Overview of Practice Transformation Supports for Providers

	Person-Centered Medical Home Program (PCMH)	Advanced Medical Home Initiative (AMH)	Medicaid Person-Centered Medical Home Plus (PCMH+)	Clinical and Community Integration Program (CCIP)	Practice Transformation Network Grant (PTN)
Lead Entity	DSS; CHN-CT (Connecticut Medicaid's medical Administrative Services Organization (ASO))	State Innovation Model (SIM) Project Management Office (PMO) through contracted practice transformation vendors (Qualidigm and Planetree)	DSS	SIM PMO through contracted technical assistance vendor Qualidigm	Community Health Center Association of Connecticut (CHCACT)
Goal	The Connecticut Medicaid PCMH program aims to enable comprehensive primary care for children, youth and adults through: • partnerships between individuals and their personal physicians • a whole person approach to providing and coordinating care • systematic performance of quality improvement activities with a focus on patient safety • enhanced access to care through improved scheduling	The goal of the AMH Glide Path is to ease the burden of transformation while improving the primary care experience for patients and every member of the primary care team.	While PCMH will remain the foundation of Medicaid care delivery transformation; and Intensive Care Management (ICM) will continue to be a resource to high need, high cost beneficiaries; PCMH+ incorporates new requirements related to integration of primary care and behavioral health care, as well as linkages to the types of community supports that can assist beneficiaries in utilizing their Medicaid benefits.	One of CCIP's primary aims is to integrate more effectively care management, behavioral health, health equity, oral health, medication management, e-Consults and non-clinical community services into routine clinical care.	CT-PTN will build upon FQHC PCMH recognition to enhance team-based care delivery, integration of specialty/behavioral health with primary care, resource coordination and population health through training, technical assistance, data sharing and collaborative learning. CT-PTN will focus on improving health outcomes for three conditions common to health center patients: asthma, diabetes and hypertension.

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	and communication				
Target Population	Medicaid members	Medicaid and commercially covered individuals	Medicaid members	Although participation in PCMH+ is an eligibility requirement, the CCIP programs are focused on improving care for all patients, regardless of their payer	Individuals served by member FQHCs
Current Status	As of April 1, 2017, 111 PCMH practices are currently participating (475 sites, 1,664 providers) serving 336,100 Medicaid members which accounts for approximately 44% of all Medicaid members	Prior to the AMH, a pilot was initiated with state funding. From that pilot, a total of 90 practice sites are currently participating. Of these, 50 have achieved 2014 NCQA Level II or III recognition. On November 14, 2016, the SIM PMO began recruitment for an additional 150 practices into the AMH Program with federal funding. To date, 37 practices have enrolled. The program will support recognition for both 2014 and new 2017 NCQA PCMH standards.	PCMH+ was implemented on January 1, 2016. The following FQHCs and "advanced networks" were selected by Request for Proposal and are PCMH+ Participating Entities: • Northeast Medical Group AN • St. Vincent's AN • Fair Haven CHC • Cornell Scott-Hill Health Ctr. • Generations Fam. Health Ctr. • Southwest CHC, Inc. • CHC, Inc. • Optimus Health Care, Inc. • Charter Oak Health Center	CCIP was implemented concurrently with PCMH+. The following three PCMH+ entities are participating in CCIP with SIM grant funding of approximately $500K each: • St. Vincent's AN • Northeast Medical Group AN • CHC, Inc.	CT-PTN is in the second quarter of Year 2 (Year is 9/30/16 through 9/29/17). Fifteen FQHCs are participating, representing 97 practice sites (54 primary care, 43 specialty care) and 974 enrolled clinicians (440 primary, 534 specialty), serving 270,553 HUSKY patients. Specialty care includes behavioral health and dental.
Duration	Ongoing	Practices are in the program for approximately 15 months.	Three-year grant period (2016-2019)	Participating Entities are in the program for 15 months.	Four years (9/30/15 through 9/29/19)

