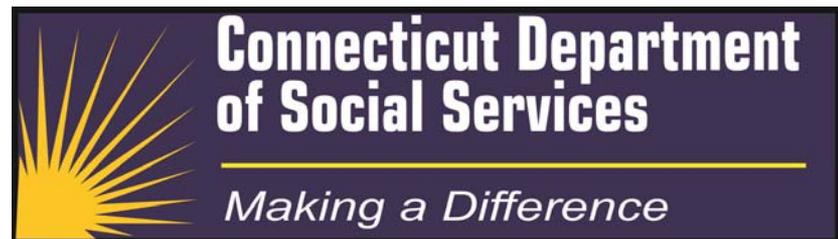


Presentation to the Medical Assistance Program Oversight Council

July 8th, 2011



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Person-Centered Medical Home (PCMH) Stakeholder Input Process and Update

PCMH Stakeholder Input Process

- Very broad input from stakeholders:
 - MCMOC/MAPOC
 - Consumers (with involvement from advocates, community-based organizations, providers and MCOs)
 - PCCM Sub-committee
 - PCMH Provider Advisory Workgroup
 - PCMH Pediatric Workgroup
 - Other interested parties
- DSS synthesizes input and ultimately drives policy, program and reimbursement

Stakeholder Input On Key Topics

■ Underway...

- Standards for Recognition
- Glide Path
- Special issues (e.g. pediatric practice)
- Provider Survey
- Consumer Input/Focus Groups

■ Planned...

- Required provider supports
- Enrollment/Attribution (just starting)
- Reimbursement (just starting)



PCMH Standards Update



PCMH Standards Need to Be ...

- Person-centered
- Data-driven
- Multi-payer compatible
- Easy to administer
- Outcomes-oriented
 - high-risk individuals
 - Structure, process and outcomes

NCQA PCMH Standards

Strengths

- Addresses elements noted desired by the PCMH Standards Sub-committee
- Most widely used set of PCMH standards available
- Selected by the Comptroller's Office for State Employees
 - Already used throughout Connecticut
- 2011 standards are significantly more user friendly than 2008 standards
- Application fee has come down significantly

NCQA PCMH Standards

Limitations

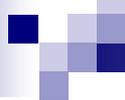
- Need to balance structure and outcomes
- Costly for smaller practices (which may) lack resources
- Potential special issues for pediatric practices (e.g. EHR among others)
- Need to ensure that client-specific issues and needs can be addressed
- Some FQHCs have TJC (with PCMH add-on as an option)

PCMH Standards “Straw Man”

- Propose NCQA Level 2 PCMH Certification
 - 2008 for those already certified
 - 2011 going forward
- Areas of focus for Medicaid through P4P
 - But not within the certification process
- The Joint Commission w/ PCMH add-on *under review and consideration*

PCMH Standards: “Straw Man” Proposal (cont)

- Recognition Process and Monitoring
 - NCQA Level 2 would represent a significant “lift” for providers to achieve
 - Provider Advisory Council and sub-workgroups suggest that DSS not utilize:
 - Submission of documentation (NCQA is all electronic in any case)
 - Site visits or ongoing audits
 - Utilize outcomes data to monitor PCMH
 - ASO role in reviewing ongoing progress TBD



PCMH Standards: “Straw Man” Proposed Glide Path Approach

- Allow practices a Glide Path of 9-15 months to achieve full NCQA recognition
- Partial payment once a practice is on the Glide Path based on:
 - Demonstrated clear commitment to PCMH standards
 - Work plan, milestones and a time line
 - Agreement to meet milestones or lose payment going forward

The Joint Commission (TJC) PCMH Approach to Recognition

- New July 1, 2011
- TJC PCMH standards are part of the on-site accreditation process as an add-on including 57 PCMH questions
 - Only available to 8 Federally Qualified Health Centers (FQHC's) that are already TJC accredited; 4 prefer JCAHO to NCQA but all would be "willing" to seek NCQA according to CHCACT
 - The Bureau of Primary Care pays for TJC or NCQA recognition for FQHCs
 - Also affects hospital-based ambulatory sites (not surveyed)

High-level Comparison of NCQA and TJC's PCMH Standards

- TJC standards most significantly vary from NCQA at a high level:
 - TJC does not require an EHR
 - Affects providers' ability to manage chronic conditions and easily collect data on outcomes
 - TJC and NCQA take a different approach to gathering information on patients
 - TJC is more focused on patient safety while NCQA is more focused on medical management of high-risk consumers
 - Described by one stakeholder as the “vessel” (TJC) as compared to what is inside of it

High-level Comparison of NCQA and TJC's PCMH Standards (cont)

- DSS will meet with TJC on July 15th to review a “crosswalk” to NCQA
- Considerations identified to date
 - Ensure quality and access based on ability to meet standards
 - Payment based on qualifications and effort
 - Ease and cost of administration to the State and “bang for the buck” (e.g. how many practices are affected?)

