Becoming a PCMH: Is It Right For Our Practice?

December 7, 2012

What is a Person-Centered Medical Home?

- Team-based health care delivery model led by a physician
- Comprehensive & continuous primary care with a triple aim goal of lowering costs while enhancing the patient care experience and maximizing health outcomes
- Care coordination is an essential component of the PCMH
- Appropriately trained staff provide coordinated care through team-based models
- Additional resources are needed such as health information technology

Model of Care for CMAP Beneficiaries

- Providing health care that is patient-focused
- Puts doctors, not insurers, in charge of medical decisions
- Improves health care outcomes and reduces costs
- Primary care doctor coordinates care with specialists, hospitals and pharmacists to reduce duplication and errors
- Ensures patients follow through with treatment plans
- Preventative medicine keeping people healthy and out of the emergency rooms

In 2011, Lt. Governor Nancy Wyman Stated:

"The person-centered medical home concept is not only a better way to care for patients, but is a benefit for taxpayers because it is another step toward a self-insured coverage program that will mean significant savings over the existing managed-care system."

Lieutenant Governor Nancy Wyman

PCMH Press Release, May 12, 2011

The Criteria to Become a DSS-Recognized PCMH

- Connecticut Medicaid participating primary care provider
- Must be recognized at NCQA PCMH Level 2 or 3 Or file a "Glide Path" application with DSS to pursue NCQA recognition working with the Community Practice Transformation Specialist team
- Participating providers must devote 60% of clinical time to primary care
- Must have a panel of CMAP patients – includes community preceptors or APRNs and PAs serving another physician's panel
- Must share all medical records within the practice
- Meet state/federal requirements for EPSDT, smoking cessation (Rewards 2 Quit), addressing racial & ethnic disparities, and adherence to Consumer Protections

Differences in this Initiative and NCQA

- CHNCT's Community Practice Transformation department will guide and support practices through the NCQA process at no cost to the practice
- DSS will pay enhanced rates for either achieving or working to achieve PCMH recognition
- Additional financial incentives for PCMH program participation
- This initiative is designed to get as many practices in Connecticut that provide primary care to Medicaid recipients to be recognized by NCQA as a PCMH

Electronic Health Record

- An EHR is necessary to reach level 3 recognition with NCQA
- It is recommended that a practice purchase or plan on updating current EHR products to achieve Meaningful Use Criteria
- Practices may receive EHR Incentive payments from either Medicare or Medicaid to assist with the expenses associated with acquiring and operating an EHR
- Must begin by 2016 to receive Medicaid EHR incentive payments; last incentive payment year is 2021

Four Types of Incentives

1. Participation Fee Differentials- an add-on to the per visit medical rate for 81 selected CPT codes based on Glide Path status or Level 2 or 3 NCQA recognition.

2. PCMH Performance Payments- specific payments made to NCQA-recognized practices based on performance of DSS selected health measures.

3. Improvement Payments-specific payments to PCMH practices that demonstrate improvement over their previous years performance.

4. Medicaid EHR Incentives- available to any practice in which Medicaid beneficiaries comprise 30% of their patient encounters, 20% for pediatric practices - maximum EHR incentive payments are $63,750 over six years

The Role of Community Health Network of Connecticut, Inc.

- CHNCT is the Medical Administrative Services Organization (ASO) contracted with DSS
- Network Managers will educate practices about the program and assist with the application process
- Community Practice Transformation Specialists will provide assistance throughout the NCQA process consisting of 18 to 24 months

Application Process

- Applications and instructions are available at www.ct.gov/husky. Click the "For Providers" link and then click "Person-Centered Medical Home" in the left navigation. You can also email pcmhapplication@chnct.org.

- Practices should work directly with their Regional Network Manager on their Readiness Evaluation Questionnaire and their PCMH Application.

Learn More About This Initiative

- Contact the Network Management Department at CHNCT by calling 203.949.4194

- Visit the website for the National Committee for Quality Assurance at www.ncqa.org and review the information on PCMH recognition