



Patient-Centered Medical Homes

From the Division of Medical Services

Please note that your preliminary reports for Performance Period 2014 were posted June 9th on the AHIN portal. Processing is under way for Q3 2015, which is expected to yield shared savings incentives at the end of September. All PCMH providers will receive letters notifying them of whether or not they will receive a shared savings payment.

DMS is eagerly anticipating results of the 2015 PCMH performance period, and we are looking forward to open enrollment in September. We have worked closely with our providers and vendors in helping shape the PCMH Program into a total transformation for our providers, physicians, and the beneficiaries of Arkansas. In this program, we have asked our providers to work toward achieving the following three goals:

- » To improve the health of the population
- » To enhance the patient experience of care
- » To reduce or control the cost of care

DMS feels that these goals are attainable and present a challenge to our providers by asking them to adhere to specific metrics,

Contents This Issue:

[AFMC: What's New in QA?](#)..... 2

[ACHI: Program Continues to Thrive](#)..... 3

[AFMC: Positive Effects for Pooling](#)..... 3

[Qualis: Pool Party, Anyone?](#) 4

[PCMH Model in Pediatrics](#) 5

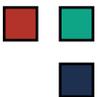
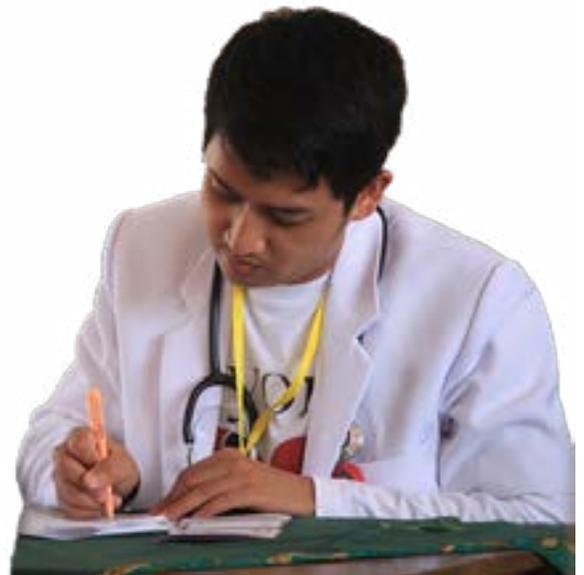
[Success Story: Betton Clinic](#) 5

[PCMH Frequently Asked Questions](#)..... 6-7

Key dates:

Open enrollment: Sept. 1–Nov. 13
 Q3 PBPM Payments: August 1
 PCMH Reports: September 22

activities, and process metrics. We are very proud of the success of the PCMH program, because we have heard testimonies that the program is working great. So as we move toward the second performance period and open enrollment — which will run **Sept. 1 – Nov. 13, 2015** — we ask that you continue to work hard, and continue to ask those challenging questions that will make the program better. We want to continue to meet these three goals to better the health of all Arkansans.



What's New in PCMH Quality Assurance?

by Shelley Fedor, Arkansas Foundation for Medical Care (AFMC)

On May 6, 2015, the PCMH Quality Assurance (QA) team presented a webinar primarily focused on discussing the results and findings of the recent care plan validation activity. There were approximately 141 attendees who signed in to the webinar. The QA team has received positive feedback from providers regarding the webinar, and 1.25 CME credits were awarded to those who participated.

The care plan metric indicates that 70% of high-priority beneficiaries whose care plan is contained in the medical record must include the following: documentation of a beneficiary's current problems; plan of care integrating contributions from health care team (including behavioral health professionals) AND from the beneficiary; instructions for follow-up; assessment of progress to date; and updates to the care plan at least twice a year (within a 12-month period).

During the webinar, an in-depth discussion was held on each necessary component of a care plan. Included in the discussions were examples for each component that would pass validation. A few examples include: an up-to-date list of all problems for each patient; a note with input from other providers who care for a patient and information from the patient's parents; a statement from the provider that a patient should follow up within a certain time frame; an assessment of progress to date that should include a reference to the problem stability; and at least two updates to the care plan, conducted in person or by phone, every 12 months. An example of a care plan template was shown to give participants an idea of how one document can be used to address all required components of a care plan. Using a template is the best practice. Practices are encouraged

to work with their Electronic Health Record (EHR) vendor for possible upgrades or assistance with creating a template.

Practices will have until September 30, 2015 to remediate care-plan performance. After that time, the QA team will begin the validation process to ensure remediation progress. This process will be based on the information PCMHs provided in their Quality Improvement Plan (QIP). The QIP required practices to address the following questions:

1. Why were you unable to meet the activity? What's the cause of the deficiency?
2. What specific actions will be taken to correct/improve the deficiency? For example, policy/procedure changes, training/retraining staff, or implementing new processes.
3. A time frame for the improvement efforts to include expected dates for implementation of all changes and expected dates of completion of your improvement activities.
4. Who is responsible for making sure the improvements take place? (Provide e-mail and telephone contact information.)

In addition, the QA team may request practices to submit randomly selected care plans for review as part of the validation process for remediation.