High-level Comparison of NCQA and TJC's PCMH Standards (cont)

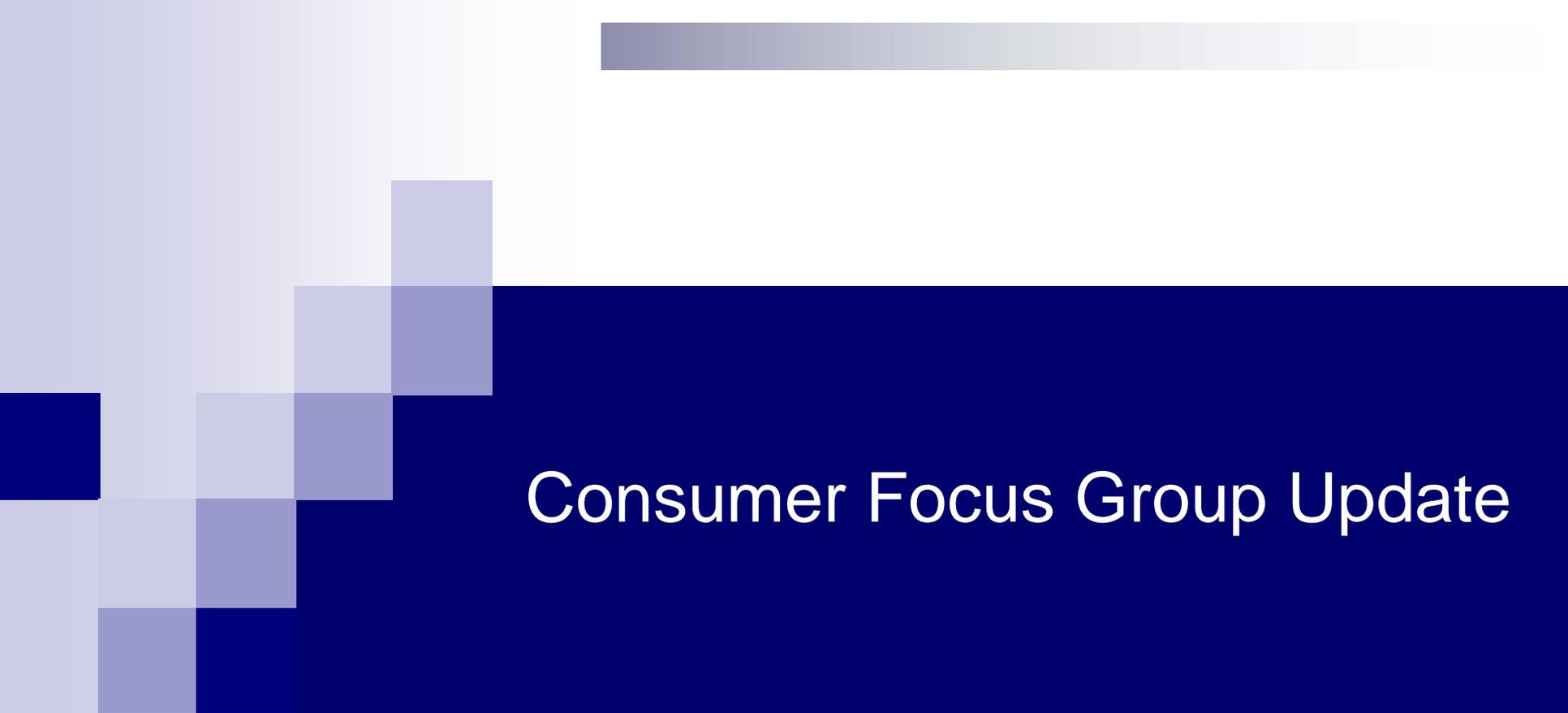
- TJC goes on-site; NCQA is electronic
- TJC recognizes by organizations as a whole; NCQA recognizes by site
- Standards themselves differ; TJC believes they are “less prescriptive” with different ways to come into compliance; NCQA is more “detail-oriented”
- NCQA requires 25%, 50%.....JCAHO is frequency-based (e.g. 3/5 records indicate...)

