

MO HealthNet Division (MHD) Primary Care Health Home (PCHH) Conference Call Highlights - December 15, 2011

Frequently Asked Questions (FAQs) from this call will soon be available at this same website.

Learning Collaborative

- Dr. McCaslin attended the first Learning Collaborative Session and reported that it was exciting, energizing, and groundbreaking.
- Marge Houy with Bailit Health indicated the following:
 - The St. Louis Central Learning Collaborative was held December 15 and 16, 2011.
 - The Columbia Learning Collaborative will be held on January 18 and 19, 2012.
 - The Kansas City Learning Collaborative will be held on March 7 and 8, 2012.
 - The St. Louis South Learning Collaborative will be held on April 4 and 5, 2012.
- The goal of the Learning Collaborative is to provide an interactive experience drawing upon the collective experience of the attendees. It is requested each practice site have a team member present, plus a trainer from the multi-site practice.

Primary Care Health Home State Plan Amendment (SPA) Update

- The answers to the questions received from CMS for the SPA that was submitted have been sent back to CMS, and we are awaiting approval.
- The questions were fairly minor and easily addressed.

Implementation

- Implementation is still anticipated on January 1, 2012, however it is recognized that some organizations will need to start later in the quarter.

Enrollment Process

- The auto-enrollment criteria is described as
 - Consumers with the eligibility criteria who had claims with a minimum of \$2600 spend were identified.
 - CMHC claims were removed.
 - A member must have two chronic medical conditions from the list on the SPA or one condition and tobacco usage.
 - A member could not be locked into hospice, and must have met their spenddown and premiums if in a premium or spenddown category.
- After each organizations list was checked for any overlap with the CMHC members, it was returned to the organization to assist them in their staffing calculations.

- Although some organizations added DCN's to their list in a separate area, the process for adding has not been finalized yet. Dr. McCaslin noted that every effort will be made to assist the providers in adding patients to their lists.

Staffing

- The initial auto-enrollment projections constituted each organization's slots, against which organizations were to calculate their Health Home team staffing numbers. Given the refinement of the auto-enrollment lists, calculations will need to be updated.
- A process is being developed to enroll additional DCNs up to the organization's maximum number of initial slots, if an organization falls below its initial maximum.
- The PMPM amount was a result of the costs associated with the staffing ratios.
 - The overall PMPM payment, and in particular the \$8.87 administrative portion, includes \$3.47 for data analytics, technical assistance, and for centralized administration of the initiative.
- Questions have been raised regarding the use of new or existing staff. While the practical realities of hiring an RN are understood, the following requirements need to be met:
 - Supplementation is not allowed. This means an organization may not use existing staff and essentially pay for them with the new dollars from this initiative. This is necessary to satisfy CMS requirements that they "not pay for the same staff twice" and must clearly indicate that there is a new capacity.
 - If existing staff are more appropriate to use in this initiative, the organization must transfer the staff to the Health Home initiative and backfill the FTEs with new hires for the non-Health Home duties.
 - For part-time staff who have some Health Home duties and some existing non-Health Home duties, some reporting and or monitoring structure to demonstrate where the Health Home dollars are being spent will need to be done.
 - A good faith effort to hire an RN for the Nurse Care Manager must be demonstrated as the PMPM is based on RN staffing. If difficulties arise in employing an RN, exemptions may be requested and discussed on a case by case basis.

Potential to adopt and adapt mechanisms developed for the CMHC Health Home Initiative

- The enrollment letter will be a single letter with an attached provider list from which the patient can select an alternative provider that serves the county in which they live. This was the basis for asking for which counties you are intending to serve.
- The flyer is for the organization to share with the patient.
- The transfer and discharge forms are to be used for patients who wish to opt out of Health Homes or to transfer to another.
- Training
 - Leadership training will be for the supervisory and management levels.

- Health Home training is for the Health Home team members themselves, is focused on the details of the initiatives such as reports, distinct from the Learning Collaborative, and will be provided through webinars and phone conferences.

Things an organization can begin working on

- Checking CyberAccesssm for medication adherence, and ER/hospital visits.
 - Receipt and management of notice of hospitalizations.