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		The program will be operational during the three-year grant period (2016-2019)		The program will be operational during the three-year grant period (2016-2019)	
Eligible Entities	To be eligible for enhanced fee-for-service (FFS) as well as performance and improvement payments, a practice must 1) either be an independent private practice or a hospital-based outpatient clinic; and 2) be recognized by the National Committee for Quality Assurance (NCQA) as a "Level 2" or "Level 3" PCMH. Community Health Centers, Federally Qualified Health Centers (FQHC) and hospital-based clinics are eligible to participate in the PCMH Accreditation Program and to receive technical assistance. All participating practices must be enrolled as providers in the Connecticut Medical	Practices that are: • not currently recognized under an existing national medical home standard including NCQA 2011 or 2014 (Practices that have NCQA 2008 are permitted to apply); and • have an established ONC-certified Electronic Health Record	PCMH+ Participating Entities include: • a Federally Qualified Health Center, or • an "advanced network" (AN), defined as: 1) One or more DSS PCMH program participants plus specialists (physical health, behavioral health and oral health providers); 2) One or more DSS PCMH program participants plus specialists and hospitals; or 3) A Medicare Accountable Care Organization (ACO) that includes a DSS PCMH program participant Key features of the provider qualifications of the participating entities include the following:	PCMH+ Participating Entities that are not participating in PTN.	FQHC members of CHCACT

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	Assistance Program. Non-standard sites (i.e. school-based health centers, mobile vans, homeless shelters; practice settings that are staffed by one or more primary care providers and are licensed as a separate health care facilities by the Department of Public Health through a parent entity) are not eligible for the Connecticut Medicaid PCMH Program.		• Must have a minimum of 2,500 attributed Medicaid beneficiaries • Must include a current participant in the DSS PCMH program • All providers in participating entities must be enrolled as Medicaid providers		
Means of Support	• Free multi-disciplinary practice transformation team support convened by CHN-CT toward recognition by NCQA (all participating practices) or the Joint Commission (includes FQHCs and hospital outpatient clinics) as PCMH • Financial incentives	• 15-months of SIM-funded transformation services from Qualidigm and Planetree • Interactive learning collaborative, practice facilitation visits, and a variety of evidence-based Quality Improvement (QI) interventions • Support to achieve	FQHC PCMH+ Participating Entities are eligible for up front care coordination payments and, all Participating Entities including Advanced Networks are eligible to receive shared savings payments based on meeting identified quality measures.	PCMH+ Participating Entities are eligible for technical assistance in developing new capabilities for improving care, especially for at-risk populations. The TA vendor, Qualidigm will: 1) assist the network in assessing their capabilities to identify areas of improvement towards meeting CCIP	Member FQHCs will be eligible for technical assistance support (including such elements as the TCPI Change Package; QI methodologies and culture; working with data and implementing effective PDSAs; effective care team development; risk stratification and population health management, use of

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	(enhanced fee-for-service payments) for 18-24 months while practices are on the Glide Path working towards NCQA Recognition with a Community Practice Transformation Specialist (CPTS) (Please note: FQHCs are not eligible for these incentives) • Increased incentives (enhanced fee-for-service payments plus eligibility for performance and improvement incentives) when the practice is recognized as NCQA 2 or 3 PCMH • Ongoing, free coaching toward renewal of PCMH recognition	Advanced Medical Home Designation: NCQA PCMH 2014 standards level 2 or 3 with additional required elements and factors • Eligibility for discounted NCQA application fees • Facilitation for AMH participants to enroll in the Medicaid PCMH program and thereby qualify for enhanced fees and incentive payments .		standards 2) support the network in developing a Transformation Plan that outlines their strategy to achieving the CCIP standards 3) provide technical assistance including webinars, materials, and other tools 4) offer subject matter expertise, including through designated technical assistance partners. PCMH+ Participating Entities also participate in local Community Health Collaboratives that focus on creating standard protocols to link the clinical and community sectors. Entities that apply for PCMH+ and CCIP (and who are not participating in the Transforming	Care Analyzer data and measures; use of population health clinical measures; defining data needs, using data extraction tools; chronic care management; primary care/behavioral health integration; primary/specialty care coordination; transitional care protocols/practices; and contributing to TCPI's knowledge management system) and will participate in learning Collaboratives.

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				Primary Care Initiative) are eligible to apply for a Transformation Award of up to $500k.	
Care Coordination Elements	Those elements that are embedded in NCQA Level 2 or 3, or the Joint Commission, PCMH standards	Those elements that are embedded in NCQA Level 2 or 3 PCMH standards	PCMH+ care coordination elements focus upon the following: • Behavioral and physical health integration: Care coordinator training and experience, use of screening tools, use of psychiatric advance directives, use of Wellness Recovery Action Plans (WRAPs) • Culturally competent services: Training, expansion of the current use of CAHPS to include the Cultural Competency Item Set, incorporation of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) standards • Care coordinator	CCIP is comprised of core and elective program standards. CCIP requires participating entities to meet the core standards which include the following: • Comprehensive Care Management • Health Equity Improvement • Behavioral health These core standards are designed to enhance competencies related to care management of individuals with complex needs with a focus on person-centered assessment; care plans that emphasize individual values, preferences and goals; the enhancement of the primary care teams with additional clinical and community	CT-PTN measures the following care coordination elements (baseline & every 6 months for primary and behavioral health): 1) Practice has defined its medical neighborhood and has formal agreements in place with these partners to define roles and expectations. 2) Practice follows up via phone, visit, or electronic means with patients within a designated time interval (24 hours/ 48 hours/ 72 hours/ 7 days) after an emergency room visit or hospital discharge. 3) Practice clearly defines care

