Person-Centered Medical Home (PCMH) Instructions and Application

Revision E – 06.01.2025

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I. Introduction to the PCMH Application Instructions and Application

Under the Department of Social Services' ("the Department" or DSS) PCMH program, 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 program is described in its entirety according to PCMH Policy, which can be located on the HUSKY Health website at www.ct.gov/husky.

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

Practices eligible to pursue either full PCMH qualification or Glide Path status, according to PCMH policy, which is located on the HUSKY Health website at www.ct.gov/husky, must complete a PCMH Application. Please contact the PCMH Program Administrator at the Medical Administrative Service Organization (ASO) at 203.949.4194 prior to completing the application. Instructions for practices in each of the following categories are:

A practice eligible for PCMH Accreditation and wishes to…	**Would need to…**
Participate in the PCMH Accreditation program and is already enrolled as a Connecticut Medical Assistance Program (CMAP) provider	Complete the PCMH Application, described herein. Please contact the PCMH Administrator prior to completing the application.
Apply to participate in the PCMH Accreditation program but does not participate in CMAP CMAP Enrollment Link: www.ctdssmap.com	First apply to participate in 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 Accreditation program, but has not yet obtained its National Committee for Quality Assurance (NCQA) PCMH recognition	Complete the PCMH Application. Please contact the PCMH Program Administrator at 203.949.4194 or pcmhapplication@chnct.org prior to completing the application.
Any DSS PCMH Participating Practice that wishes to…	**Would need to…**
Add a new Medicaid Group ID to an existing DSS PCMH Participating practice	Complete the PCMH Application. Please contact your Regional Network Manager or the PCMH Program Administrator at 203.949.4194, or pcmhapplication@chnct.org prior to completing the application.
Add a new site/location to an existing DSS PCMH Participating practice	Complete the PCMH Application. Please contact your Regional Network Manager or the PCMH Program Administrator at 203.949.4194 or pcmhapplication@chnct.org prior to completing the application.

Glide Path applications must be submitted within 30 days of submitting the PCMH application.

If awarded PCMH Status, your practice will receive a letter from the DSS PCMH Program.

II. Instructions to Complete the PCMH Application

To complete the PCMH Application:

- Review the PCMH policy, located on the HUSKY Health website at www.ct.gov/husky. Click on the "***For Providers***" link, and then "***Person-Centered Medical Home***" to view document(s) with particular attention to all PCMH requirements.
  - Determine that the practice is willing to abide by the requirements described in the PCMH policy.
  - Confirm which Primary Care Providers (PCPs) are eligible to participate in the PCMH program 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.

Electronic submission of the PCMH Application:

- Please read the instructions before submitting. It is important to download the file before filling out and **to save the file before submitting the document**. Please submit using the current form on the website, as the content is periodically revised.

  This form was created using Adobe® Acrobat® 10 Pro Version 10.1.16. It has been tested using Adobe® Acrobat® Reader 11 and Microsoft Internet Explorer® 11.0.
- The form should be submitted using an Adobe® Acrobat® application using Internet Explorer®. The free version of Acrobat® Reader is available from Adobe® at http://get.adobe.com/reader/.
- Electronic Signature Agreement. By clicking "I agree" and typing your name, you are signing this application electronically. You agree your electronic signature is the legal equivalent of your manual signature on this document.
- When the form is complete and correct, save the form as a PDF as follows: ***PracticeName_PCMHApplication_mm-dd-yyyy.pdf.*** Make sure to retain the form for any updates or changes to prevent re-entry of the information.

  -- SAVE THE FORM – OTHERWISE, ANY DATA NOT SAVED WILL BE LOST --
- After the form is saved, click the **SUBMIT** button on the last page to transmit the data to the Medical ASO.
- You will automatically receive a **Message Received** reply with a tracking number. Save the **Message Received** reply and note the **tracking number** for future reference and any future additions or changes to your application.
- If you are recognized as an NCQA PCMH practice, email your Certificate of Recognition to pcmhapplication@chnct.org. Reference your tracking number from the **Message Received** reply.

Additions or Changes to the PCMH Application:

- Prior to approval of this application, if any additions or changes to this PCMH Application are necessary, be sure to reference the **tracking number** received after your original submission.
- An individual authorized to act as a signatory for the practice must re-sign the application when you re-submit. In doing so, the signatory certifies that all updated information provided in the application is accurate.
- Direct any questions regarding the PCMH application process to the PCMH Program Administrator at 203.949.4194 or by email at pcmhapplication@chnct.org.

