



Council on Medical Assistance Program Oversight Care Management (PCCM/PCMH) Committee

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www.cga.ct.gov/med/

***Co-Chairs: Rep. Michelle Cook & Rep. Charlie Stallworth
February 13, 2013 Summary LOB Room 2A***

Attendance: Representative Michelle Cook, Representative Charlie Stallworth, Dr. Robert Zavoski DSS, Erica Garcia DSS, Kara Rodriguez CHNCT, Annie Jacob DSS, Deborah Amato CHNCT, Laura Demyer CHNCT, Mary Krenztnan CHNCT, Vernice Franvis-Chariltor CHNCT, Maureen Fiore CHNCT, Tiffany Huntoon CHNCT, M. Alex Geertsma ACES/CMC, Lori-Anne Russo CHCACT, Jesse White-Frese CASBHC, Mark Keenan DPH, Sheldon Toubman NHLA, Lisa Honigfeld CHDI, Sandi Carbonari CT-AAP, Ann Foley Office of Policy and Management, Rep. Charlie Stallworth

Representative Cook opened the meeting at 10:00 AM in LOB Room 2A. There were introduction of committee members.

Office of Policy and Management Update on FQHC

Ann Foley gave an update on the changes in FQHC in the governor's budget. There are four proposed changes to FQHCs.

1. Rolling forward with the deficit mitigation plan, it will eliminate incentive payments to FQHCs. The projected savings will be 5.3 million the first year and 7.3 Million the following year.
2. Requirement of timely filing of cost reports. Accurate Reporting.
3. DPH reducing number of people insured. Grants 300,000.
4. Final Change. Grant program how much earmarks. During the budget deliberations looking for a significant amount of savings DPH allocation of # of people served. Comments about Redistribution of funds among FQHCs.

Comments and Discussion

- Sheldon asked why and what is taken into consideration when making this decision and did this proposal come from DSS or Office of Policy and Management.
- Ann made comments about how there was a number of things put on the table by all parties and it came from the administration.
- Sheldon made comments about the committee and department have been working hard on this program and incentives. He inquired how DSS works towards PCMH certification if they wouldn't receive the glidepath payments.

- There is still going to be technical assistance that is already included in the reimbursement costs.
- Zavoski- Still be receiving technical assistance and already in the program will be receiving reimbursement at cost. JCAHO accreditation with technical resources.
- Questions if this means the end of DSS recruitments and how do they see the recruitments of FQHCs They will receive technical support but no money.
- Questions if specific quality measures improvement if they are not getting incentive payments. FQHC have federal requirements. There will be no other category of PCMH.
- Questions if expanding PCMH and Qualifying PCMH and the Medical Home, are other carriers giving incentive payments. Medicaid is the only payer that gives incentives up front with no extra compensation.
- They are reimbursed at cost. Reasons for primacy incentive payments. Other providers are not even paid close to cost.
- Mike Cordjulo asked why was it not considered or discussed when designing this model.
- Office of Policy and Management responds with they needed reevaluate everything and the policy needs additional scrutiny.
- Alex Geerstma M.D made comments about level of reimbursement depends on providing services. Care to Medicaid Payments how it is determined is not clear.
- Ann Foley made comments about reducing by maintaining DPH grants.
- Mike Cordjulo made comments about activity participating in the PCMH committee, how the state can still maintain its commitment and faith into the system because of the health care model.
- Ann commented about the FY 2012 Budget and the governor's proposal. There may be other important legislative ideas.
- Lori Ann Russo commented about not going to the level of recognition them originally intended. Place more focus and shift in the workflow. Production decreases. Cost may increase but decrease in productivity.
- Sandi Carbonari commended about in order to be NCQA must have an EHR. It is a negative impact- 200 man hours for one state.
- Sheldon made comments about specific targets and federal law requirements. He made comments about how it will solve with 0 financial incentives for those measures.
- Lori Ann Russo made comments about prioritizing UDS measures. Not to have the quality measures focus.
- Alex made comments about not volume generated like fee for service. What kind of long term commitment for PCMH and outcomes related. Comments made about other payment system.
- Budget cuts ready to make that move collectively as a state. Access health with limited.
- Zavoski- department committed to look at payment reform. Largest reform to Health Care level to Medicaid. Balance budget with the demand.
- Sheldon commented about the process with deficit mitigation and what the commitment any more proposing cuts.
- Ann made comments about how the legislators were in the room assumed deficit mitigation plan would get out to other legislators. The 2 year budget is balanced. The process is going to move forward with no further cuts to PCMH.
- There was discussion on how the closing of FQHCs and cuts to them are going to be impacted by the budget.
- Rep. Cook thanked Ann Foley for the presentation and answering questions.

DSS Report Glidepath Update

Erica Garcia provided the PCMH and Glidepath Update. The Presentation is in a separate attachment. Kara Rodriguez provided an overview of the PCMH Glidepath Application update. Deb Amato gave an update on the recruitment status.