For additional information, A recording of the webinar may be accessed under the PCMH QA section on the AFMC website at www.afmc.org and on the APII website at www.paymentinitiative.org, under the Patient Centered Medical Home section. In addition to the recording, a list of questions (with answers) submitted before and during the webinar can be found at these locations. The QA team would like to thank everyone who attended the webinar.



Arkansas's PCMH Program Continues to Thrive With Enhanced Multipayer Support

by Mike Motley, Arkansas Center for Health Improvement (ACHI)

While the state looks ahead to 2016 enrollment, it is important to recognize the progress and success that has been achieved via ongoing participation of providers, patients, public and private carriers, and other stakeholders. Overall enrollment and engagement has continued to exceed initial expectations. With approximately 135 PCMHs enrolled and 764 physicians participating, Arkansas's statewide model is one of the largest of its kind in the US. A large majority of practices successfully achieved first-year transformation milestones, and with the first shared-savings payments scheduled to be made later this year, early outcome measures for quality and utilization are promising.

Arkansas's program is leading the nation in multi-payer participation, with providers receiving the reinforcing support of Qualified Health Plans including Arkansas Blue Cross Blue Shield, Qualchoice, and Centene/Ambetter. Several of the state's largest self-insured employers, including Walmart, Arkansas State Employees' Plan, and Arkansas Public School Employees' Plan, are now supporting the model with per-beneficiary-per-month payments. Currently, there are approximately 800,000 patients served under practices that are participating in either the State PCMH program or Comprehensive Primary Care Initiative (CPC) — a number that is expected to increase as additional payers join in supporting the State's PCMH model. Future participation is anticipated from United Health, which will offer a Qualified Health Plan in 2016. Most recently, Medicare has shown renewed interest in supporting the state's model, and is actively working on developing a path to allow financial support for participating practices.

Positive Effects for Pooling Partners

by Rhelinda McFadden, AFMC

The option for more than two practices to pool together to reach the 5,000 attributed beneficiary minimum for shared-savings incentives starting in 2015 has led to a significant increase in the number of pooled practices. It is now more important than ever for providers to be aware of who they are pooling with: Knowing pool partners' levels of performance and attribution should be a high priority for practices. PCMHs that chose their pooled partners are meeting together on a regular basis and a new level of accountability is emerging among the providers. The PCMHs are sharing best practices with one another and collaborating on barriers and gaps that have been identified. Discussion among these PCMHs regarding opportunities for improvement and overcoming identified gaps and barriers has created sustainable and spreadable results.

As we move toward 2016, PCMHs are assessing the community of PCMH providers and are inquiring about not only the attribution level but also the level of performance in order to make informed decisions about pooling partners for the upcoming year.



Pool Party, Anyone?

by Stephen Tonguis, Qualis Health

The Arkansas Payment Improvement Initiative (APII) includes an innovative PCMH model that rewards primary care providers for quality and cost of care improvements through shared savings incentive payments. Since the program requires PCMHs to have at least 5,000 Medicaid beneficiaries to participate in shared savings, many PCMHs have chosen to enter into risk pools with other like-minded PCMHs. Pooling has proved to be an effective way for clinics to meet PCMH objectives through collaboration, quality improvement, and cost savings.

Clinics are not required to organize their own shared savings pools, but those that have are seeing benefits. Take, for instance five clinics that were brought together in the Forrest City area by one practice's PCMH lead and another practice's lead physician. Over the years, the five clinics that ultimately pooled together had often shared patients, but they were otherwise unconnected and had no formal reason to coordinate outcomes. Now, they are all trying to achieve the same APII quality and cost savings objectives through mutual collaboration and sharing of best practices.

The members of this pool have learned that joining a group is easy, but becoming a team built on work and trust is challenging. Members met as a group for the first time with the help of their Qualis Health practice transformation coach, Rhonda Hill. The group learned about program requirements and their own performance metrics. It didn't take long for the individual members to realize that they couldn't succeed in Medicaid's PCMH model alone: Each practice depends upon the other members of the pool to be successful. By the end of the first group meeting, clinics were sharing best practices and creating a plan for success. The group has already identified policy enhancements that would make caring for Medicaid patients easier.



Applying the PCMH Model to Pediatrics

by Amber McGuire, Central Arkansas Pediatric Clinic

Central Arkansas Pediatric Clinic is proud to be among a select group of providers improving primary care in Arkansas by adopting the PCMH model. As a PCMH, we have developed a Case Management Clinic, which is specifically designed for our patients afflicted with asthma and/or obesity. These patients are closely monitored by a specific APRN on a regular basis. The main objective of this clinic is to improve the ability of patients and families to manage these chronic diseases. Secondary objectives include: improve patient and parent understanding of the diagnoses, improve continuity of care, and reduce overall medical costs/emergency department visits.

Visits include: assessment and physical examination; labs as indicated; behavioral risk assessment and self-monitoring tools; action planning and goal setting; intervention and prevention counseling; and health-education

materials. Reimbursement is excellent for these services; because of the extensive counseling and prolonged nature involved, the 99354 CPT code is charged at all initial visits.

