

DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

Updates to the Person-Centered Medical Home (PCMH) Program (SPA 16-002)

The State of Connecticut Department of Social Services (DSS) proposes to submit the following Medicaid State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS).

Changes to Medicaid State Plan

Effective on or after January 1, 2016, SPA 16-002 will amend Attachment 4.19-B of the Medicaid State Plan to update the methodology for the person-centered medical home (PCMH) program as described below. Under the existing approved Medicaid State Plan, in addition to rate add-ons, based on their performance in specified quality measures, PCMH practices may be eligible for supplemental payments for performance incentives and supplemental payments for performance improvement (PCMH supplemental payments). First, this SPA updates the quality performance measures that are used in determining PCMH supplemental payments. Second, this SPA enables DSS to include PCMH practices' risk score factors in calculating PCMH supplemental payments. Third, this SPA adjusts the timeframe for making PCMH supplemental payments to better align with the process for analyzing practices' performance.

Fiscal Information

This SPA is not expected to change annual aggregate expenditures.

Information on Obtaining SPA Language and Submission of Comments

In accordance with federal Medicaid requirements, upon request, DSS will provide copies of the proposed SPA. Copies of the proposed SPA may also be obtained at any DSS regional office and on the DSS website: <http://www.ct.gov/dss>. Go to "Publications" and then "Updates".

Written, phone, and email requests should be sent to Ginny Mahoney, Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105 (Phone: 860-424-5145, Fax: 860-424-5799, Email: ginny.mahoney@ct.gov). Please reference "SPA 16-002: Updates to PCMH Program".

Members of the public may also send DSS written comments about this SPA. Written comments must be received at the above contact information no later than January 13, 2016.

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- i. For Glide Path clinics, the total payment for each visit that included one or more procedures corresponding to the procedure codes listed above, including the rate add-on, is 109% of the medical visit rate.
- ii. For NCQA PCMH Level 2, the total payment for each visit that included one or more procedures corresponding to the procedure codes listed above, is 114% of the medical visit rate.
- iii. For NCQA PCMH Level 3, the total payment for each visit that included one or more procedures corresponding to the procedure codes listed above, is 116% of the medical visit rate.

2. PCMH Supplemental Payments for Outpatient Hospital Clinic Performance

For PCMH practices only, the two types of supplemental payments detailed below will be paid to outpatient hospital clinic PCMHs on a retrospective annualized basis based upon an attribution methodology, where recipients will be attributed to outpatient hospital clinic PCMHs based on their claims history, in accordance with the department's current written attribution methodology. The attribution methodology assigns recipients to primary care practitioners based on claims volume analyzed retrospectively every three calendar months. If a recipient receives care from multiple providers during a given period, the recipient is assigned to the practice that provided the plurality of care and if there is no single largest source of care, to the most recent source of care. Recipients may affirmatively select a PCMH practice as their primary care provider. After making a selection, regardless of the sources of care received prior to their selection during the period of claims measured in an attribution cycle, the recipient will be automatically attributed to their selected practice in the next attribution cycle. However, the recipient's selection will be overridden if, after making a selection, the recipient later receives more care from another practice in the same period of claims measured, although attribution is not changed if the recipient receives care from another practitioner within the same practice. Payments will be issued to eligible outpatient hospital clinic PCMHs retrospectively in a lump sum on an annualized basis during the quarter ending September 30th for services provided in the previous calendar year (the "measurement year").