Standards: Comments?

- Use of NCQA?
- Glide path?
 - How much time?
 - What should be required?
 - Payment on Glide Path?
- Use of the recognition process and outcomes data (with stakeholder input on desired outcomes)?
- Use of TJC Standards?

Pediatric Practice Issues

- Standards are more adult oriented and disease oriented
 - Who is the “patient” and how does PCMH relate to families
 - More to follow (meeting on 7/13 and again on 7/19)
- General issues for “smaller” practices
 - Not all practices are familiar with PCMH or NCQA Standards
 - Provider education re: PCMH and standards???
 - Costs of operating as a PCMH are a concern (for many “small” practices – not just pediatrics)
 - Certification fees
 - Costs associated with developing PCMH capabilities (e.g. Electronic Health Record)
 - Resources required to conduct care coordination

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Consumer Focus Group Update

PCMH Consumer Focus Groups

- Goal is to obtain unbiased input to inform the development of a truly “Person-Centered” Medical Home
- Development process includes:
 - Community Health Center Association of CT
 - DPH
 - Mothers for Justice
 - Community-based groups
 - Numerous advocates and other participants

PCMH Consumer Focus Groups (cont.)

- Plans to recruit and run include:
 - Medicaid/Title XIX, HUSKY A & B, Charter Oak and MLIA consumers
 - Multiple groups including: adolescents; individuals with disabilities; pregnant women and mothers of newborns; children with special health care needs; general population
 - Geographically dispersed
 - One group run in Spanish with a translator

PCMH Consumer Focus Groups (cont.)

- Plans to recruit seven groups of 10-12 consumers include:
 - Involvement of community-based organizations in collaboration with DSS stakeholders
 - Written and telephonic outreach and follow-up to confirm (an over-sampling) of participants
 - Consumer incentives to participate (\$20 gift certificate, refreshments, reimbursement for transportation and child care)

PCMH Consumer Focus Groups (cont.)

- Sample topics for input include:
 - Current patterns of use
 - Presence of a usual source of care
 - Current and desired experience of care
 - Follow-up after appointments
 - Sense that staff at your doctor “know” you
 - Sense of understanding and respect for background and culture

PCMH Consumer Focus Groups (cont.)

- Groups will run in late July and August
- Facilitator and note taker will be present
- Plans to audiotape the sessions
- Will produce a summary of each meeting and implications for PCMH planning and development early in September



PCMH Consumer Focus Groups (cont.)

- Comments? Suggestions?



Changes to the CT Dental Health Partnership

Participating Dental Practitioners as of June 30, 2011

County	Endo	General Dentists	Oral Surgeons	Ortho	Pediatric Dentists	Perio	Hygienists	Totals
FAIRFIELD, CT	4	187	11	11	19	1	20	253
HARTFORD, CT	5	292	33	26	34	1	26	417
LITCHFIELD, CT	0	36	5	3	3	0	0	47
MIDDLESEX, CT	0	41	1	1	8	0	10	61
NEW HAVEN, CT	7	221	29	18	25	1	12	313
NEW LONDON, CT	2	51	3	4	7	0	6	73
TOLLAND, CT	0	24	1	3	2	0	0	30
WINDHAM, CT	0	34	0	1	0	0	4	39
Out of State	0	58	0	0	3	0	0	61
Totals	18	944	83	67	101	3	78	1,294

Participating Dental Service Locations

as of June 30, 2011

County	Endo	General	Oral	Ortho	Pediatric	Perio	Totals
		Dentists	Surgeons		Dentists		
FAIRFIELD, CT	1	134	10	14	12	1	172
HARTFORD, CT	2	174	20	18	23	1	238
LITCHFIELD, CT	0	33	6	6	2	0	47
MIDDLESEX, CT	0	24	1	3	5	0	33
NEW HAVEN, CT	5	137	15	14	12	1	184
NEW LONDON, CT	2	26	2	5	4	0	39
TOLLAND, CT	0	16	3	2	2	0	23
WINDHAM, CT	0	19	2	2	0	0	23
Totals	10	563	59	64	60	3	759