A recent chart analysis revealed that we are succeeding in more effectively managing patients' care to keep them healthy and prevent complications of these conditions. We have upcoming plans to do a more in-depth insurance audit to confirm our success in meeting our cost-effective goals. We are also consistently exceeding our PCMH quality-metric indicators.

We at CAPC are pleased to say we have been implementing several of the recommended principles of a successful medical home for years. However, we never rest in improving what we do, and we always welcome ideas to better our medical home.

Success Story: Betton Clinic Sees benefits of SHARE

by Justin Villines, Arkansas Office of Health Information Technology

The Betton Clinic in Little Rock knows firsthand the benefits of using SHARE - Arkansas' statewide health-information exchange. When one of the clinic patients was recently discharged from the local hospital, the clinic used SHARE's web-based Virtual Health Record to review the patient's lab values. Saving time and money, this review gave the clinic the tools it needed to offer better care to the patient.

"By providing the ability to exchange information today in a way that adapts to how our care team actually works is critical," Said Dr. Harold Betton, MD "SHARE is committed to helping our clinic improve care, reduce costs, and protect privacy." As of June 1st, 123 PCMH clinics are connected to SHARE via the Virtual Health Record and/or full integration into their Electronic Health Record. These connected clinics are able to realize the value of SHARE, which includes:

- Improving quality of care and patient safety;
- Enhancing coordination of care through a provider-driven and patient-centered model;
- Facilitating real-time access to data across the care continuum, minimizing delays, and allowing clinicians to focus on patient care;
- Reducing redundancy, improving efficiency, and creating value-added services;
- Improving care. Reducing costs. Protecting privacy.

PCMH Frequently Asked Questions

Q. What happens if one PCMH that is part of a shared savings entity pool meets shared savings requirements, but the other PCMH does not?

A. Practices that pool for the purposes of qualifying for shared savings incentives agree to have their performances measured together, so they must qualify collectively to receive payments. If a pooled entity meets total-cost-of-care requirements and passes at least two-thirds of quality metrics for which it is eligible at an aggregate level, the entity may earn shared savings. Beyond this, each PCMH is measured individually on practice-support metrics and activity eligibility to determine whether or not it will receive a portion of the entity's earned shared savings. See section 233 of the PCMH provider manual for more information on pooling requirements.

Q. If a Behavioral Health specialist initiates the script for ADHD on one of my attributed patients, is the 30-day follow-up requirement still required?

A. If a Behavioral Health specialist who is not part of the PCMH sees a patient attributed to your PCMH and writes a prescription, no follow-up visit is required. A follow-up is required when the prescription is written by a PCP within the PCMH.

Q. If a PCMH failed to attest to 70% of HPB having a care plan in 2014, will the PCMH have an opportunity to attest to the metric by end of 2015?

A. Practices cannot go back and amend failed 2014 care plans. Because of the design of the AHIN portal, we are not able to reopen the

2014 data, so practices will not be able to go back and select care plans for 2014.

Q. Will the PCMH only have the 2015 High Priority Beneficiaries list available and therefore attest to the care-plan threshold of 80% by the end of 2015?

A. We are moving forward with the 2015 HPBs. Validation for remediation purposes will be conducted based on the Quality Improvement Plan (QIP) submitted by the practice.

Q. Once a PCMH selects pooling partner(s), can/will they change or do they remain pooled together until the end of the performance year?

A. Once pooling partners are chosen, they will stay the same throughout the performance year.

Q. What criteria will be used to validate if a practice has met Activity K (Incorporate e-prescribing into practice workflows)?

A. Meaningful use submissions will be accepted. A PCMH can print a current meaningful use dashboard report and a previous report for a baseline. PCMHs will have to show the ability to provide electronic prescribing functionality.

At this time, there is not a minimum percentage threshold to meet. A standalone E-prescribing system will also work until you meet the 12/24 month activity, use of an Electronic Medical Record. There are no special requirements for payers, mail order, etc.



PCMH Frequently Asked Questions (continued)

If a clinic does not currently have an EMR, “plans” to incorporate into the workflow are not sufficient. A PCMH must have and be utilizing the functionality of the EMR. There is no special consideration for rural clinics; the requirement applies to all PCMHs regardless of location.

Q. Are hospitalizations that end in someone being transferred to another facility included in the 10-day follow-up metric?

A. A 10-day follow-up would be required following the release from the hospital to which the patient was transferred. The

calculations take into consideration the initial hospital stay, the transfer and the “final” hospital stay. These three things are defined as a “total hospitalization.” A discharge from an inpatient hospital stay (total hospitalization) requires a 10-day follow-up by any provider.

Q. When should providers expect to see their payments for 2014 shared savings?

A. Providers that qualify for 2014 shared savings incentives should expect to see payments in the third quarter of 2015. This is an initial payment with a final reconciliation payment to follow in early 2016.



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We want your articles! Contribute to the Patient-Centered Medical Homes program by sharing your success story with a featured provider submission.

Please email your ideas to us at ARKPCMH@hp.com.



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