



Person-Centered Medical Home (PCMH) Instructions and Application

December 1, 2011

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I. Introduction to the PCMH Application Instructions and Application

Under the Department of Social Services' (the "Department") new PCMH initiative, practices that demonstrate a higher standard of person-centered primary care service delivery will qualify for a higher level of reimbursement for primary care services from the Department. Qualified PCMH practices will also be eligible for additional financial incentives. The PCMH initiative is described in its entirety in Policy Transmittal 2011-36. Both HUSKY Health and Charter Oak Health Plan recipients will also be included in the PCMH initiative.

The purpose of this document is to provide those practices or clinics ("practices") seeking to participate in the Department's PCMH Initiative with all of the materials necessary to apply. This document includes the PCMH instructions and application.

Practices that wish to pursue either full PCMH qualification or Glide Path status, as defined in the Policy Transmittal, must complete a PCMH Application. Instructions for practices in each of the following categories are:

A practice that wishes to...	Would need to....
Participate in the PCMH initiative and already is enrolled as a CMAP provider	Complete the PCMH Application, described herein.
Apply to participate in the PCMH initiative but does not participate in CMAP	First apply to participate in the CMAP and sign a CMAP Enrollment Agreement as a prerequisite to PCMH Participation with the Department. Then, the practice must complete the PCMH Application as described herein.
Participate in the PCMH initiative, but has not yet obtained its NCQA PCMH recognition as a Level 2 or Level 3 PCMH	Consider applying for Glide Path status, which offers practices that wish to participate in PCMH resources and time to meet PCMH requirements with some enhanced reimbursement. Practices seeking Glide Path status must complete this PCMH Application and must further complete a Glide Path Application. At that time, go to www.huskyhealth.com and click on the "For Provider" link.
Decline the opportunity to participate in the PCMH initiative	Continue to serve recipients on a fee-for-service basis in the CMAP under their current CMAP Provider Enrollment Agreement at the existing standard fee-for-service rates.

Glide Path applicants with five or fewer Full Time Equivalent (FTE) PCPs can also apply for Supplemental Start-up Funds by completing a Supplemental Start-up Fund Request for Support from the Department. The form to request such funds will be available from the Department after December 15th, 2011. At that time, go to www.huskyhealth.com and click on the "For Provider" link.

The Department will review each PCMH application, make a determination, and notify the practice regarding their PCMH status. At that time, the Department will send qualified PCMH practices an Addendum to their Enrollment Agreement with PCMH conditions of participation as described in the PCMH Policy Transmittal 2011-36.

II. Instructions to Complete the PCMH Application

To complete the PCMH Application:

- Review the PCMH Policy Transmittal 2011-36 at www.huskyhealth.com. Click on the “For Provider” link to view this document with particular attention to all PCMH requirements.
 - Determine that the practice is willing to abide by the requirements described in the PCMH Policy Transmittal 2011-36.
 - Confirm which Primary Care Practitioners (PCPs) are eligible to participate in the PCMH initiative and review PCMH requirements to ensure their willingness to meet such terms.
- Save the Application form that follows in the Acrobat file format (PDF).
- Directly populate all fields on the PCMH Application form electronically. Electronic drop-down selections are provided for appropriate fields.
- FAX the complete PCMH Application including any attachments requested to the PCMH program administrator at **203-774-0540**.

Direct any questions regarding the PCMH application process to the Department, Richard Spencer, at 860-424-5913 or by e-mail at Richard.Spencer@ct.gov.

Effective December 15th, 2011 this PCMH application can be sent electronically via a Submit Button that will be located on the form. This Submit button allows for secure transmission of the PCMH application to the PCMH program administrator. Instructions will be provided on use of secure transmission ability when capability is available.

III. Overview of PCMH Application Requirements

PCMH SECTION	INFORMATION REQUIRED
Section A	Primary Practice Site Information.
Section B	Primary Clinical Contact Information.
Section C	Primary Office Manager Contact Information.
Section D	Additional Required Information. A copy of the practice’s PCMH Certificate of Recognition from the National Committee on Quality Assurance, if applicable.
Section E	Detailed Practitioner Information.
Section F	Signature.

