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DEPARTMENT OF SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

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Commissioner

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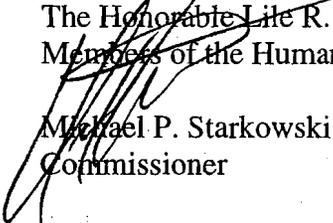
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To: The Honorable Toni Nathaniel Harp, Senate Chair
The Honorable Denise Merrill, House Chair
The Honorable David Cappiello, Senate Ranking Member
The Honorable Kevin DelGobbo, House Ranking Member
Members of the Appropriations Committee

The Honorable Jonathan Harris, Senate Chair
The Honorable Peter F. Villano, House Chair
The Honorable John A. Kissel, Senate Ranking Member
The Honorable Lile R. Gibbons, House Ranking Member
Members of the Human Services Committee

From: 
Michael P. Starkowski
Commissioner

Date: August 25, 2008

Re: Primary Care Case Management (PCCM) Pilot Plan

In accordance with Public Act No. 07-2, June Special Session, I am pleased to submit a plan for implementation of a Primary Care Case Management Pilot. Specifically, the state legislation directs the development and implementation of a pilot program for alternative approaches in the delivery of health care services through a system of primary care case management to not less than one thousand individuals who are otherwise eligible to receive HUSKY Plan, Part A (Medicaid managed care) benefits.

This plan has been developed with significant input from representatives of the provider, client advocacy and legal services communities.

Primary Care Case Management will be offered to HUSKY A-eligible clients as an alternative to enrollment in a managed care plan. HUSKY A clients choosing Primary Care Case Management will be enrolled with a participating primary care provider who will be responsible for providing case management and care coordination services in addition to providing primary and preventive care to their enrolled. Reimbursement for primary and preventive services will be made through the Department's fee for services claims processing system, managed by EDS. Case management services will be reimbursed at \$7.50 per member per month.

The geographic areas for the pilot will be defined based on the catchment area of providers who choose to enroll in the PCCM pilot. Contingent on approval of the plan,

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the anticipated target date for the beginning of client enrollment is January 1, 2009. HUSKY A members living in geographic areas of PCCM-enrolled providers will be offered PCCM as an additional option at the time that they are notified that they must enroll in managed care.

Please do not hesitate to contact me should you have any questions or concerns pertaining to this matter or you may contact the department's legislative liaison, Matthew Barrett, at (860) 424-5012.

Thank you.

C: David Parrella, Director of Medical Care Administration
Matthew Barrett, Legislative Liaison

Attachment



Plan to Implement a Primary Care Case Management Pilot Program

*Submitted in accordance with Section 16 of
Public Act No. 07-2, June Special Session*

August 2008

Michael P. Starkowski
Commissioner

Connecticut Department of Social Services
Medical Care Administration
Connecticut Primary Care Case Management Pilot Program Plan

Introduction

The Connecticut legislature in the June 2007 special session directed the Commissioner of Social Services to develop and implement a pilot program for alternative approaches in the delivery of health care services through a system of primary care case management to not less than one thousand individuals who are otherwise eligible to receive HUSKY Plan, Part A (Medicaid managed care) benefits.

Primary Care Case Management (PCCM) is a system to manage and coordinate care by a primary care provider (PCP), instead of a managed care organization. The PCP is responsible for approving and monitoring the care of enrolled Medicaid beneficiaries, typically for a monthly case management fee in addition to fee-for-service reimbursement for medical services and treatment. This case management fee pays for such things as locating, coordinating, monitoring and reporting the health care services received by their patients.

Pilot Goals

Through this pilot PCCM program, the Department seeks to explore the efficacy and viability of the PCCM model in Connecticut.

The goal of PCCM is to:

- Improve overall medical outcomes.
- Improve access to primary and preventive care while reducing unnecessary emergency room visits and other non-optimal treatment options.
- Improve doctor-patient relationships.
- Increase education of our clients about disease management and healthy lifestyles.
- Lower overall medical expenditures.
- Result in a methodology to support best practices to improve patient outcomes.
- Enhance provider support services.
- Improve linkage of patient to existing non-medical community based services.

