MO HealthNet Primary Care Health Home Initiative

Potential Provider Application Webinar

August 13, 2018

Goals of the Primary Care Health Home Initiative

- Reduce inpatient hospitalization, readmissions and inappropriate emergency room visits
- Improve coordination and transitions of care
- Improve clinical indicators (e.g. A1C, LDL, blood pressure)
- Implement and evaluate the Health Home model as a way to achieve accessible, high quality primary health care and behavioral health care;
- Demonstrate cost-effectiveness in order to justify and support the sustainability and spread of the model; and
- Support primary care and behavioral care practice sites by increasing available resources and improving care coordination to result in improved quality of clinician work life and patient outcomes.

Health Home Qualifications

- Minimum of 25% (site-specific) covered by MO HealthNet or uninsured
- Develop/maintain a health home capable of overall effectiveness
- Have strong engaged leadership
  - Medical director
  - Physician champion
  - Administrators
  - Information technology

Health Home Qualifications (cont'd)

- Empanelment for providers
- Use CyberAccess for care coordination
- Interoperable patient registry (e.g. for tracking and measuring care, automated reminders and exception reports)
- Minimum access – third next available appointment within 30 days and same-day urgent care

Health Home Qualifications (cont'd)

- Electronic Health Record
  - Must have been using current EHR system for a minimum of six months

Application Timetable

- Applications due August 31, 2018
  - Electronic or hard copy
- Responses back to applicants – September 28
- Series of new provider Webinars – October – December
- Initial enrollment panel is finalized and batch enrolled - December
- Anticipated PCHH start date – January 1, 2019

Health Home Service Requirements

- Staffing
  - Health home director – 1:2500
    - No specific licensure/degree requirement
  - Nurse care manager – 1:250
    - Must be RN
  - Behavioral health consultant – 1:750
    - Must be LCSW, LMSW or Psy.D.
  - Care coordinator – 1:750
    - No specific licensure/degree requirement
  - Physician champion – no set FTE requirement

Note: you must have at least one person in the health home director, nurse care manager and care coordinator role to begin providing services. You have 60 days to get at least one BHC onboard.

Health Home Service Requirements (cont'd)

- Training/Assistance
  - New provider Webinars
  - Orientation*
  - Periodic (every 4 to 6 weeks) provider webinars*
  - Periodic (every 3 to 4 months) conference calls for medical directors and physician champions (with MO HealthNet's Chief Medical Officer)
  - Nurse care manager learning collaboratives (twice a year)
  - Behavioral health consultant training (initial and ongoing)
  - PCHH Care Team Forums*
  - Practice Coaching (MPCA)
    - PCMH application process
    - Data submission/measures and other quality indicators
    - High utilizers

*For all PCHH team members, medical director, physician champion and administrators

Health Home Service Requirements (cont'd)

- Daily (or as needed) huddles
  - Pre-visit planning; discuss the day's patients
- PCHH Team Meetings
  - Regular (minimum of monthly) PCHH team meetings
    - Practice transformation
    - PCHH operations/issues
    - PCMH application
    - Data transmission/reports – clinical measures

Health Home Service Requirements (cont'd)

- Patient Registries
  - system for tracking information critical to the health management of a primary care practice's patient population, including dates of delivered and needed services, laboratory values needed to track a chronic condition, etc. These are used for:
    - patient tracking;
    - patient risk stratification;
    - analysis of patient population health status and individual patient needs

Health Home Core Competencies and Requirements

- Patient/family/peer/advocate/caregiver-centeredness
- Multi-disciplinary team-based approach to care
- Personal patient-primary care clinician relationships
- Planned visits and follow-up care
- Population-based tracking and analysis with patient-specific reminders

Health Home Core Competencies and Requirements (cont'd)

- Care coordination across settings, including referral and transition management
- Integrated clinical care management services focused on high-risk patients
- Patient and family education
- Self-management support by members of the health home team
- Involvement of the patient in goal setting, action planning, problem solving and follow-up

Health Home Core Competencies and Requirements (cont'd)

- Evidence-based care delivery, including stepped care protocols
- Integration of quality improvement strategies and techniques
- Enhanced access

Health Home Core Competencies and Requirements (cont'd)

- NCQA PCMH* Recognition
  - Must submit application for recognition by 18 months following first health home payment (e.g. September 2020 if services start in January 2019)
  - Must achieve at recognition under most current standards

*or The Joint Commission ambulatory Primary Care Medical Home certification (or other recognition/ certification approved by MO HealthNet

Required Health Home Core Competencies and Requirements (cont'd)

- Clinical Care Management Services
  - identification of highest-risk patients
    - "high utilizers"
  - intensive monitoring, follow-up, and clinical management of such patients (including addressing social determinants of health)

Required Health Home Core Competencies and Requirements (cont'd)

- Hospital Care Coordination
  - Develop policies and procedures (and formalized in a MOU with area hospital[s] when feasible) addressing:
    - transitional care planning;
    - notification from local hospitals, MHD, and managed care plans of inpatient admissions of the organization's patients;
    - notification by MHD of emergency department visits;
    - maintaining a mutual awareness and collaboration to identify individuals seeking emergency department services that might benefit from connection with the practice
    - motivating hospital staff to notify the practice's designated staff of such opportunities.

