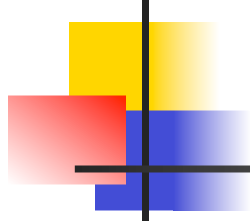


The New
HUSKY Health Program and Charter Oak Health Plan

Introductions:

- Department of Social Services
- Community Health Network of Connecticut, Inc. – the Department’s Administrative Services Organization for the HUSKY Health Program and Charter Oak Health Plan
- Hewlett-Packard Enterprise Services – the Department’s Medicaid Management Information System fiscal agent contractor

- We are expanding the services that were only available to HUSKY and Charter Oak members to Medicaid/FFS clients
- Smoking cessation services
- Focus on preventive care – **right care at the right place and at the right time**
- Person-centered care: ICM and PCMH

The New HUSKY Health Program and Charter Oak Health Plan

- Starting January 1, 2012, all DSS medical assistance clients will get services through our single, statewide HUSKY Health & Charter Oak administrative services organization (ASO)

- DSS has chosen Community Health Network of Connecticut, Inc. to be the administrative services organization for the new HUSKY Health Program and Charter Oak Health Plan

Who Will Participate in the HUSKY Health Program and the Charter Oak Health Plan?

- **HUSKY A members**
  - Children and qualified adults, including pregnant women
- **HUSKY B members**
  - Children (0-18) whose families are over income for HUSKY A
- **HUSKY C members**
  - Single eligible adults in the Aged, Blind and Disabled category;
  - This includes people who have both Medicare and Medicaid

Who Will Participate in the HUSKY Health Program and the Charter Oak Health Plan?

- **HUSKY D members**
  - Low-Income Adults (former SAGA clients)
- **HUSKY Limited Benefit members**
  - Individuals who have been diagnosed with tuberculosis and do not qualify for full Medicaid coverage and the inpatient inmate program
- **Charter Oak Health Plan members**
  - Adults ages 19-64

What is Not Changing

- Benefits stay the same
- Eligibility – no changes in eligibility requirements, application and renewal process
- Premiums and cost-share – HUSKY B and Charter Oak members

- It will replace the current managed care delivery system with a single administrative services organization (ASO) model beginning with dates of service January 1, 2012
- This model of care covers all of the Department's medical assistance clients
- All HUSKY Health and Charter Oak members will be getting all health services only from CMAP-enrolled providers

Am I a Medicaid-CMAP Enrolled Provider and how do I enroll?

- If you are unsure whether you are a CMAP enrolled provider, please contact the Hewlett Packard (HP) Provider Assistance Center at: In state callers:**1-800-842-8440,** out of state providers call: **1-860-269-2028.**
- If you are currently a fee for-service Medicaid provider (i.e., you are reimbursed directly by HP for services you provide to non-managed care Medicaid clients), you do not need to take any action at this time.
- Note, if you previously enrolled but have not submitted a claim for over one year, you may have been disenrolled from the CMAP network.
    - Please contact the HP Provider Assistance Center at: **1-800-842-8440** for help with determining if you are enrolled or not.

- Member and Provider Services
- Referral assistance and appointment scheduling
- Provider Recruitment
- Health education
- Utilization management including prior authorization
- Case management including intensive care management
- Quality management
- Health Data analytics and reporting

Frequently Asked Provider Questions:

Will clients use their current ID cards and number?

- Members will continue to use their current ID card, they will receive new identification cards in the near future.
- The identification number will not change; HUSKY members may use their grey connect card and Charter Oak members may continue to use their white card until the new card is received.

When do you contact CHNCT?

- Call CHNCT when you:
  - To locate a CMAP provider
  - For authorization of a service
  - To identify a member who may need intensive care management or a disease management program
  - To verify a member's eligibility
  - Smoking Cessation
  - Translation Services
  - Person-Centered Medical Home

New Process, Effective March 1, 2012

- Web portal will be available allowing a secure automated process for providers to request authorizations
- During the month of February, CHNCT will outreach to providers to provide more detail and training on the new process

Submission of Claims

(processed daily, payments are run every 2 weeks)

- Claims for dates of service December 31, 2011 and prior must be submitted to the appropriate MCO.
- Effective with dates of service January 1, 2012, all claims for members in the HUSKY Health Program and the Charter Oak Health Plan will be submitted to HP.
- For deliveries on or before December 31, 2011, provider may submit global obstetric codes for CHNCT member to CHNCT.
- For deliveries on or after January 1, 2012 with prenatal care prior to January 1, 2012, providers should submit prenatal care codes to CHNCT or appropriate MCO, and delivery codes to HP rather than bill global obstetric codes.