Pilot Program Design

Target Population

1915b waiver HUSKY A Recipients

Target Primary Care Providers

The Department of Social Services (the Department) will seek out physician groups and clinics that have substantial HUSKY A patient bases that are willing to participate in the PCCM pilot program. Provider recruitment efforts will include collaboration with the various medical societies and a release of a request for enrollment (RFE) for interested providers, which will be posted on the Department's website.

Provider Advisory Group

An advisory group comprised of PCCM participating PCPs will meet quarterly to advise the Department on the implementation of the PCCM pilot and to make recommendations related to ongoing operations and planning for further expansion of PCCM.

Provider Payments

Providers will be paid a \$7.50 per member per month fee (PMPM) to do case management and coordination of care. They will also be paid the standard Medicaid rates in accordance with the Medicaid fee schedule for visits and procedures.

Consumer Input

Consumer input will be solicited through focus groups, surveys, etc.

Case Management

Participating PCCM providers and practices will receive an all inclusive case management fee to hire case managers, to provide the resources and support needed for physician practices to better manage the care of enrollees. Case managers may be social workers, nurses or other clinicians. They may serve as patient advocates, and intervene with other community based health and social service organizations to assure the patient receives all necessary and coordinated services.

PCCM case management brings PCPs, hospitals, health departments, and other community providers together to manage the health care needs of Medicaid recipients. Each selected PCP or group practice will identify and designate a case manager who will assist in the development, implementation, and evaluation of the case management strategies, including:

1. Performing risk assessment—utilizing an “at-risk” screening tool that identifies both medical and social risk factors; to assess all patients’ risk factors and identify high risk conditions or needs;
2. Identifying high costs and high utilizers—developing and implementing activities that lower utilization and cost and collecting data on process and outcomes measures, such as EPSDT, etc;
3. Establishing written care plans signed by both the patient and the PCP;
4. Implementing and providing a case management process—identifying and targeting case management activities based on the screening process and other methods of identifying enrollees at risk;
5. Helping patients coordinate their care or access to needed services;
6. Implementing and providing disease management services that shall encompass, but not be limited to the Department’s disease management initiatives. At a minimum, PCPs are expected to provide disease management support and education for asthma, depression, diabetes, and childhood obesity. ;
7. Reviewing emergency department utilization—integrating appropriate outreach, follow-up, and educational activities based on emergency department use by enrollees;

Services that need either Prior Authorization or Referral

Specialist/ Procedure	Referral Needed By PCP	Prior Authorization From PCP Needed	Prior Authorization By State or Agent of the State needed
Non- Emergency Hospital Admissions	Required*	No	Required
Visits to Specialists	Required*	No	N/A
Out patient Procedures	Required*	No	As required by Medicaid Policy

Emergency Care	No	No	No
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* A Referral can be for one visit or longer duration based on patient need.

Services provided by the Department (or it's agents)

The Department has “carved out” three major services of the “family Medicaid program.” These three programs are behavioral health, pharmacy, and dental services.

- Behavioral health services are provided by the Connecticut Behavioral Health Partnership (CT BHP). The Department of Children and Families and the Department of Social Services have formed CT BHP to plan and implement an integrated public behavioral health service system for children and families.
- Pharmacy benefits are administered by the Department in concert with our outside contractor EDS.
- Dental services will be coordinated through the Departments’ dental benefits manager (DBM) under an administrative services contractual arrangement.

Coordination with CT-BHP and Dental Benefits Management (DBM) Contractors

PCPs will be required to:

- Make appropriate referrals to the CT-BHP and DBM for patients assessed as requiring either behavioral health or dental services;
- Provide medication management;
- Utilize the Department’s Preferred Drug List and PA process.
- Coordinate care with the patient’s behavior health and dental providers.

Quality

The success of the PCCM program will depend on the ability of participating providers to develop and implement case and disease management initiatives and to participate in measuring the effectiveness of those initiatives through effective and measurable clinical, financial and functional outcomes.

It is expected that PCPs and their office staff will focus on implementing processes that will improve care of the Medicaid population within their practice. Importantly, each participating practice will utilize dedicated case managers who will assist in managing the care of Medicaid enrollees and will participate in

quality improvement initiatives with other PCCM participants including the measurement of disease management outcomes.