Required Health Home Core Competencies and Requirements (cont'd)

- Data Reporting
  - monthly clinical quality indicator reports utilizing clinical data contained within the practice's patient registry or a third-party data repository
    - Creating and implementing specific templates in EMR system to capture PCHH measure elements
    - Data extraction (for FQHCs or other organizations directly connected to MPCA's DRVS system)
    - Monthly SQL "flat file" (developed per specific instructions that will be provided) with data from EMR templates
  - periodic qualitative reports/surveys
  - other reports, as specified by DSS

Health Home Core Competencies and Requirements (cont'd)

- Demonstrated evidence of health home transformation
  - demonstrated development of fundamental Health Home functionality at 6 months and 12 months based on an assessment process to be applied by DSS or its designee, and
  - demonstrated significant improvement on clinical indicators specified by and reported to DSS or its designee.

Health Home Core Competencies and Requirements (cont'd)

- Notification of organization or clinic changes
  - the health home physician champion or administrative leadership changes
  - Contact and FTE information on all PCHH staff and any changes to that information (resignations, changes in FTE, new staff, etc.)
    - Monthly verification and/or notification of changes
  - any substantive changes in organization ownership or composition, including:
    - the organization is acquired by or acquires another organization or site*
    - the organization closes any of its sites or can no longer maintain health home services in one or more of its approved sites
    - the organization merges with another organization

*Note: Health home approval is done by site and new sites cannot be added as health home sites until the next open application period

Health Home Core Competencies and Requirements (cont'd)

- Participation in Evaluation
  - submission of monthly clinical indicator reports
  - submission of periodic reports describing the practice's transformation process
  - responding to surveys and requests for interviews of staff and patients
  - site visits by MO HealthNet or other designated evaluators

Enrollment and Eligibility

- Eligibility
  - Stand alone criteria (no other diagnosis required)
    - Diabetes
    - Obesity (BMI ≥ 30 [adults] or 95th percentile [children]
    - Pediatric Asthma
  - Two or more conditions or risk factors
    - Asthma/COPD (adults)
    - Behavioral health (only one of these can count as qualifying)

      Anxiety Depression Substance use disorder*
    - Cardiovascular Disease (including CHF, hyperlipidemia, hypertension)
    - Developmental Disabilities
    - Overweight
    - Tobacco Use (risk factor)

(*Note: Requires at least one clinical provider have certification to provide medication-assisted treatment [MAT])

Enrollment and Eligibility (cont'd)

- To start, MO HealthNet will send a list of potentially eligible individuals
  - Have existing PCP relationship with your organization (as determined by MO HealthNet claims)
  - Have requisite eligible conditions/risk factors
  - You will determine who to enroll (from that list and add others you can identify)
  - MO HealthNet will also send a monthly list of potential enrollees

Payment

- Per-member-per-month payment
  - Attest that one or more health home services was provided to a participant
    - Comprehensive care management
    - Care coordination
    - Health promotion
    - Comprehensive transitional care
    - Individual and family support services
    - Referral to community and social support services

Note: A document showing examples of activities that can count as a touch will be available on the PCHH Resources web site following today's webinar.

Payment

- Per-member-per-month payment - $63.72
- Breakdown
  - Staff $49.68
    - Health home director $ 2.86
    - Nurse care manager $32.08
    - Behavioral health consultant $ 7.80
    - Care Coordinator $ 6.94
  - Contracted Data Analytics/Reporting and Administration $ 3.75

Payment

- Breakdown
  - Physician Champion $ 2.65
  - Training & Technical Assistance $ 3.39
    - Practice Coaching (MPCA) $ 1.63
    - Other (remains with PCHH) $ 1.76
  - Additional Care Coordination/Community Health Workers $ 4.25

Note: A total of $5.38 of each PMPM payment is required to be paid to MPCA to cover data analytics/reporting, administration and practice coaching.

Payment (cont'd)

- Timeline for PMPM payments
  - Health home service is provided to an enrolled patient in a particular month – e.g. January
  - The health home attests for that service in the subsequent month – e.g. February
  - In the month following attestation, the health home receives a PMPM payment for that service – e.g. March

Payment (cont'd)

- Ineligible Participants
  - A health home patient will not generate a PMPM payment even if a service is provided if:
    - The patient lacks the required eligibility as of the last day of the service month
    - Payment is rejected due to one or more reasons – e.g. invalid Medicaid eligibility, residing in a skilled nursing facility, on hospice care, did not meet spend down
      - Patients who consistently reject for payments may be discharged
      - MO HealthNet will perform a retrospective review of payment rejections several months later to determine those who are retroactively eligible for payment

Payment (cont'd)

- Performance Incentive Payment
  - "shared savings"
    - shared savings was under discussion with CMS as health home was implemented; though it is not in place currently there continues to be interest in pursuing this type of model with CMS

Next Steps if Approved

- Sign “Conditions of Participation” document
- Have your IT/EMR folks begin working with MPCA and the data warehouse (Azara) on creating the SQL flat file
- MO HealthNet will host a series of webinars prior to start date
  - Clinical performance measures
  - Staffing
  - Data requirements and reporting
  - Behavioral health consultants (hiring, training)

Next Steps if Approved

- MO HealthNet will continue with webinars after the start date for new providers
  - How to manage your PCHH participants
    - Add new enrollees
    - Discharge people
    - Transfer process
  - Reports
  - How to attest for services
- Orientation for PCHH staff (~2 months after start)

Questions?

See the Question and Answer document created following the Webinar. It is available at the website address in the next slide.

PCHH Resources Web Site:

https://dss.mo.gov/mhd/cs/health-homes/resources.htm

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(Note: Please email this address and let me know your organization participated in the Webinar)