PCMH+ Information Session for Members

What we will cover today

PCMH+ Overview

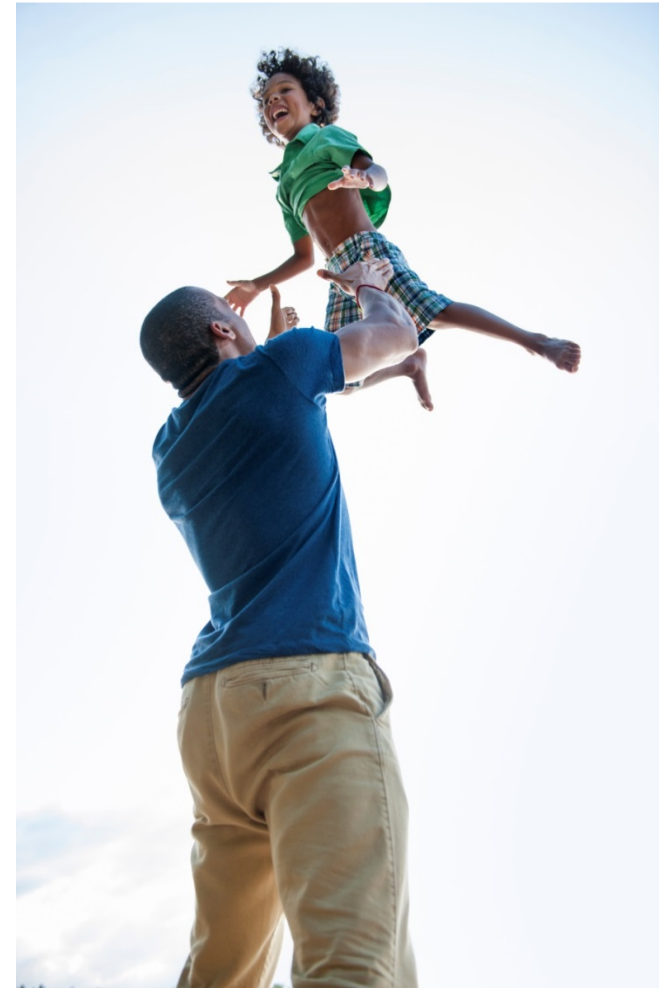
Provider Responsibilities

Member Information

PCMH+

PCMH+ starts January 1, 2017 and builds on the success of Connecticut Medicaid's Person-Centered Medical Home (PCMH) program which works to improve the quality of care our members receive.

The PCMH+ program is being provided to you to improve your overall health and help you get services you need like access to healthy food, transportation to your appointments and assistance finding community agencies that may be able to help you with things like housing or finding employment.



What is a PCMH?

- A PCMH provides person-centered, comprehensive and coordinated care.
- In a PCMH, your preferences are important and your primary care clinician works closely with other healthcare providers who may be providing you care.
- PCMHs improve access to care, lower avoidable health care costs, and improve the quality of care provided to members.

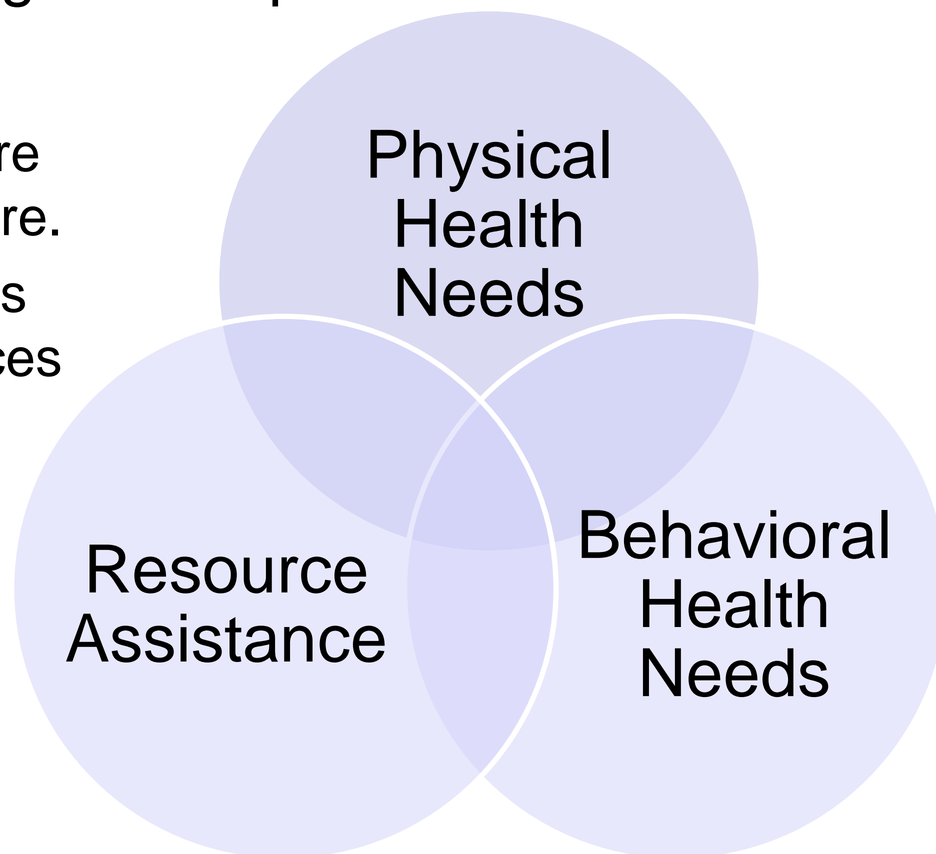
CT Medicaid: PCMH Program Success

- Over 43% of Connecticut HUSKY members are being served by a PCMH provider.
- This has led to improved quality of care for HUSKY Members.
- PCMHs have improved how members value their providers.

