



Committee

Council on Medical Assistance Program Oversight *Care Management – PCMH*

Legislative Office Building Room 3000, Hartford CT 06106
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5306

www.cga.ct.gov/ph/medicaid

Co-Chairs: Rep. Michelle Cook & Rep. Catherine Abercrombie **March 14, 2012 Meeting Summary**

Attendance:

Rep. Catherine Abercrombie, Karylee Hall, Sheldon Touban, Eileen Boulay, Michael Corjulo, Sandra Carbonari, Lisa Honefeld, Lori-Ann Russo, Jesse White-Frese, Dr. Alex Geertsma, Dr. Robert Zavoksi, Mark Keenan, Annie Jacob, Erica Garcia, Patricia Fostino, Kar Rodriguez, S. Kelly, Kathy Britos-Swain, Stewart Joslin, Paula Massey

The meeting begins with DSS presentation on the PCMH Update.

PCMH Update



Microsoft PowerPoint
Presentation

DSS and CHN-CT presented on an update on PCMH.

Application Status:

- 150 Practices Identified being enlisted
 - 29 former PCCM providers
- 21 Practices have submitted application

- Representing 136 practice sites with 421 PCMH providers
- 12 FQHC Applications
- 9 Community/ Independent Applications

Application Approval Status

- 2 Practices Approved for PCMH Status
- 6 Additional Practices Prepared for Approval
- Totalling 13 Location/Sites and 90 PCMH Providers
 - 72 Glidepath Eligible Providers

PCCM

- 29 PCCM Practices
- 22 PCCM Practices Outreached

Provider Portal and Charter Oak Health Plan - Demonstration from CHN Provider

Portal



Microsoft PowerPoint
Presentation

- CHN demonstrated their provider portal to be LIVE April 1, 2012.
- Questions were raised about waivers and releases. There were questions and discussion about the disclosure of substance abuse and behavioral health information. The release and protection of information and HIV disclosure was discussed. Questions about how PCP and specialists can know about releases that have already been signed. Once CHN receives the consent form and other doctors will be able to see the information. Questions are raised about the process of getting the information over to the consent officer. Question were

raised about the information be appropriate interface electronically.

- The portal can be used to run reports. A sample report is presented on slide 12. The PCMH will be able to see.
- There will be procedural codes with primary diagnosis. Questions and comments were raised about how much information a doctor would need or have to see. Comments were made about what makes the most sense for the members.
- There was discussion and interest made about having a group of pediatrics together to add and revise the portal. The group will be able to contribute to the formation of the portal.
- Comments are made about what information specialists, ER, inpatients need to see.
- Questions were raised about how the behavioral health information will be sent to behavioral health specialists about ER visits. How soon will all parties know.
- Questions about attribution and accuracy to being attributed to the panel.
 - How can we fix attribution and accuracy within the providers?
 - Information based off of actual claims.
 - Can you put well-child care visits?
 - Access of the utilization reports.
- Questions were raised about pharmacy codes. Long term pharmacy will be included. Behavioral health and substance abuse drugs will eventually be included.
- Members will be able to change attribution. Providers need to know the transfer of care has been moved. Questions were raised about how many transfers of the

- DSS will come back to the committee to address these issues.

Next meeting: There will be conclusion to the issue of having an attorney to work on mechanics and address questions about waivers.

Discussion:

There was discussion about what other states are doing in terms of – Enrollment vs. Attribution. The change of PCP to the practice to let them know who has been added or been moved. When they go live- how can they see who has been attributed. Find a group to refine the reporting. There was discussion about having a phased approach- phased information- nothing with PHI and different approach. The agency is working with flexible vendor so they can change different aspects of the portal.

CPCI Multi-Payer

- The Multi-payer is federally funded. Integrate Initiative because it directs hash-share savings which may not be so good to providers.
- CPCI initiative. CMMI Set up it is focused only on PCP providers. It goes directly to the PCP providers based upon the savings they made. It not directly associated with quality. Any application would be the outcomes of savings.
- Suggestion: Aetna- PCMH is not for care coordination. It is for NCQA defray application cost. There should be incentive wise to outreach and waive PCMH application costs. Providing education on where they can get help on the PCMH. They would supplement agreement. 25 % discount on getting NCQA.

Language PMPM Payment

- Discussion based upon last meeting suggestions the language would be discussed. The department received the comments and the regulations have not been finalized. The regulations are open for further discussion. The department may in the future go to the prospective PMPM payment. Regulations have become finalized. Follow-up conversations are necessary to see the direction of the conversation.

Other Comments:

- Discussion about the Quality Improvement Subcommittee:
 - Proactively involved to define measures and process of health care provision on the level.
 - Definition of quality measure
 - Combination of QI committees.
 - Appropriate utilization of health care dollars.
 - Need adult providers at the table.
 - Encourage everyone to participate in QI committee.
 - Update on the quality committee.
 - How we figure out the essential components of health care to achieve these outcomes.
 - Important measures that DSS and CHN have been looked at for Adult and Children from the QI Committee.

Next Meeting: April 11, 2012 10:00 -12:00 Room 2A