PRIMARY CARE HEALTH HOME NEW PCHH APPLICATIONS
QUESTIONS AND ANSWERS FROM 8/13/2018 WEBINAR

Q: We are a small hospital owned Rural Health Clinic with 2 full time physicians and 4 nurse practitioners (2 locations). We are wondering since we are in a designated HPSA area with a Rural Health Clinic Status would we qualify to become an Missouri HealthNet Primary Care Health Home? If so, how would the payments to our RHC change?

A: Yes, you would qualify to become a primary care health home - assuming your organization and site(s) meet the qualifications noted in the application. Being in a HPSA is not a requirement for being a PCHH provider organization. Participating in the PCHH initiative would not affect your MO HealthNet claims payments as a RHC since the per-member-per-month payment for PCHH enrollees is over and above regular claims (e.g. office visits, etc.).

Q: What is the timing for receipt of the PMPM (i.e. is there a lag between when the program/staff commence on 7/1, and when the PMPM is distributed)?

A: PMPM payments are received two months following the service month. Here is a sample timeline:

- Service provided in January
- Attested for in February
- Paid on the first Medicaid payment cycle in March (check to be received around the 20th)

Q: If our initial enrolled patient population is 750 patients, is the PMPM support for the Home Health Director (based on 2,500 patients) prorated or paid in full?

A: The Health Home Director component of the PMPM payment is based on 1 Director for every 2,500 patients. The PMPM rate does not change based on health home enrollment -- every health home gets the same PMPM rate. MO HealthNet performs a reconciliation between a health home's estimated staff costs (based on its staffing reports) and the health home's PMPM payments. If the health home with 750 enrollees has 1 full-time Director, it will be incurring estimated Director staff cost of $7,000 per month, while getting paid for 30% (750 / 2500), or $2,100, of a Director's staff cost. In this case, the health home would want to have .3 Health Home Director FTE for its incurred costs to be covered by its PMPM payments.

Q: How is the final initial enrollment eligibility determined for the patient population (i.e. MO HealthNet data, or our internal data review)?

A: MO HealthNet will provide a list of potentially eligible individuals (based on relationship with provider and diagnoses from submitted claims). Providers will have an opportunity to review the list and determine which they should enroll. Providers can also add to that list patients they identify as eligible from their internal resources (EMR). In addition, providers can continue to identify and enroll eligible participants on an ongoing basis. A list of potentially eligible individuals will be sent to providers each month.

Q: Are people in a Medicaid managed care plan eligible to be enrolled in a health home?

A: Yes. The health home is responsible for managing conditions covered by the health home, while the managed care plan remains responsible for all other care/case management activities. When people are in both a managed care plan and a health home, the managed care plan and the health home must develop a mutually agreeable process to communicate about these shared patients, and ensure that there are no care gaps or duplications of service.

Q: Is there a list of diagnosis codes that are eligible for PCHH enrollment?

A: Yes. A list of eligible diagnosis codes will be posted on the PCHH website by the end of this week.

Q: We see that you have to have at least 25% Medicaid or uninsured patients to apply. Is this determined at a physician/provider level or site level?

A: Site level.

Q: Is it possible to get a list of potentially eligible patients from MO HealthNet prior to the application deadline?

A: Yes, email Kathy Brown (mary.k.brown@dss.mo.gov) with a list of the Medicaid clinic provider number(s) of the clinics you are including in your application. Our data analysts will run a report and we will provide you with that information as soon as we can.

Q: When did the program start and has it been successful?

A: PCHH began in 2012. There have been two additional open application periods (2014 and 2016). The program has shown an improvement in clinical indicators, a reduction in hospitalizations and ED visits, and overall cost savings. You can read more in our 2014-2017 progress report available on the PCHH Resources website.

Q: When will the next open application period be?

A: Although this decision is based on many factors, and there are no guarantees, it is likely that we will seek to open applications again in 2020.

NEW ITEMS ADDED 8/15/2018

Q: What information is required in the attestation file?