Person-Centered Medical Home Initiative

- Concept was developed in 1969 by the American Academy of Pediatrics
- Medical home has been around for 40 years beginning as a physical location and evolving to a model of care delivery - typically known as the *patient*-centered medical home
- *Person*-centered more accurately reflects DSS's underlying model and design
- PCMH is a process of providing comprehensive primary care with patient as a partner

Person-centered Care (cont)

- Greater care coordination
- Increased access (especially after hours)
- Greater staffing to support increased access
- Receive educational support with a focus on self-care and personal empowerment
- Benefit from the ability of providers to share documentation in an HER
- Right care in the right place at the right time – focus on prevention

PCMH Standards for Participation

- National Committee for Quality Assurance (NCQA) Recognition required:
  - Level 2 or 3
  - 2008 or 2011 (with 2011 going forward)
- Additional DSS PCMH participation requirements (in process):
  - Federal EPSDT requirements
  - Smoking cessation incentive program
  - Efforts to decrease racial and ethnic disparities among consumers
  - Consumer protections (PCMH and ASO)

How NCQA PCMH 2011 Standards Work

The PCMH 2011 program's six standards align with the core components of primary care. They score practices on six areas that define patient-centered medical homes

PCMH 1: Enhance Access and Continuity
PCMH 2: Identify and Manage Patient Populations
PCMH 3: Plan and Manage Care
PCMH 4: Provide Self-Care Support and Community Resources
PCMH 5: Track and Coordinate Care
PCMH 6: Measure and Improve Performance

Six “must pass” elements are essential for PCMHs at all three recognition levels. Practices must score of at least 50 percent on these elements, which include:

- PCMH 1, Element A: Access During Office Hours
- PCMH 2, Element D: Use Data for Population Management
- PCMH 3, Element C: Care Management
- PCMH 4, Element A: Support Self-Care Process
- PCMH 5, Element B: Referral Tracking and Follow-Up
- PCMH 6, Element C: Implement Continuous Quality Improvement

These scores result in a level – 1, 2 or 3 of PCMH Recognition – and states and other sponsors often tie payment to the level of PCMH Recognition practices achieve.

Proposed PCMH Glide Path Approach

- Support less well resourced practices or those who are just beginning the PCMH transformation process over time based on actual PCMH development processes with medical ASO support for:
  - NCQA application process and related requirements
  - DSS Glide Path requirements
- And data analysis/quality on an ongoing basis

Proposed PCMH Glide Path Approach (cont)

- All Glide Path practice sites must:
  - Submit a gap analysis to achieve PCMH recognition
  - Develop a detailed work plan based on gap analysis
  - Comply with requirements (consistent with Meaningful Use and NCQA process) to meet timeframes:
    - PCMH Phase 1 Glide Path – no more than 6 mos.
    - PCMH Phase 2 Glide Path – no more than 6 mos.
    - PCMH Phase 3 Glide Path – no more than 6 mos.
    - Opportunity for 6 month extension total
  - Total Glide Path timeframe not to exceed 24 months

Glide Path Financial Support

- Glide Path practices will receive:
  - 50% of fee differential that will be paid to fully qualified PCMH practices or clinics
    - Increment will cease if a practice fails to advance to the next phase
  - Supplemental start-up payments
    - For 5 FTE equivalents or fewer
    - $13-$25K over Glide Path Phases w/in first 12 months of participation based on practice size
    - Funding must be returned if a practice doesn't ultimately qualify within 24 months of starting
  - Support from the medical ASO and UCONN BMI

General Performance Measurement

- “Triple-Aim”:
  - Enhance the health of individuals
  - Enhance the health of populations and
  - Control the cost of care
- Measure and reward performance across a range of *domains* for both:
  - Participation
  - Ongoing improvement

General Performance Measurement

- Proposed criteria for the selection of measures:
  - Relevance to consumers, improved experience and improved health
  - Relevance to PCMH and improved quality
  - Basis in evidence
  - Minimize or manage the burden on providers and the State to collect data
  - Actionable for improvement

General Performance Measurement

- Year 1 to start:
  - Claims-based measures
  - EHR Documentation to demonstrate phone/e-mail, care coordination, disease education
  - PCMH CAHPS to look at consumer experience
- Year 2: Performance payments based on both claims-based and EHR measures and outcomes (plus consumer experience)