III. Overview of PCMH Application Requirements

PCMH SECTION	INFORMATION REQUIRED
Section A	Practice Site Information
Section B	Primary Contact Information
Section C	Primary Office Manager Contact Information
Section D	Additional Required Information
Section E	Detailed Practitioner Information
Section F	Signature
Section G	Electronic Submission

IV. Detailed Description of PCMH Application Requirements

*** Please complete all required fields marked by an asterisk ***

A.	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	**Practice Federal Tax Identification Number (TIN)**	Enter the Federal TIN associated with the CMAP Group ID numbers entered in A.3. All Groups IDs must be enrolled with Medicaid under the same TIN.
*A.3	**Practice National Provider Identifier Number (NPI)**	Enter the NPI associated with the practice.
*A.4	**List all Connecticut Medical Assistance Program (Group CMAP) numbers for the individual practice site under which the practice bills primary care services for all Primary Care Providers (PCPs) listed in Section E of this PCMH Application (ENTER CMAP GROUP ID NUMBERS ONLY)**	Enter all applicable billing CMAP Group ID numbers used by the practice to bill the Department for care provided to HUSKY Health program recipients. Typically, a practice may have different CMAP numbers (which may map to one or multiple NPIs) maintained for different specialties such as internal medicine, family practice, pediatrics, and nurse practitioners.
*A.5	**Address Line 1**	Enter the street name and number of the practice's site address. **This cannot be a P.O. Box**. Address Line 1 must exactly match the same field in the Alt Service Address of site in the Gainwell Technologies Medicaid interChange system.
A.6	**Address Line 2**	Enter additional information for the practice's site address. **This cannot be a P.O. Box**. Address Line 2 must exactly match the same field in the Alt Service Address of site in the Gainwell Technologies Medicaid interChange system.
*A.7	**Practice City**	Enter the city name of the practice's site address. Practice City must exactly match the same field in the Alt Service Address of site in the Gainwell Technologies Medicaid interChange system.
*A 8	**Practice State**	Enter the state abbreviation of the practice's site address.
*A 9	**Practice Zip Code**	Enter the 5-digit zip code of the practice's site address (required for claims purposes). The zip code must exactly match the same field in the Alt Service Address of site in the Gainwell Technologies Medicaid interChange system.
*A.10	**Practice Telephone Number**	Enter the telephone number at site address.
A.11	**Practice Fax Number**	Enter the practice's fax number at the site address.

A.12	**Is there at least one provider at this site that has an open panel to accept new HUSKY Health members (includes Connecticut Medicaid and the Children's Health Insurance Program)?**	Check appropriate box ○ Yes ○ No

B. Primary Contact Information

FIELD NUMBER AND NAME		DESCRIPTION
*B.1	**Primary PCMH Contact First Name**	Enter the first name of the primary PCMH contact (**e.g., the lead contact for the PCMH program**) in the practice. This individual will be the Medical ASO's and the Department's primary contact regarding the PCMH program for the practice.
*B.2	**Primary PCMH Contact Last Name**	Enter the last name of the primary PCMH contact for the PCMH program.
*B.3	**Primary PCMH Contact Email**	Enter the email address for the primary PCMH contact.
*B.4	**Primary PCMH Contact Address Line 1**	Enter the street name and number of the primary PCMH contact. **This cannot be a P.O. Box**.
B.5	**Primary PCMH Contact Address Line 2**	Enter additional information for the primary PCMH contact. **This cannot be a P.O. Box**.
*B.6	**Primary PCMH Contact City**	Enter the city name of the primary PCMH contact.
*B.7	**Primary PCMH Contact State**	Enter the state name or abbreviation of the state for the primary PCMH contact.
*B.8	**Primary PCMH Contact Zip Code**	Enter the zip code of the primary PCMH contact.
*B.9	**Primary PCMH Contact Telephone Number and Extension**	Enter the primary PCMH contact's telephone number and extension.

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 street name and number of the address for the primary office manager contact. **This cannot be a P.O. Box**.
C.5	**Office Manager Address Line 2**	Enter additional information for the primary office manager's site address. **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**	Enter the zip code of the primary office manager's contact information.
*C.9	**Office Manager Contact Telephone Number and Extension**	Enter the primary office manager's telephone number and extension.

D. ADDITIONAL REQUIRED INFORMATION

FIELD NUMBER AND NAME		DESCRIPTION

*D.1	**Indicate Type of Practice**	Select the type of practice:
		• Independent Private Practice.
		• Federally Qualified Health Center.
		• Hospital outpatient clinic.
		• Primary Care Clinic
		  ○ Note: For the purpose of the DSS PCMH Program, hospital outpatient primary care clinics must enroll as a practitioner group to bill for outpatient professional services.
		  ○ Per DSS policy, Provider Bulletin 2016-06, as of July 1, 2016, hospital outpatient primary care clinics need to create and enroll as a practitioner group(s) in the Connecticut Medical Assistance Program (CMAP).