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			availability and education • Supports for children and youth with special health care needs: Advance care planning discussions and use of advance directives, incorporation of school-related information in the health assessment and health record (e.g. existence of IEP or 504) • Competence in providing services to individuals with disabilities: Assessment of individual preferences and need for accommodation, training in disability competence, accessible equipment and communication strategies, resource connections with community-based entities	participants; and linkages with community based services and supports. The standards also introduce processes to support continuous quality improvement aimed at reducing health equity gaps and a related intervention targeting hypertension, asthma, or diabetes. Community health workers play an important role in these standards, recognizing that community health workers can serve as a trusted partner and bridge to community services and supports. The third of these standards focuses on individuals with unidentified behavioral health needs. The standards address screening, primary care based treatment, referral, and coordination with behavioral health care in the community. CCIP also encourages participating entities to meet elective standards**,** which	coordination roles and responsibilities and these have been fully implemented within the practice.

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				include: • Electronic Consults (“e-consults”) • Comprehensive Medication Management ("CMM”) • Oral Health	
Quality Measures	**Child/Adolescent Measures:** • Well-Child Visits in the First 15 Months of Life • Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life • Adolescent Well-Care Visits • Annual Dental Visit • Asthma Patients with One or More Asthma-Related ED Visit • Developmental Screening • ED Visits Ages 0-19 • Use of Appropriate Medications for People with Asthma	AMH practices are not responsible for reporting on quality measures.	Please see this link for a complete list of quality measures: http://www.ct.gov/dss/lib/dss/pdfs/ratesetting/pcmhplus/pcmh_quality_measure_list.pdf	Participating Entities select and track quality measures related to the CCIP standards. Reporting of these results is only required in aggregate and is used to affirm the network’s efforts in managing and analyzing their own progress towards improvement.	• Diabetes: Optimal Diabetes Care Composite (NQF 0729) • Asthma Composite: Optimal Asthma Care (Composite based on PQRS Asthma Measures Group) • Adult Asthma Admission Rate. **Details**: Admissions for a principal diagnosis of asthma per 100,000 population, ages 18 to 39 years. (PQI #15) • Asthma Emergency Department (ED)/Urgent Care Utilization Rate. **Details**: This measure

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	• PCMH Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey **Adult Measures:** • Adult Diabetes LDL-C Screening • Adult Diabetes Eye (retinal) Screening • Post Hospitalization Follow-up • Follow-up after New Mental Health Diagnosis with /Medication Prescription • Cholesterol Management for Patients with Cardiovascular Conditions • ED Usage • Use of Appropriate Medications for People with Asthma • Readmission Rate - 30				is used to assess the percent of patients who have had a visit to an (ED)/Urgent Care office for asthma in the past six months (NQMC 1615) • Asthma in Younger Adults Admission Rate. **Details**: Admissions for pediatric asthma per 100,000 population (PQI #15) • Uncontrolled Diabetes Admission Rate. **Details**: Admissions for a principal diagnosis of diabetes without mention of short-term complications per 100,000 population, ages 18 years and 18 years and older. (PQI #14) • Hypertension Admission Rate. **Details**: Admissions with a principal diagnosis of hypertension per

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	days • PCMH Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey				100,000 population, ages 18 years and older. (PQI #7) • Access during office hours for a medical question. **Details:** Data derived from the CAHPS on each FQHC participating in the PTN). • Cost savings are based on an iterative expansion of care management interventions over four years.
Relationship to Medicaid ASO	CHN-CT (Medicaid medical ASO) provides practice transformation coaching, ongoing support, and pushes member data to participating practices	AMH Program will coordinate with CHN-CT to enable practices that achieve AMH Designation to apply to participate in the Medicaid PCMH initiative	CHN-CT will continue to support and collaborate with PCMH+ Participating Entities with ICM supports for high need, high cost individuals (e.g. coordination of services, referrals, support in instances in which members miss appointments or experience access barriers) and support practices in interpreting data on patient portal reports	The technical assistance vendor, Qualidigm, will coordinate with CHN as needed.	CT-PTN members will continue to rely on CHN-CT CareAnalyzer for data analytics in support of serving Medicaid members