IV. Detailed Description of PCMH Application Requirements

A		PRIMARY PRACTICE SITE INFORMATION
FIELD NUMBER AND NAME		DESCRIPTION
A.1	Practice Name	Enter the name of the practice that is applying to the Department for PCMH qualification. If the practice has multiple sites, complete an application for each site.
A.2	Connecticut Medical Assistance Program (CMAP) numbers under which the practice bills primary care services for all PCPs listed in Section E of this PCMH Application	Enter all applicable billing CMAP provider ID numbers used by the practice to bill the Department for care provided to HUSKY Health or Charter Oak Health Plan recipients. CMAP provider numbers are sometimes referred to as "AVRS ID's", e.g., on CMAP remittance advice. Typically, a practice will have different CMAP numbers (which may map to one or multiple NPI's) maintained for different specialties such as internal medicine, family practice, pediatrics, and nurse practitioners; all relevant CMAP billing provider numbers should be included.
A.3	Address Line 1	Enter the first line of the practice's primary site address.
A.4	Address Line 2	Enter the street name and number of the practice's primary site address. This cannot be a P.O. Box.
A.5	Practice City	Enter the city name of the practice's primary site address.
A.6	Practice State	Enter the state name or abbreviation of the practice's primary site address.
A.7	Practice Zip Code	Enter the 9-digit zip code of the practice's primary site address.
A.8	Practice Telephone Number	Enter the practice's telephone number at their primary site address.
A.9	Practice Fax Number	Enter the practice's fax number at their primary site address.

B.		PRIMARY CLINICAL CONTACT INFORMATION
FIELD NUMBER AND NAME		DESCRIPTION
B.1	Primary PCMH Clinical Contact First Name	Enter the first name of the primary PCMH clinical contact (e.g. the lead practitioner for the PCMH initiative) in the practice. This individual will be the medical ASO's and the Department's primary clinical contact regarding the PCMH initiative for the practice.
B.2	Primary PCMH Clinical Contact Last Name	Enter the last name of the primary PCMH clinical contact for the PCMH initiative.
B.3	Primary PCMH Clinical Contact Email	Enter the email address for the primary PCMH clinical contact.
B.4	Primary PCMH Clinical Contact Address Line 1	Enter the first line of the address for the primary PCMH clinical contact.
B.5	Primary PCMH Clinical Contact Address Line 2	Enter the street name and number of the address for the primary PCMH clinical contact. This cannot be a P.O. Box.
B.6	Primary PCMH Clinical Contact City	Enter the city name of the primary PCMH clinical contact.
B.7	Primary PCMH Clinical Contact State	Enter the state name or abbreviation of the state for the primary PCMH clinical contact.
B.8	Primary PCMH Clinical Contact Zip Code + Four	Enter the 9-digit zip code of the primary PCMH clinical contact.
B.9	Primary PCMH Clinical Contact Telephone Number	Enter the primary PCMH clinical contact's telephone number.

C.		PRIMARY OFFICE MANAGER CONTACT INFORMATION
FIELD NUMBER AND NAME	DESCRIPTION	
C.1	Office Manager First Name	Enter the first name of the primary office manager contact.
C.2	Office Manager Last Name	Enter the last name of the primary office manager contact.
C.3	Office Manager Email	Enter the email address for the primary office manager contact.
C.4	Office Manager Address Line 1	Enter the first line of the address for the primary office manager contact.
C.5	Office Manager Address Line 2	Enter the street name and number of the address for the primary office manager contact. This cannot be a P.O. Box.
C.6	Office Manager City	Enter the city name of the primary office manager contact's address.
C.7	Office Manager State	Enter the state name or abbreviation of the state of the primary office manager's address.
C.8	Office Manager Zip Code + Four	Enter the 9-digit zip code of the primary office manager's contact information.
C.9	Office Contact Telephone Number	Enter the primary clinical contact's telephone number.