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 EHR product(s) and modules.
D.3	**Indicate current PCMH National Committee for Quality Assurance (NCQA) Recognition by Standard Year, Distinction Module, Level, and Expiration/Anniversary Date** If the practice has not yet achieved NCQA recognition, complete the PCMH Glide Path application available at www.ct.gov/husky and click on the "**For Providers**" link.	Select the proper box for each section: • Choose current NCQA Recognition Standard Year, Indicate Distinction Module: Behavioral Health Integration – (BHI); Electronic Quality Measures Reporting – (eCQM); Patient Experience Reporting – (PEX); or Not Applicable. • Check the appropriate box of level of NCQA recognition as applicable. • Enter the date the recognition expires or anniversary date. • Attached a copy of the practice's NCQA Certificate of Recognition.
D.4	**The Joint Commission (TJC) Ambulatory Care Accreditation/Primary Care Medical Home Certification**	Select the proper box for current accreditation/certification and expiration date.

*** Please complete all required fields marked by an asterisk ***

E. Detailed Practitioner Information

All eligible practitioners, including APRNs and PAs, must function as PCPs and have or support 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, except APRNs and PAs. Please list APRNs and PAs who do not have their own panel of patients.

For each 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:

*** Please complete all required fields marked by an asterisk ***

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. **Note:** PAs should be listed under the Medicaid Physician Group ID that they are associated within the Gainwell Technologies interChange system.
*E.5	**Practitioner's Area of Service**	Enter the practitioner's Area of Service (Must select one of the following from drop-down list): ▪ Family Medicine ▪ Internal Medicine ▪ Pediatrics ▪ Geriatric Medicine
*E.6	**Practice Medicaid Group (CMAP/AVRS) Billing Number**	Enter the practice's Medicaid (CMAP/AVRS) number.
*E.7	**Practitioner's National Provider Identifier (NPI) Number**	Enter the practitioner's National Provider Identifier number.
*E.8	**Practitioner's Medicaid (CMAP/AVRS) Number**	Enter the practitioner's Medicaid (CMAP/AVRS) number.
*E.9	**Is the practitioner a CMAP provider?**	Indicate whether the practitioner is CMAP provider by selecting "YES" or "NO."
*E.10	**Does the practitioner manage or support a panel of primary care patients?**	Indicate whether the practitioner manages or supports a panel of primary care patients by selecting "YES" or "NO," or "NO-Community Preceptor." "Community Preceptor" is a physician who supervises one or more residents who provide care to patients at a practice other than the community preceptor's primary practice.
*E.11	**Are at least 60% of the practitioner's clinical hours spent providing primary care services to a panel of patients?**	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.
By clicking the "I agree" box and typing your name, you are signing this application electronically.
You agree your electronic signature is the legal equivalent of your manual signature on the Agreement.

G. ELECTRONIC SUBMISSION

IMPORTANT: SAVE THIS FORM! While editing the PCMH application and when it is completed, save this form using the naming convention ***PracticeName_PCMHApplication_mm-dd-yyyy.pdf.***
-- ANY DATA NOT SAVED WILL BE LOST --
By clicking the **SUBMIT** button at the bottom of this document, and **after saving this form**, you certify that all information provided in the application is accurate and correct.
Clicking the **SUBMIT** button transmits the information to the PCMH Program Administrator.

Person-Centered Medical Home (PCMH) Application

Revision E – 06.01.2025

PCMH APPLICATION

A. PRACTICE SITE INFORMATION

FIELD NUMBER AND REQUIRED INFORMATION		PRACTICE RESPONSE	
*A.1	**Practice Name** **If the practice has multiple sites, *complete an application for each site* with different addresses. You may incorporate the name of the Practice with its location. For example, "ABC Practice – South Street."**		
*A.2	**Practice Federal Tax Identification Number (TIN)**		
*A.3	**Practice National Provider Identifier (NPI) Number**		
*A.4	**List all Connecticut Medical Assistance Program (Group CMAP) numbers for the individual practice site under which the practice bills primary care services for all Primary Care Providers (PCPs) listed in Section E of this PCMH Application (ENTER GROUP CMAP ID NUMBERS ONLY; AT LEAST ONE GROUP CMAP ID NUMBER MUST BE ENTERED)**	1.	
		2.	
		3.	
		4.	
		5.	
		6.	
*A.5	**Address Line 1**		
A.6	**Address Line 2**		
*A.7	**Practice City**		
*A.8	**Practice State**		
*A.9	**Practice Zip Code**		
*A.10	**Practice Telephone Number**		
A.11	**Practice Fax Number**		
A.12	**Is there at least one provider at this site that has open panels to accept new HUSKY Health members (includes Connecticut Medicaid and the Children's health Insurance Program)?**	◯ YES ◯ NO	

B. PRIMARY CONTACT INFORMATION

FIELD NUMBER AND REQUIRED INFORMATION		PRACTICE RESPONSE
*B.1	**Primary PCMH Contact First Name**	

*** Please complete all required fields marked by an asterisk ***

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*B.2	**Primary PCMH Contact Last Name**	
*B.3	**Primary PCMH Contact Email**	
*B.4	**Primary PCMH Contact Address Line 1**	
B.5	**Primary PCMH Contact Address Line 2**	
*B.6	**Primary PCMH Contact City**	
*B.7	**Primary PCMH Contact State**	
*B.8	**Primary PCMH Contact Zip Code**	
*B.9	**Primary PCMH Contact Telephone Number**	Ext.