- PCMH Application Status
 - **50 PCMH Program Participants**
 - **232 Individual Sites**
 - ✓ 18 PCMH Approved Practices
 - 118 Sites
 - 446 PCMH Approved Providers
 - ✓ 1 Practice Pending PCMH Approval
 - 1 Site
 - 3 Providers Pending Approval
 - ✓ 18 Glide Path Practice Participants
 - 37 Sites
 - 116 Glide Path Providers
 - ✓ 13 FQHC-PCMH Eligible Participants
 - 76 Sites
 - 293 FQHC-PCMH Providers
 - 18 Current Glide Path Practice Participants
 - ✓ 37 Total Practice Sites:
 - ✓ 12 Practices Currently in Phase 1
 - ✓ 4 Practices Currently in Phase 2
 - ✓ 2 Practices Currently in Phase 3
 - **193 practices contacted since 1/1/12**
 - 50 practices enrolled in the program
 - 85 prospective practices in open status
 - 28 practices on a Watch-List
 - 30 practices on a Closed-List
 - **EHR Status of 85 practices in open status:**
 - 50 practices (59%) have live EHRs, purchased or implementing an EHR
 - 8 practices (9%) are searching for an EHR
 - 4 practices (5%) have no EHR
 - 23 practices (27%) the EHR status is unknown at this time
 - **2 new PCMH practices since the last committee update (December 12, 2013)**
 - Avon Health – 1 site, 3 providers (Hartford County)
 - Soundview Medical Associates – 1 site, 19 providers (Fairfield County)
 - **2 practices advised PMCH applications are being worked on:**
 - Fairfield County Integrative Family Medicine, LLC (Fairfield County)
 - Grove Hill (Hartford County)
 - Comments and Discussion
 - Discussion about how many practices have met the time table. Some practices have met the time table and others have got an extension. It is included in the chart.
 - Some practices have decided to remain in open status or have not given a definitive response. Some practices are not EHR ready yet.

- Rep. Cook inquired in 30 practices is open and if any of the practices have become closed after the deficit mitigation.
- Request to break the list down by pediatrics.
- Discussion about FQHC's and JCAHO.

JCAHO Accreditation for PCMH

There was discussion on how DSS is looking into accreditation for FQHCS in the JCAHO Accreditation.

- There is a crosswalk between NCQH and JCAHO.
- CPS staffs are active in the practices. The education component is already in place. There is tool kit information live on their website. There is no longer work plan documentation. They will be able to focus on accreditation. A lot of research is being done.
- Laura gave a working example of how a NCQA Level 1 in Torrington is learning the process. GAAP Analysis is being done.
- There are some differences with the process.
- If the FQHC is already accredited JCAHO, is it less intensive.
- It is submission based. Ambulatory care accredited.
- Focus on the PCMH Component. Question of where does the practice put their efforts.
- Lori Ann Russo made commented about 8 of the Health Care Centers are already accredited.
- Discussion about the differences.
- There was a discussion about HRSA funding. What are the incentives?
- The incentive is technical support, resources and identifying resources. Work is being done with DSS and other partners. It is a collaborative engagement.
- Discussion about using current evidence based guideline especially for Chronic Multi Co-morbid member. Need to keep that member as healthy as possible. How can the provider be as supportive as possible?
- Discussion about having providers being part of the process for care coordination. Having providers see the care plan will help the providers know what the member needs to be focusing on.

Intensive Care Management Program Intensive Care Management Program

- Intensive Care Management
 - Intensive Care Management provides Care Coordination to high risk Husky Health and Charter Oak members
 - Intensive Care Managers partner with you, the Provider, to facilitate a smooth transition of care across settings.
 - Promote Wellness and Preventive Care
- Program Goals
 - Assist the patient to follow through on your recommended treatment plan
 - Promote Medication knowledge, safety and adherence
 - Coordinate care by assisting you and your patient to access medically necessary services.
 - Empower members in self-care through education, self-help coaching and patient centered care planning.
- Role of ICM Care Manager
 - Collaborates with the interdisciplinary team, member and provider
 - Assess, develop and coordinate a member centric integrated care plan
 - Offers a hybrid model of “face to face” and telephonic communication
 - Work collaboratively with external regulatory agencies, waiver programs and ASO partners
- Referral Process

Contact Provider Line - 1.800.440.5071 and when prompted dial EXT 2011 to request ICM services

- ICM Contacts

There referrals come from the PCP, DSS, CHNCT. There was a question regarding consent assessment and mail to the provider. There was a question about how frequent they are contacting that provider. DSS made comments about how the program is being worked and ramped up. Sheldon asked about Criteria, sharing of material and who ICM can be done for. Coordination is done for those who have chronic and frequent hospitalization, gaps in care, behavioral conditions, those going to ED, and don't have a PCP. ICM is doing Patient Centered Care Planning; Sandi Carbonari recommends the plan gets sent to PCP, it would beneficial to get PCP's opinion.

Meeting ends at 12:00 PM. The Next meeting will cover a glidepath/PCMH Update and Community Support Services Presentation.

Next Care Management Committee is April 10, 2013 at 10:00 AM in LOB Room 2B.