D.		ADDITIONAL REQUIRED INFORMATION
FIELD NUMBER AND NAME	DESCRIPTION	
D.1	Practice Enrolled in the Connecticut Medical Assistance Program (CMAP) as:	Select the designation under which the practice is enrolled in CMAP: <ul style="list-style-type: none"> ▪ Physician group, nurse practitioners or solo practice; ▪ Federally Qualified Health Center; or ▪ Hospital outpatient clinic.
D.2	Office of National Coordinator for Health Information Technology (ONC) Electronic Health Records (EHR) Certification Number(s) for the practice's complete EHR System or, for modules as applicable:	Provide the ONC EHR Certification Number(s) applicable for all of the practice's HR product(s) and modules.
D.3	Level of current PCMH National Committee for Quality Assurance (NCQA) Recognition (If Applicable):	Check one appropriate box for level of NCQA recognition as applicable. For NCQA Level 1, 2, or 3 enter the date the recognition expires. Attach a copy of the practice's NCQA Certificate of Recognition that is consistent with the PCMH Level indicated. If the practice has achieved Level 1 PCMH recognition, or if the practice has not yet achieved NCQA recognition, go to PCMH Glide Path Application included, available after December 15 th , 2011 go to www.huskyhealth.com and click on the "For Provider" link.

E. DETAILED PRACTITIONER INFORMATION	
<p>All eligible practitioners must function as PCPs and have a panel of primary care patients or a patient panel, defined as a set of patients for whom the practitioner is responsible for providing primary care services. These primary care services must account for at least 60% of the practitioner's time in providing care to patients across all payers. Specialists or other practitioners who do not have their own patient panels are not eligible for PCMH participation and should not be listed within the PCMH Application.</p> <p>For each PCP practitioner in the practice who meets the definition stated above, indicate the following information on the form provided or on an Excel spreadsheet with the identical fields requested:</p>	
FIELD NUMBER AND NAME	DESCRIPTION
E.1	Practitioner first name Enter the practitioner's first name.
E.2	Practitioner middle initial Enter the practitioner's middle initial.
E.3	Practitioner last name Enter the practitioner's last name.
E.4	Practitioner Credential (MD, DO, APRN or PA) Enter the practitioner's credential. Indicate whether the practitioner is an MD, DO, APRN or PA.
E.5	Primary Board Specialty (Not applicable for APRNs and PAs) Enter the practitioner's Primary Board Specialty. <ul style="list-style-type: none"> ▪ Family Medicine ▪ Internal Medicine ▪ Pediatrics ▪ Geriatric Medicine ▪ Other ▪ Not Applicable
E.6	Practitioner's National Provider Identifier (NPI) number Enter the practitioner's National Provider Identifier number.
E.7	Indicate whether the practitioner manages a panel of primary care patients by checking "yes" or "no".
E.8	Indicate whether at least 60% of the practitioner's clinical hours are spent providing primary care services across all payers by selecting "yes" or "no".
F. SIGNATURE	
An individual authorized to act as a signatory for the practice must sign the application. In doing so, the signatory certifies that all information provided in the application is accurate.	



Person-Centered Medical Home (PCMH) Application

PCMH APPLICATION

A		PRIMARY PRACTICE SITE INFORMATION	
FIELD NUMBER AND REQUIRED INFORMATION		PRACTICE RESPONSE	
A.1	Practice Name*		
A.2	Connecticut Medical Assistance Program (CMAP) numbers under which the practice bills primary care services for all Primary Care Practitioners (PCPs) listed in Section E of this PCMH Application	1.	
		2.	
		3.	
		4.	
		5.	
A.3	Address Line 1		
A.4	Address Line 2		
A.5	Practice City		
A.6	Practice State		
A.7	Practice Zip Code		
A.8	Practice Telephone Number		
A.9	Practice Fax Number		

*If the practice has multiple sites, complete an application for each site.