Because of the success of the DSS PCMH program, only PCMH providers can participate in PCMH+

Building on the DSS PCMH Program

- PCMH+ will build on the DSS PCMH program by incorporating new requirements related to:
  - Integration of primary care and behavioral health care.
  - Actively helping members access non-health services such as rent assistance, locating housing and obtaining food.



Primary Concepts of PCMH+

- **Added Care Coordination:** Getting care from other doctors, help with housing, getting food or addressing other problems that impact your health.
- **Behavioral Health Integration:** Getting screenings and care for your physical *and* behavioral health issues at your provider's office (for members who have behavioral conditions).
- **Shared Savings:** In PCMH+, organizations that meet quality standards and reduce the cost of care may be eligible for a bonus payment from the State of Connecticut.

Why Care Coordination?

Managing your health and navigating the health system can be confusing and challenging.

Care Coordination, provided as part of your visit with your primary care provider, has shown tremendous promise in improving overall health.

Care coordination is the critical link between members, your family members and the multiple providers who provide your care.

PROVIDER RESPONSIBILITIES

Provider Responsibilities

- Providers must have partnerships with community resource agencies to help you find and obtain non-health resources.
- Providers must work with you in a person-centered way and provide care that meets your values and preferences.
- Providers must have members on their advisory board.
- Providers must provide “Enhanced Care Coordination” to members. This is in addition to the care coordination they provide as a PCMH.

Provider Responsibilities: Enhanced Care Coordination

All PCMH+ Providers			
Providers must have a care coordinator that is located in their office and who works with you to coordinate your care and help with non-health related problems.	Providers must help identify and treat behavioral health issues.	Providers must ask about your cultural preferences and train their staff to better understand the cultural needs of their members.	Providers must help members who have disabilities or have special health needs and train their staff to better understand how to care for members who have disabilities or special health needs.

Community Health Center Responsibilities: Additional Enhanced Care Coordination

If your provider is a Community Health Center, they have additional care coordination requirements:		
Have a behavioral health care coordinator and help develop a Wellness Recovery Action Plan with members who have behavioral health challenges.	The behavioral health care coordinator must be part of the treatment team for the provider.	Assist youth who are transitioning to adult services.

Care Coordination Example 1

Alex is an 8 year old boy who has been having vision problems at school. He has no other health concerns.

How your Care Coordinator can help

- Referral to a pediatric eye doctor
- Help obtaining glasses if prescribed for Alex

Care Coordination Example 2

Jane is a 38 year old who has recently found out she has high blood pressure. Jane doesn't understand high blood pressure and is worried about getting her medications because she does not have a car.

How your Care Coordinator can help

- Education on managing high blood pressure
- Education on taking medications correctly
- Help finding healthy food in her neighborhood
- Help finding a pharmacy that can deliver medications

Care Coordination Example 3

Mary is a 45 year old who has diabetes and is also homeless and living in a shelter. Mary does not understand diabetes or what she should be eating. She does not check her blood sugar levels because she doesn't have a testing kit. She wants a safe place to live.

- Teaching Mary about diabetes and healthy blood sugar levels
- Teaching Mary about healthier food options at the shelter
- Obtaining a blood sugar testing kit and teaching Mary how to use it
- Talking to the local housing agency to identify housing options and eligibility standards
- Scheduling follow up appointments and arranging transportation
- Talking with the shelter to ensure stability of placement during housing search
- Finding a pharmacy to deliver medications to Mary at shelter
- Teaching Mary what to do if her blood sugar is low or high

Community Partnerships

- There are non-health related issues that members face that can impact your ability to stay healthy.
- Your provider will be partnering with local community agencies who may be able to assist you in getting help with things that are not specifically health related but that make it hard to stay healthy and focus on your healthcare.
  - Examples:
    - Child care organizations
    - Housing organizations
    - Rent and utility assistance
    - Other doctors' offices or other clinics
    - Nutrition and food assistance organizations

PCMH+ Monitoring Group

- Community Health Centers and Advanced Networks must have a group (oversight body) that monitors their PCMH+ activities.

And because your feedback is important to the PCMH+ Program:

- PCMH+ members must be part of the group.
- The provider must help PCMH+ members be active in the group.

MEMBER INFORMATION

Member Opt-Out Process

Your Medicaid benefits do not change in PCMH+

- You do not have to participate in PCMH+ and may choose to “opt-out”.
- You should have received a PCMH+ welcome letter with information on how to opt-out.
- You may opt-out at any time.
- If you opt-out:
  - Your Medicaid benefits will not change and you can still continue to see any qualified Medicaid provider.
  - Your provider will not receive a bonus based on saving money on your health care costs.

What Does Not Change

- Your Medicaid benefits **do not** change.
- You can still see any provider.
- You can file a complaint or grievance if you are unhappy about your care.

Quality of Care Measures

- In PCMH+, providers are scored on how well they improve their member's health. This is done using nationally recognized health quality measures.
- Some examples include ensuring:
  - Children are getting their well check-ups.
  - Members are getting the right developmental screenings.
  - Pregnant members are getting care before and after delivery.
  - Members with asthma are on the right asthma medication.
  - Members with diabetes are receiving screenings.

Concerns/Questions/Issues?

- If you do not want to take part in PCMH+, you can call
  1-877-858-7012 Option #2.

- If you do not take part in PCMH+, you can still get help. Call HUSKY Health Member Services 1-800-859-9889 and ask about care coordination in the HUSKY Health program.