- a. Supplemental Payment for Performance Incentives: Outpatient hospital clinics that meet all requirements for this supplemental payment will receive a payment totaling a maximum of \$0.97 for each member's enrollment month attributed to the clinic. Payments will be issued retrospectively in a lump sum on an annualized basis during the quarter ending September 30th for services provided in the previous calendar year. The payment amount will be based on the clinic's performance compared with all other PCMH practices during the measurement year using the quality performance measures described in subsection (2)(d) below. The Department may adjust each practice's performance based on the practice's risk score factor. PCMH practices are eligible for this payment only if they participate as a PCMH for the entire measurement year. The tiers of performance are as follows:

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Performance Percentile	Level of Supplemental Payment
Under 25th percentile	No payment
25th–50th percentile	25% of possible payment
51st–75th percentile	50% of possible payment
76th–90th percentile	75% of possible payment
91st–100th percentile	100% of possible payment

- b. Supplemental Payment for Performance Improvement: Outpatient hospital clinic PCMHs that meet all requirements for this supplemental payment will receive a payment totaling a maximum of \$0.81 for each member’s enrollment month attributed to the clinic. Payments will be issued retrospectively in a lump sum on an annualized basis during the quarter ending September 30th for services provided in the previous calendar year. PCMH practices are eligible for this payment only if they have participated as a PCMH for at least two full calendar years. The payment amount will be based on the practice’s performance using the quality performance measures described in subsection (2)(d) below. The Department may adjust each practice’s performance based on the practice’s risk score factor.

The Department will make tiered payments based on each clinic’s degree of improvement compared with the previous year. Performance targets and tiers will be set collectively and for each quality performance measure described in subsection (2)(d) below based on the clinical or social significance of each measure and the practice’s ability and need to improve in each measure. The tiers will be adjusted each year to account for variation in past performance. Clinics performing in the 91st to 100th percentile at both baseline and measurement years will be eligible for this supplemental payment even without any improvement in a given measurement year.

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(b) Rural health clinic services – not provided.

(c) Federally Qualified Health Centers (FQHC) rates are set according to the Regulations of Connecticut State Agencies, governing community health centers (Attached Page 1(b) Addendum). The rate setting methodology conforms to the prospective payment system under Medicare, Medicaid and SCHIP Benefits Improvement and Protections Act (BIPA) of 2000.

Effective only from January 1, 2012 through December 31, 2012, Person Centered Medical Home (PCMH) practices are individual FQHC sites that have met National Committee for Quality Assurance (NCQA) Level 2 or Level 3 medical home recognition. PCMH practices must comply with all NCQA PCMH requirements and all additional written department requirements, including participation in various primary care initiatives operated by the State. Effective only from January 1, 2012 through December 31, 2012, the department offers a PCMH Glide Path program, which pays enhanced rates to FQHCs that are providing some of the additional Medicaid services required for NCQA PCMH recognition. In order to qualify for Glide Path, an FQHC must demonstrate that it has begun providing a more advanced standard of primary care and has committed to achieving NCQA PCMH recognition in a set period of time. Glide Path practices must also comply with all additional written department requirements, including participation in various primary care initiatives operated by the State. Effective only from January 1, 2012 through December 31, 2012, FQHCs participating in PCMH and Glide Path may be eligible for an add-on to the encounter rate for encounters that included one or more procedures corresponding to the procedure codes on the physician fee schedule listed below.

1. Glide Path and PCMH Rate Add-On to the FQHC Encounter Rate

Effective only from January 1, 2012 through December 31, 2012, the rate add-on is paid in addition to the FQHC encounter rate for encounters that include one or more procedures corresponding to the following procedure codes on the physician fee schedule: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99339, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99354, 99355, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99406, 99407, 99408, 99409, 99411, 99412, 99374, 99377, 99379, 99380, 96110, 99050, 99051, 99053, D0145, D1206, and 99420. These codes were selected to pay providers for providing a more advanced level of primary care and to encourage

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more providers to provide primary care to beneficiaries, which will help expand access to primary care services. For a procedure that is included in a qualifying FQHC encounter that was provided to a beneficiary outside of the FQHC in a nursing facility, rest home, or the beneficiary's home, the applicable rate add-on will be paid if the beneficiary is attributed to the FQHC. The rate add-on is paid at the same time as the underlying claim and is scaled based on the stages of NCQA PCMH recognition:

- i. For Glide Path FQHCs, the total payment for each encounter that included one or more procedures corresponding to the procedure codes listed above, including the rate add-on, is 103.6% of the encounter rate.
- ii. For NCQA PCMH Level 2, the total payment for each encounter that included one or more procedures corresponding to the procedure codes listed above, including the rate add-on, is 105.3% of the encounter rate.
- iii. For NCQA PCMH Level 3, the total payment for each encounter that included one or more procedures corresponding to the procedure codes listed above, including the rate add-on, is 106.3% of the encounter rate.