B		PRIMARY CLINICAL CONTACT INFORMATION	
FIELD NUMBER AND REQUIRED INFORMATION		PRACTICE RESPONSE	
B.1	Primary PCMH Clinical Contact First Name		
B.2	Primary PCMH Clinical Contact Last Name		
B.3	Primary PCMH Clinical Contact Email		
B.4	Primary PCMH Clinical Contact Address Line 1		
B.5	Primary PCMH Clinical Contact Address Line 2		
B.6	Primary PCMH Clinical Contact City		
B.7	Primary PCMH Clinical Contact State		
B.8	Primary PCMH Clinical Contact Zip Code + Four		
B.9	Primary PCMH Clinical Contact Telephone Number		

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C		
PRIMARY OFFICE MANAGER CONTACT INFORMATION		
FIELD NUMBER AND REQUIRED INFORMATION		PRACTICE RESPONSE
C.1	Office Manager First Name	
C.2	Office Manager Last Name	
C.3	Office Manager Email	
C.4	Office Manager Address Line 1	
C.5	Office Manager Address Line 2	
C.6	Office Manager City	
C.7	Office Manager State	
C.8	Office Manager Zip Code + Four	
C.9	Office Contact Telephone Number	

D																	
ADDITIONAL REQUIRED INFORMATION																	
FIELD NUMBER AND REQUIRED INFORMATION		PRACTICE RESPONSE															
D.1	Practice Enrolled in CMAP as:	Select the designation under which the practice is enrolled in CMAP from this list:															
D.2	ONC EHR Certification Number(s) for the practice's complete EHR System or, for modules as applicable	1.															
		2.															
		3.															
		4.															
		5.															
D.3	Level of PCMH National Committee for Quality Assurance (NCQA) Recognition Check the appropriate box Attach a copy of the practice's NCQA Certificate of Recognition in accordance with the PCMH Level as indicated.	<table border="1"> <thead> <tr> <th colspan="2">Level</th> <th>Expiration Date (mmddyyyy)</th> </tr> </thead> <tbody> <tr> <td>Level 1*</td> <td></td> <td></td> </tr> <tr> <td>Level 2</td> <td></td> <td></td> </tr> <tr> <td>Level 3</td> <td></td> <td></td> </tr> <tr> <td>Not Recognized*</td> <td></td> <td></td> </tr> </tbody> </table>	Level		Expiration Date (mmddyyyy)	Level 1*			Level 2			Level 3			Not Recognized*		
		Level		Expiration Date (mmddyyyy)													
		Level 1*															
		Level 2															
		Level 3															
Not Recognized*																	
* If the practice is recognized as an NCQA Level 1 PCMH, or if the practice is not recognized by NCQA as a PCMH, refer to Glide Path information and application available as of December 15 th , 2011. At that time, go to www.huskyhealth.com and click on the "For Provider" link.																	

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CONNECTICUT MEDICAL ASSISTANCE PROGRAM

Person-Centered Medical Home Instructions and Application

Complete this form **OR** submit a separate Excel spreadsheet containing the identical data elements.
 Please include all MDs, DOs, APRNs and PAs in your practice within this form.

E	DETAILED PRACTITIONER INFORMATION							
	E.1	E.2	E.3	E.4	E.5	E.6	E.7	E.8
	PRACTITIONER FIRST NAME	M.I.	PRACTITIONER LAST NAME	PRACTITIONER CREDENTIAL	PRIMARY BOARD SPECIALTY (NOT APPLICABLE FOR APRNs AND PAs)	PRACTITIONER NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	DOES THE PRACTITIONER MANAGE A PANEL OF PRIMARY CARE PATIENTS?	ARE AT LEAST 60% OF THE PRACTITIONER'S CLINICAL HOURS SPENT PROVIDING PRIMARY CARE SERVICES TO A PANEL OF PATIENTS?
							SELECT YES OR NO	SELECT YES OR NO
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CONNECTICUT MEDICAL ASSISTANCE PROGRAM
Person-Centered Medical Home Instructions and Application

F	SIGNATURE
<p>THE INFORMATION PROVIDED IN THIS PCMH APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AS AN INDIVIDUAL AUTHORIZED AS A SIGNATORY FOR THE PRACTICE THAT IS APPLYING FOR PCMH RECOGNITION FROM THE DEPARTMENT, BASED ON THE SUBMISSION OF THIS APPLICATION.</p>	

Provider Entity Name (doing business as)

Name of Authorized Representative (typed) (Must be an Authorized Officer, Owner, or Partner of the Practice Or Clinic)

Signature

Date