The Department or its agent will assist by providing administrative support, including feedback information and data, data analysis and reporting.

Administrative Support

The Department will collect and review data and provide utilization feedback to providers. The Department through its enrollment broker will coordinate member enrollment with participating providers. The Department will pay participating providers a monthly case management (PMPM) fee based on enrollment for that month.

Member Enrollment Policies

Enrollment into PCCM is voluntary for 1915b waiver HUSKY A eligible individuals.

Enrollment will be processed by ACS, the Department's contracted Enrollment Broker. Enrollment policies and exemptions will be similar to those in place for MCO enrollment.

Outreach

PCCM information may be incorporated into existing HUSKY informational materials, depending on the purpose of individual materials, such as brochures, flyers, enrollment forms, comparison charts and letters used by the Department or its HUSKY outreach partners. PCCM offices will also be allowed to conduct limited marketing, in compliance with the Department's HUSKY marketing guidelines.

Additionally, PCCM specific informational materials will be made available to providers and patients.

Enrollment requirements for Primary Care Providers (PCPs)

A provider who is interested in serving as a PCCM provider must complete an application for participation that will be issued by the Department when the Department releases its "Request for Enrollment". All providers who participate in the PCCM Program must be enrolled with the Department as a Medicaid provider and must meet the minimum requirements for participation in the Medicaid program as set forth in the Regulations of Connecticut State Agencies, Section 17b-262-522 to Section 17b-262-533, as applicable.

To be approved as Connecticut PCCM participant, providers must meet the following requirements:

1. Be enrolled as one of the following Medicaid provider types:
Family medicine

General practitioner

Internist

A Primary Care Physician affiliated with a Federally qualified health center

Pediatrician

Osteopath

OBGYN

APRN (Consistent with state statutes)

Nurse Midwife

Physician Assistant (Consistent with state statutes)

A Specialist that may function as a PCP, per DSS approval.

2. Have and maintain hospital admitting privileges or maintain a collaborative relationship that allows for hospital admissions.
3. Have a provider readily available to see patients a minimum of 30 hours per week.
4. Provide access to medical advice and care for enrolled recipients 24 hours a day, 7 days a week and allow same or next business day appointments for urgent visits.
5. Authorize care for the enrollee or schedule an appointment with the enrollee based on the HUSKY program standards of appointment availability.
6. Promptly facilitate the referral for medically necessary health care services that are not provided directly and document referrals for specialty care in the medical record. Provide the authorization number to the referral provider either in writing or by telephone.

PCCM Selection and Participation

The Department will issue a "Request for Enrollment" inviting interested and qualified PCPs to participate in a pilot PCCM program. The Department will select PCPs for participation based on the PCP's commitment to the PCCM design and agreement to:

- Provide primary care and patient care coordination services to each enrollee in accordance with the policies set forth in Ct Medicaid provider manuals and Medicaid bulletins and as defined by CT Medicaid policy
- Provide coverage under program rules and access to medical advice/services 24/7;
- Develop and apply recommended practice guidelines to assess patients and develop treatment plans;
- Develop an ongoing patient/provider relationship for the purpose of providing continuity of care;

- Submit information, such as clinical or process data, to the Department for PCCM program management purposes;
- Collaborate with the Department in the development and implementation of a reporting methodology that will support best practices to improve patient outcomes and meet the needs of the Medicaid waiver authority.
- Submit to performance measurement and review;
- Provide patient education designed to assist patients manage their own care and to appropriately use medical equipment and pharmaceutical products;
- Consult with specialty providers for their patients and ability to refer or authorize services to other providers when the service cannot be provided by the PCP;
- Offer hours of operation for treating patients of at least 30 hours per week;
- Have weekend and/or evening office hours;
- Participate in the Medicaid Program;
- Receive enrollment files, data and reports electronically from the Department;
- Collaborate with the Department to develop and implement quality initiatives of disease management programs, including the measurement of outcomes, the development and testing of protocols and reports and the dissemination of results and feedback to other PCCM providers;
- Have or purchase an Electronic Medical Record (EMR) system or an electronic disease management data registry that satisfies the Departments' data requirements within one year.