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**	
*C.9	**Office Manager Contact Telephone Number**	Ext.

D. Additional Required Information

FIELD NUMBER AND REQUIRED INFORMATION		PRACTICE RESPONSE
*D.1	**Indicate Type of Practice**	Select the type of practice: ○ Independent Private Practice ○ Federally Qualified Health Center ○ Hospital outpatient clinic ○ Primary Care Clinic Note: For purposes of the DSS PCMH Program, hospital outpatient primary care clinics must enroll as a practitioner group. Per DSS policy, as of July 1, 2016 hospital outpatient primary care clinics need to create and enroll as a practitioner group(s) in the Connecticut Medical Assistance Program (CMAP) in order to bill for outpatient professional services.

*** Please complete all required fields marked by an asterisk ***

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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	**Indicate current PCMH National Committee for Quality Assurance (NCQA) Recognition by Standard Year**	*Standard Year	☐ 2014 ☐ 2017 ☐ Not Recognized
	If the practice is not recognized by NCQA, refer to the Glide Path information and application available at www.ct.gov/husky and click on "For Providers."	*Level	○ Level 1 ○ Level 2 ○ Level 3 ○ Not Applicable
	Expiration/Anniversary Date		Enter Date: (mm/dd/yyyy)
	Indicate Distinction Module (if applicable)		
	Behavioral Health Integration – (BHI)	*Distinction Module	☐ BHI
	Electronic Quality Measures Reporting – (eCQM)		☐ eCQM
	Patient Experience Reporting – (PEX) Level (2011 and 2014 only)		☐ PEX
D.4	**THE JOINT COMMISSION (TJC) AMBULATORY CARE ACCREDITATION/PRIMARY CARE MEDICAL HOME CERTIFICATION**	Accreditation Status	☐ Ambulatory Care Accreditation ☐ PCMH Certification
		Expiration Date	Enter Date: (mm/dd/yyyy)

*** Please complete all required fields marked by an asterisk ***

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	*E.9	*E.10	*E.11
	Practitioner First Name	M.I.	Practitioner Last Name	Practitioner Credential	Practitioner's Area of Service (Must Select One From List)	Practice Medicaid (CMAP/AVRS) Billing Number	Practitioner National Provider Identifier (NPI) Number	Practitioner's Medicaid (CMAP/AVRS) Number	Is the Practitioner a CMAP Provider?	Does the Practitioner Manage or Support 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, No, or No- Community Preceptor	Select Yes or No
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*** Please complete all required fields marked by an asterisk ***

F. SIGNATURE

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.

An individual authorized to act as a signatory for the practice must also provide an electronic signature on the application. In doing so, the signatory certifies that all information provided in the application is accurate. Direct any questions regarding the PCMH application process to the PCMH Program Administrator at 203.949.4124 or by email at pcmhapplication@chnct.org.

Provider Entity Name (doing business as)

Name of Authorized Representative

Electronic Signature Agreement. By clicking "I agree" and typing your name below, you are signing this application electronically. You agree your electronic signature is the legal equivalent of your manual signature on this document.

☐ *** I agree**

** Signature* **Date (mm/dd/yyyy)*

G. ELECTRONIC SUBMISSION

IMPORTANT: Please read the instructions before submitting.

It is important to download the file before completing, and saving the file before submitting the document.
Please submit using the current form on the website, as the content is periodically revised.
This form was created using Adobe® Acrobat® 10Pro Version 10.1.16.
It has been tested using Adobe® Acrobat® Reader 11 and Microsoft Internet Explorer® 11.0.
This form should be submitted using an Adobe® Acrobat® application using Internet Explorer®.
The free version of Acrobat® Reader is available from Adobe® at **http://get.adobe.com/reader/**.
SAVE THIS FORM! While editing the PCMH Application and when it is completed,
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-- ANY DATA NOT SAVED WILL BE LOST –

SUBMIT

By clicking the **SUBMIT** button, **after saving this form**,
you certify that all information provided in this application is accurate and correct. You will automatically receive a **Message Received** reply with a tracking number. Save this for future reference. You can expect to be contacted by the Medical ASO within three business days.

If you have any questions about this PCMH Application, please contact the Medical ASO at **203.949.4194** or pcmhapplication@chnct.org.