Changes to the CT Dental Health Partnership

- Effective July 1, 2011, changes to the adult (> 21) dental benefits went into effect
 - No services have been eliminated
 - Reductions in the number of services allowed per rolling 365 day period for healthy adults
 - Periodic examination
 - Cleaning
 - Bitewing X-rays
 - Prior authorization added to select services
- 365 day look-back from the date the service is performed

Changes to the CT Dental Health Partnership

- One time replacement per seven-year period for:
 - Partial dentures
 - Complete dentures
- Reduce coverage for posterior composite resins (white fillings) on posterior teeth
 - Remove molar teeth as eligible teeth, premolar teeth remain eligible for the service
- Limit the comprehensive examination to one time per client; this will help promote the dental home concept

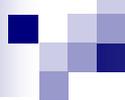


Changes to the CT Dental Health Partnership

- Limit fluoride coverage to clients who have xerostomia (dry mouth) or had head and/or neck radiation treatment
- Limit periapical X-rays to no more than four per year
- Prior authorization necessary for panoramic X-rays except for orthodontists, oral surgeons and radiologists

Changes to the CT Dental Health Partnership

- On June 1, 2011, the ability to submit Prior Authorization requests via the Web went live
- Address is www.ctdhp.com under “Provider Partners”
- Allows providers to fill out an easy PA request form and submit digital X-rays
- Results in a cost savings for postage
- Ensures that requests are not lost in the mail

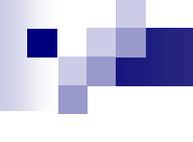


General Reminder

If you or your staff are contacted by a HUSKY or Medicaid client regarding dental services, please have them contact the CTDHP call center.

866-420-2924

24 hours a day, 7 days a week



Medical ASO update

- Four applications received
- Reviews are on schedule
- Selection: late July/early August 2011
- Contract: September 2011
- Go live: January 1, 2012



Medical ASO update



Charter Oak Health Plan Changes

Charter Oak Health Plan

- Anticipated premium increases effective 9/1/11
 - Increased rate for new enrollees and those enrolled 6/1/10 or after, regardless of income. Current premium is \$307 per member per month.
 - Increased rates for members receiving premium subsidy; affects those enrolled as of 5/31/10 currently paying \$129 - \$296 per member per month. Premium subsidies will be reduced.
 - Effective 9/1/11 eligibility will be limited to those applicants who do not qualify for the CT Pre-Existing Condition Insurance Plan.



CT Pre-Existing Condition Plan Changes



CT Pre-Existing Condition Insurance Plan

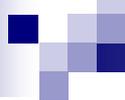
- DSS is seeking federal approval to implement a single “flat” premium rate, regardless of age. Current premiums \$243 - \$893 per member per month.
- Rate will be more affordable for most members.
- Allows the state to take full advantage of the \$50 million federal allotment to provide health coverage to those with pre-existing conditions.
- Anticipate premium change effective 9/1/11



HUSKY B Band 2 Premium Refunds

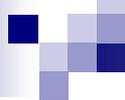
HUSKY B Band 2 Premiums Reduced

- CT passed legislation in 2010 that raised premiums for families with income between 235% FPL and 300% FPL by \$8 or \$10 per month
- In February 2011, CMS clarified maintenance of effort rules for CHIP
- Clarification considers a premium increase to be a restriction on eligibility



HUSKY B Band 2 Premiums Reduced

- DSS must restore premiums to former levels and refund families
 - Invoices were adjusted with the new rates in April for the June service month
 - Families enrolled between 7/1/10 and 5/31/11 will be credited or refunded the difference in premium amounts
 - Families who disenrolled or were locked out due to unaffordability will be contacted and allowed to re-enroll retroactively if they remained uninsured during that period



HUSKY B Band 2 Premiums Reduced

- Families actively enrolled will receive a credit to their account by 7/1/11
- Other families will receive a refund check in the mail by 7/31/11
- Notices were sent to families on 6/15/11

HUSKY B Band 2 Premiums Reduced

	Premiums 7/1/10-5/31/11	Premiums on June 1, 2011 (& retro to 7/1/10)
Income Band 2		
One child	\$38	\$30
More than one child	\$60	\$50