General Performance Measurement

- Year 3: Review all measures with gradual movement toward increased EHR submission (plus PCMH CAHPS)
- Outcome/EHR measures will be established going forward with the benefit of:
  - Data to inform priorities
  - Experience of PCMH practices who have actual EHR experience
  - Even more consumer, provider and advocate input

PCMH Reimbursement Model

- Determine Total Practice Revenues
- Calculate PCMH Fixed Costs
- Calculate PCMH Variable Costs/Offsets
- Calculate PCMH Net Impact
- Allocate Dollars to Hybrid Reimbursement Components

EHR and PCMH Fixed and Variable Costs

EHR Start-up	***EHR On-going***
• EHR Planning and Selection • Hardware – Initial/Upgrades • Software/License – Initial/Upgrades • Incremental Staffing – Temporary • Training – Existing Staff • Infrastructure – Misc space/other • EHR – Implementation expenses	• Annual Maintenance • Field Engineering • Licenses – Upgrades • Hardware/IT – Replacement • Thru-put Capacity – Expansion • IT Consulting • Financing Costs
PCMH Start-up	***PCMH On-Going***
• PCMH Planning • NCQA – Consultation and fees • Physician Training – Initial/Monthly • Staff Training – Initial/Monthly • Patient Reminder Process • Automated Scheduling Process	• On-going PCMH Eval/Improvement • Care Coordination/Integration • Social Services Integration • Physician Non-visit interaction • Patient-Centered Team Meetings • Annual Practice Training

Participation Payment

- Fee-for-Service add-on to selected Primary Care Service Codes for all individuals seen by PCPs within PCMH
  - Evaluation and Management codes including sick and well visits TBD
- Add-on amount varies by:
  - Certification - Glide Path, Level 2, and Level 3
  - Setting - Adult, Pediatric, Hospital Clinic, FQHC

Performance Payments

- Payment will be calculated (and risk-adjusted) separately:
  - For each measure to bring focus to improvement
  - For each providers' performance
- Paid in the aggregate to the practice or clinic
- PMPM Performance payments will be risk-adjusted

Proposed Performance Incentive Payment Methodology

- Performance incentives will be paid for each measure based on relative targets for 50% of the total incentive pool
  - 50th – 75th percentile => 50% of possible incentive
  - 75th – 90th percentile => 75% of possible incentive
  - 90th – 100th percentile => 100% of possible incentive

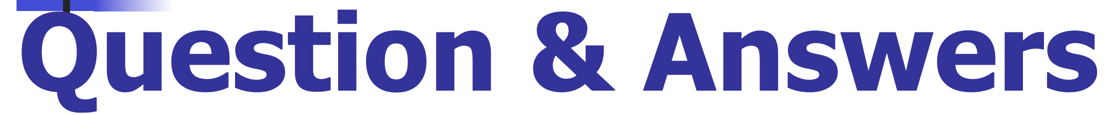
Proposed Improvement Incentive Payment Methodology

- Improvement incentives will be paid for each measure based on meeting relative targets
  - 5% improvement over prior year results => 50% of possible improvement incentive payment
  - 10% improvement over prior year results => 75% of possible improvement incentive payment
  - 90th – 100th percentile => 100% of possible improvement incentive payment

Important Phone Numbers

- Member and Provider Call Centers
  - Member phone number: 1-800-859-9889
  - Provider phone number: 1-800-440-5071

  Open 9 a.m. – 7 p.m. Monday through Friday beginning January 3rd.
- **Behavioral Health**
  CT Behavioral Health Partnership
  1-877-552-8247 (Monday through Friday 9:00am to 7:00pm
  The TTY/TDD telephone number is 1-866-218-0525
  www.ctbhp.com
- **Dental**
  CT Dental Health Partnership
  1-855-283-3682 Monday through Friday 9:00am to 7:00pm
  The TTY/TDD telephone number is 1-866-218-0525
  www.ctdhp.com
- **Prescriptions**
  Pharmaceutical Benefits or Authorization Requirements
  1-866-409-8386 or 1-860-269-2030 in the Farmington, CT area.
  www.ctdssmap.com/CTPORTAL/Pharmacy
- HP Provider Assistance Center between the hours of 8 am and 5 pm Monday through Friday at:
- **1-800-842-8440** (in-state callers)
- **1-860-269-2028** (for out-of-state callers)



Question & Answers