incentive

(2) Improvement Payments

Beginning the second year in which a practice operates as a fully qualified PCMH, the Department will make separate Improvement Payments to those PCMH practices that demonstrate improvement over their previous year's performance. Using first year data as a baseline, the Department will measure results and pay Improvement Payments 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	100% of the possible Improvement Payment

For the first full year of a practice's achievement of full qualification at NCQA Level 2 or 3, the Improvement Payment PMPM and the Incentive Payment PMPM will be combined.

A summary of the PCMH Start-up, Participation Fee Differential, Performance Incentive Payment, and Performance Improvement Payment amounts will be available for download at www.HUSKYHealth.com on or after December 1st.

Pediatric and Adult Performance Measures for Performance Payments

In Year 1 of the PCMH initiative, the Department will pay eligible practices an Incentive Payment and will establish a baseline for the purpose of making Improvement Payments in subsequent years.

Beginning in Year 2 of the PCMH initiative, the Department, in collaboration with stakeholders, including, but not limited to, participating PCMH practices, will also develop additional outcome-based measures based on EHR functionality.

While subject to revision by the Department due to methodological considerations, the following measures will be used to calculate PMPM Performance Payments for at least years one, two and three of the PCMH initiative:

PCMH Pediatric Measures – Year 1
Pediatric measures that the Department will use for the purpose of calculating PMPM Performance Payments are as follows:

- Well-care visits during the measurement period, including six or more well-child visits with a PCP in the first 15 months of life; one or more well-child visits with a PCP in the third, fourth, fifth and sixth years of life; and one or more adolescent well-care visits with a PCP or an OB/GYN practitioner for children 12 to 21 years old.
- Successful connection of children to dental services, including children age 2 to 21 years of age who had at least one dental visit during the measurement period with a separate report for children under age 3.
- ED visits for children 0 to 21 years of age with asthma diagnosis on the ED claim.
- 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 24 month well child visits
- A customized version of the PCMH CAHPS tool with supplemental questions for evaluation of both PCMHs and overall Medicaid provider network

PCMH Adult Measures – Year 1
Adult measures that the Department will use for the purpose of calculating PMPM Performance Payments are as follows:

- Adults age 18-75 with a diagnosis of Type I or Type II diabetes who had at least one LDL-C screening during the measurement period.
- Adults age 18-75 with a diagnosis of Type I or Type II diabetes who received at least one eye screening for diabetic retinal disease: either one retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) during the measurement year or, a negative retinal exam (no evidence of retinopathy) by an eye care professional during the measurement year or in the year prior to the measurement year.
- Adults age 18-75 who were discharged alive for AMI, coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) of the year prior to the measurement period or who had a diagnosis of ischemic vascular disease (IVD) during the measurement period and the year prior to the measurement period who had an LDL-C test performed during the measurement period.
- Adults age 21-75 with inpatient admissions with a claim for post-admission follow-up within seven days of the inpatient discharge.
- Adults age 21-75 who utilized the Emergency Department three or more times in a six month period during the measurement period
- Members 5-50 years of age during the measurement period who were identified as having persistent asthma and were appropriately prescribed medication for a prescription that was filled during the measurement period.
- Adults with initial new psychiatric condition per PCP claim with medication order and evidence of office follow up.
- A customized version of the PCMH CAHPS tool with supplemental questions for evaluation of both PCMHs and overall Medicaid provider network

Posting Instructions: Policy transmittals may be downloaded from the Connecticut Medical Assistance Program Web site at www.ctdssmap.com.

Distribution: 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.

Responsible Unit: Managed Care Unit, Rivka Weiser, 860.424.5486 and Erica Garcia, 860.424.5670.