For FQHCs with encounter rates under \$131, the rate add-ons described above will be increased by 0.4% for each category (104% of the encounter rate for Glide Path, 105.7% of the encounter rate for PCMH Level 2, and 106.7% of the encounter rate for PCMH Level 3). For FQHCs with encounter rates over \$150, the rate add-ons described above will be decreased by 0.3% for each category (103.3% of the encounter rate for Glide Path, 105% of the encounter rate for PCMH Level 2, and 106% of the encounter rate for PCMH Level 3).

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Supersedes
TN # 12-005**

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- (d) Quality Performance Measures for PCMH Program. The department's quality performance measures for the PCMH program were established as of January 1, 2016 and are effective for measurement of provider services and care outcomes on or after that date. The quality performance measures can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. The quality measures are used to measure PCMH practices' performance and their eligibility for certain payments that are described in the relevant section of the plan as being made or determined using these quality measures. These quality measures are based on improving quality, access, and care outcomes.

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basis during the quarter ending September 30th for services provided in the previous calendar year (the “measurement year”). Payment rates will not vary based on the practitioner type (physician, physician assistant, or nurse practitioner) to whom each recipient is attributed.

- i. Supplemental Payment for Performance Incentives: Independent physician groups, solo physicians, nurse practitioner groups, and individual nurse practitioners that meet all requirements for this supplemental payment will receive a payment totaling a maximum of \$0.60 for each member’s enrollment month attributed to the practice. Payments will be issued retrospectively in a lump sum on an annualized basis during the quarter ending September 30th for services provided in the previous calendar year. The payment amount will be based on the practice’s performance compared with all other PCMH practices during the measurement year using the quality performance measures described in subsection (5)(c) below. The Department may adjust each practice’s performance based on the practice’s risk score factor. PCMH practices are eligible for this payment only if they participate as a PCMH for the entire measurement year. The tiers of performance are as follows:

Performance Percentile	Level of Supplemental Payment
Under 25 th percentile	No payment
25 th –50 th percentile	25% of possible payment
51 st –75 th percentile	50% of possible payment
76 th –90 th percentile	75% of possible payment
91 st –100 th percentile	100% of possible payment

- ii. Supplemental Payment for Performance Improvement: Independent physician groups, solo physicians, nurse practitioner groups, and individual nurse practitioners that meet all requirements for this supplemental payment will receive a payment totaling a maximum of \$0.68 for each member’s enrollment month attributed to the practice. Payments will be issued retrospectively in a lump sum on an annualized basis during the quarter ending September 30th for services provided in the previous calendar year. PCMH practices are eligible for this payment only if they have participated as a PCMH for at least two full calendar years. The payment amount will be based on the practice’s performance using the quality performance measures described in subsection (5)(d) below. The Department may adjust each practice’s performance based on the practice’s risk score factor.

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- (c) Quality Performance Measures for PCMH Program. The department's quality performance measures for the PCMH program were established as of January 1, 2016 and are effective for measurement of provider services and care outcomes on or after that date. The quality performance measures can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. The quality measures are used to measure PCMH practices' performance and their eligibility for certain payments that are described in the relevant section of the plan as being made or determined using these quality measures. These quality measures are based on improving quality, access, and care outcomes.