HUSKY B Co-pay/Co-Insurance Refunds

HUSKY B Co-payment & Co-Insurance Refunds

- CMS notified DSS that increased co-payments and co-insurance amounts implemented in July 2010 could not be made effective until March 2011
- CMS is working with DSS on a plan to refund clients – not yet finalized
- DSS is working with ACS, MCOs and HP to identify the amount of cost-sharing clients paid out of pocket to refund families between 7/1/10 and 2/28/11
- Anticipate that ACS will be mailing refund checks directly to clients to avoid reprocessing claims and expecting health care providers to refund patients

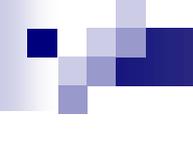


Effects of HUSKY B Cost-sharing Changes

- Enrollment in HUSKY B band 2 has steadily trended upward despite last year's cost-sharing changes.
- Enrollment of children in band 2 increased approximately 3.3% overall between 7/1/10 and 2/28/11 as compared to 7/1/09 through 2/28/10



HUSKY Primary Care Update



HUSKY Primary Care Update

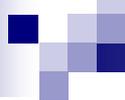
As of 6/1/11

- PCP enrollment: 250
- Member enrollment: 535

(For all four pilot areas: Waterbury, Windham, New Haven & Hartford)

Putnam Area Expansion

- Mailed to 3,340 HUSKY A households in the seven towns:
 - Letter inviting members to participate
 - Brochure explaining HUSKY Primary Care
 - Enrollment form
 - List of participating PCPs
- New HUSKY A members will receive HUSKY Primary Care mailing



Torrington Expansion

- Invited providers in towns that are part of Torrington area pilot:
 - Torrington, Barkhamsted, Winchester, Goshen, Litchfield, Harwinton & New Hartford
- Working with area hospital seeking providers who will participate
- Mailing sent to non-hospital affiliated providers

Putnam Area Expansion

- Recruited 22 providers practicing at 9 sites:
 - 9 Pediatrics MDs & 1 Pediatric APRN
 - 3 Internal Medicine MDs
 - 8 Family Practice MDs & 1 Family Practice APRN
- ACS is enrolling members effective July 1, 2011
- Addition of Putnam area brings to 5 the number of areas that have HUSKY Primary Care as an option



Other updates



Limitation in Vision Coverage

- Effective July 1, 2011
 - One replacement of eyeglasses every two years
 - Exception for change in condition
 - No replacement for accident/loss

Change in Obstetrics Fees

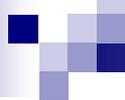
- Currently Physician Surgical Fee Schedule includes 2 rates, a surgical rate (at 57.5% of Medicare fee) and an obstetrical rate (ranging between 166%-180% of Medicare fee)
- VBAC rates have been priced as surgical rates and all other deliveries at obstetrics rates
- The goal for this new fee change is to eliminate the financial disincentive to perform VBAC deliveries by creating a consistent pricing policy for all delivery services
- C-section rate in CT Medicaid is around 35% - national goal through Healthy People 2020 calls for a reduction in C-section rate to 15%

Change in Obstetrics Fees

- Two reimbursement changes to OBGYN Fee under Physician Surgical Fee Schedule effective July 1, 2011
 - All Vaginal Birth After Cesarean (VBAC) payable at higher obstetrical rate
 - A uniform alignment of the obstetrics rates to all delivery codes to a consistent 150% of the 2007 Medicare rate

Reduction in Pharmacy Reimbursement

- Effective July 1, 2011
 - Brand reduced to Average wholesale price minus 16%
 - Generic reduced to Average wholesale price minus 72%
 - Dispensing fee reduced to \$2.00



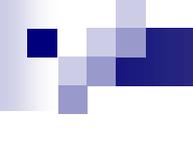
Tobacco Cessation

- Coverage for all Medicaid recipients effective January 1, 2011
- DSS submitted for Medicaid Incentive Grant in May focused on tobacco cessation in PCMH and OBGYN settings
- Total request: \$10 million
- Anticipated notification: July 2011



Other Initiatives

- New coverage/eligibility
 - Individuals with TB – October 1, 2011
 - Family planning – October 1, 2011
- Podiatry Services: October 1, 2011
- 1915(i) coverage for state funded home care for elders program: TBD



Provider Enrollment

- ACA enrollment requirement
 - Refine policies regarding enrollment of “ordering and referring” providers in clinics and hospital settings
 - Work with provider community to facilitate initial enrollment i.e. CHCACT Board of Directors
- Continue to work to streamline the enrollment process i.e. finalize work with DPH to obtain electronic feed of licensure information



Questions?