A: The attestation report is a file with the names and DCNs (Medicaid ID numbers) of all people enrolled in the health home. It requires a check of Yes or No that a health home service was provided the previous month. It is required that the service be documented in the event of a review or audit.

Q: Can we utilize our walk-in clinic for urgent care needs if the patient's PCP doesn't have a same day appointment available?

A: Yes, as long as the EMR is the same and you have access to the record.

Q: We are transitioning to a new EMR for our clinics. We have had clinic EMR access with one system for years, but the product will no longer be available after 12/31/18. We are moving our clinics to the same EMR that our hospital currently uses. We are planning to convert from the old to the new EMR without interruption to EMR access. Does the change to a new EMR make us ineligible because we haven't had the new system in place for at least 6 months?

A: We know from experience that changes in EMR systems are challenging. I would note the details of our situation and plan in the cover letter that accompanies your application. Since you have had years of experience working with an EMR, the new EMR would not automatically make you ineligible to apply.

Q: How competitive is the application process? In the past, how many organizations have applied and how many are accepted?

A: We do not have a cap on the number of organizations/sites we can add. We do have a 5,000 cap on the number of new PCHH participants we can add – but that is a large number and we have not had a new enrollment total anywhere near that number since we first began providing services in 2012 and added 24 organizations at once.

We have turned down a small number of applications during the past two open application periods because they did not meet all the required criteria. That is the main focus of our application review – to make sure that applicants have meet the minimum requirements to participate.

Q: Do you define "site" by street address, or by the various suites that are located at the same address?

A: We define by "practice." If you have separate practices that are located at the same physical street address, you would apply for them individually. Contact Kathy Brown (573-751-5542 or mary.k.brown@dss.mo.gov) if you have specific questions related to this item.

Q: What do you mean that a provider needs to have a certificate or waiver to provide medication-assisted treatment?

A: Under the Drug Addiction Treatment Act of 2000 (DATA 2000), qualified physicians may apply for waivers to treat opioid dependency with approved buprenorphine products in any settings in which they are qualified to practice, including an office, community hospital, health department, or correctional facility. A "qualifying physician" is specifically defined in DATA 2000 as one who is:

- Licensed under state law (excluding physician assistants or nurse practitioners)
- Registered with the Drug Enforcement Administration (DEA) to dispense controlled substances
- Required to treat no more than 30 patients at a time within the first year

• Qualified by training and/or certification

Also, in order to maintain a waiver, a physician must be capable of referring patients to counseling and other services.

To qualify for a waiver, a licensed physician (M.D. or D.O.) must meet any one or more of the following criteria and provide supporting documentation for all that apply:

• Hold a subspecialty board certification in addiction psychiatry from the American Board of Medical Specialties

• Hold an addiction certification from the American Society of Addiction Medicine (ASAM)

• Hold a subspecialty board certification in addiction medicine from the American Osteopathic Association

• Have completed required training for the treatment and management of patients with opioid use disorders. This involves not less than eight hours of training through classroom situations, seminars at professional society meetings, electronic communications, or training otherwise provided by ASAM and other organizations.

• Have participated as an investigator in one or more clinical trials leading to the approval of a narcotic medication in Schedule III, IV, or V for maintenance or detoxification treatment. The physician's participation should be confirmed in a statement by the sponsor of the approved medication to Department of Health and Human Services (HHS).

• Have other training or experience that the state medical licensing board (of the state in which the physician will provide maintenance or detoxification treatment) considers a demonstration of the physician's ability to treat and manage patients with opioid dependency.

• Have completed other training or experience that HHS considers a demonstration of the physician's ability to treat and manage patients with an opioid dependency. The criteria of HHS for this training or experience will be established by regulation.

IF YOU HAVE QUESTIONS THAT WERE NOT ANSWERED HERE, PLEASE EMAIL KATHY BROWN AT mary.k.brown@dss.mo.gov WITH YOUR QUESTIONS AND WE WILL INCLUDE THEM IN AN UPDATED VERSION OF THIS DOCUMENT.