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**DRAFT DSS PCMH Pediatric Quality Performance Measure Set
Effective January 1, 2016**

Measure	Measure Description	Measure Steward	NQF#	ACO#
Well-child visits in the first 15 months of life.	Members who had 6 or more well-child visits during their first 15 months of life.	HEDIS	1392	Pediatric Prevention Composite
Well-child visits in the third, fourth, fifth and sixth years of life.	Members age 3-6 who had well-child visit during the year.	HEDIS	1516	Pediatric Prevention Composite
Adolescent Well-Care Visits.	Members age 12-21 years of age that have a well-care visit during the year	HEDIS	N/A	Pediatric Prevention Composite
Annual Dental Visit	Percentage of eligible beneficiaries ages 2-21 with at least one dental visit during the measurement year. The visit must be with a dentist or dental hygienist.	HEDIS	N/A	N/A
Medication Management for People With Asthma	Percent of patients with persistent asthma who were prescribed and remained on asthma "controller medication" for at least 75% of their treatment period. The age 5-18 breakout of this measure will be used.	HEDIS	1799	N/A
Asthma Medication Ratio	The percentage of members with persistent asthma and had a ratio of controller medications to total medications of 0.50 or greater during the measurement year. The age 5-18 breakout of this measure will be used.	HEDIS	1800	N/A
ED Usage	Emergency department usage (excluding mental health and chemical dependency services). The age 0-19 breakout of this measure will be used.	HEDIS	N/A	N/A

Developmental Screening	Developmental screening in the first three years of life. Total of three age ranges will be used.	CHIPRA - OHSU	1448	Pediatric Prevention Composite
Metabolic Monitoring for Children and Adolescents on Antipsychotics	The percentage of children and adolescents 1-17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.	HEDIS	N/A	N/A
Hospital Readmissions	Total readmission rate within 30 days after discharge (behavioral and physical health). The age 0- 20 breakout of this measure will be used.	Medicaid Medical Directors Network	N/A	N/A
Member Survey	PCMH CAHPS Survey (Parent or Guardian)	AHRQ/NCQA	N/A	N/A
Asthma Emergency Department Visits	Annual percentage of asthma patients (ages 2-20) with one or more asthma-related emergency department visits.	DSS	N/A	N/A

DRAFT DSS PCMH Adult Quality Performance Measure Set
Effective January 1, 2016

Measure	Measure Description	Measure Steward	NQF #	ACO #
Diabetes HbA1c Screening	Adults age 18-75 with a diagnosis of Type I or Type II diabetes who received at least one HbA1c screening during the measurement year.	HEDIS	0057	27
Diabetes Eye Screening	Adults age 18-75 with a diagnosis of Type I or Type II diabetes who received at least one eye screening for diabetic retinal disease in a two year period.	HEDIS	0055	41
Post-Hospital Admission Follow-up	Percentage of adults age 21-75 with an inpatient "medical" or psychiatric admission with a claim for post-admission follow-up with a physician, PA, or APRN within seven days of the inpatient discharge. Medical admissions are defined as all admissions that are not maternity or surgery related.	DSS	N/A	N/A
Medication Management for People With Asthma	Percent of patients with persistent asthma who were prescribed and remained on asthma "controller medication" for at least 75% of their treatment period. The age 19-64 breakout of this measure will be used.	HEDIS	1799	N/A
Asthma Medication Ratio	The percentage of members with persistent asthma and had a ratio of controller medications to total medications of 0.50 or greater during the measurement year. The age 19-64 breakout of this measure will be used.	HEDIS	1800	N/A
Psychiatric Medication Management	Percentage of members 18 and older given a new psychiatric diagnosis and medication, by a PCP who received a follow-up visit within 30 days.	DSS	N/A	N/A
Hospital Readmissions	Total readmission rate within 30 days after discharge (behavioral and physical health). The age 21-64 breakout of this measure will be used.	Medicaid Medical Directors Network	N/A	N/A

ED Usage	Emergency department usage (excluding mental health and chemical dependency services). The age 20 and above breakout of this measure will be used.	HEDIS	N/A	N/A
Member Survey	PCMH CAHPS Survey.	AHRQ/NCQA	N/A	N/A