Shared Savings

1. When should providers expect to see their payments for 2014 Shared Savings?

Providers should expect to see 2014 Shared Savings payments in Q3 of 2015. This is an initial payment with the final reconciliation payment to follow in early 2016.

2. Once you select pooling partners, can/will they change or do they remain pooled together until the end of the performance year?

Once you choose your pooling partners, they will stay the same throughout the performance year.

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

Practices who pool for the purposes of qualifying for shared savings incentives agree to have their performance measured together, so they must qualify collectively to receive payments. If a pooled entity meets cost of care requirements and passes at least two thirds of quality metrics for which they are 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 they will receive a portion of the entity's earned shared savings. See sections 233 of the PCMH provider manual for more information on pooling requirements.

4. Are the individual practices in the default pool required to meet 2/3 of the quality metrics (in addition to the majority of practice support) and not the entire pool as it is for private pools?

According to Section 244.00 on the PCMH Manual, the quality metrics are assessed at the level of shared savings entity, except for the default pool.

Requirements

5. If a Behavioral Health specialist initiates a script for ADHD medication on an attributed patient in my PCMH, is a 30-day follow up visit still required?

If a Behavioral Health specialist, who is not part of the PCMH, sees a patient attributed to your PCMH and writes a prescription, that patient is not counted in the PCMH measure. A follow up is expected when the prescription is written by a PCP within the PCMH.

6. 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?

Practices cannot go back and amend failed 2014 care plans. Due to the design of the AHIN portal, we are not able to reopen the 2014 data therefore, practices will not be able to go back and select care plans for 2014. However PCMH Practices can remediate this by submitting a (QIP) Qualified Improvement Plan to the PCMH Quality Assurance Team at www.afmc.org.

7. Will the PCMH only have the 2015 HPB list available and therefore attest to the care-plan threshold of 80% by the end of the 2015 year?

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

8. What criteria will be used to validate if a practice has met Activity K (Incorporate e-prescribing into practice workflows)?
Meaningful use submissions will be accepted. You can print a current MU dashboard report and a previous report for a baseline. You will have to show the ability to prove E-prescribing functionality. At this time, there is not a minimum % threshold to meet. A stand-alone E-prescribing systems will also work until you meet the 12/24 month activity...use of an EHR. There are no special requirements for payors, mail order, etc.

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

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

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 IP hospital stay (total hospitalization) requires a 10 day follow up by any provider.

10. Can anyone of the care team (e.g., LPN, MA, or LCSW) update a care plans?

Please check the governing board for the specific license mentioned. Licensed personnel should only work within the scope of their practice.

11. Can a care plan be updated during or after any direct patient contact and does this include asynchronous communication like text, email, etc.?

Based on the QA care plan webinar (May 6), slide 25, the update can be done in person or by phone and must be documented.

12. Specifically, what roles can initiate care plans and when do they need PCP co-signatures?

Based on the QA care plan webinar (May 6), slide 25, the care plan can be initiated by the MD, APN, or the RN. Please check the governing boards of the license mentioned to determine the protocol and what is included in their scope of work.

13. From which period will the QA team review the care plans? Will these be reviewed from the date of the upcoming QA review and back 12 months or from the 12 months between the most recent care plan (initiation or update) and one prior?

Care plans will be selected from the 2015 HPB list. The QA team has agreed they will ask for a care plan chosen from a list of HPBs seen within the last few weeks of their onsite visit for revalidation.

14. Will the QA team review care plans initiated prior to QIP implementation deadline? In other words, is it possible that “old” care plans will be reviewed?

Care plans prior to the date the practice has stated they will implement new processes will not be reviewed.

15. Will the “plan of care integrating contributions from health care team (including behavioral health professionals) and from the beneficiary” be used as an element of the review for care plan validation?

It will not be used as an element of review for care plans and it is not included in the care plan validation process.
16. Will an “addendum” that corrects a missing element from an existing care plan be considered an update to the care plan?

Documentation guidelines as well as governing board guidelines should always be followed when adding an “addendum” to a patient record. An addendum however is not considered an update.

17. Do third party provider visits count toward 2 patient visits per year? Specifically, when a patient attributed to a PCMH is seen by another entity (e.g. Arkansas Children’s Hospital) for complex care needs, does the visit conducted at ACH count toward the attributed PCMH 2x/year metric (as long as the correct codes are indicated)?

Section 242.000 of the PCMH manual states, “Percentage of a practice’s high priority beneficiaries seen by their attributed PCP (supplemental manual states “attributed PCMH”) at least twice in the past 12 months”. If Arkansas Children’s Hospital/Clinic is part of the “attributed PCMH” then the visit would count.

18. Medicaid beneficiaries have one physician listed as the primary care provider (PCP) with AR Medicaid. When the other clinicians of the PCMH see a Medicaid patient, they bill the encounter under the physician/attributed PCP. Does it have to be the “assigned” PCP to see the high priority beneficiary (HPB) patients for that visit to “count” towards the following metric: Percentage of a practice’s high priority beneficiaries seen by their attributed PCP at least twice in the past 12 months?

Any primary care physician (PCP), not clinician, enrolled in that beneficiary’s attributed PCMH can see the beneficiary in order for it to count toward their metric.

19. What if the clinician bills under a PCP?

Metric B percentages are pulled from claims based data submitted by a PCP within the PCMH. If a clinician is billing under the PCP’s provider number then yes, that metric would count.

20. Please provide clarification regarding Activity K. The Medicaid PCMH manual indicates that Activity K is an 18 month activity, however the supplemental manual identifies Activity K as being due at 24 months.

For practices who joined PCMH in 2014, this metric is due at 18 months. The PCMH will be required to meet this activity by June 30, 2015. For practices who joined PCMH in 2015, the PCMH will be required to meet this activity by December 31, 2015.

21. Is there a particular best practice, process or label that must be used to distinguish an “amendment or correction” from an “update”?

It will be up to the practice to indicate that a care plan update has been added to or corrected based on documentation and governing board guidelines.

22. Does an “acute inpatient hospital stay” include or exclude inpatient mental health stays?

Currently GDIT is using the claims from provider type 05. Inpatient psych hospitalization provider type 25 claims are not included in the inpatient acute stay determination. (the supplemental manual is being updated to reflect this answer)

23. Will the “Plan of care integrating contributions from health care team (including behavioral health professionals) and from the beneficiary” be utilized as an element of the review as it is not included in the Care Plan Validation Process?

No, it is not included in the care plan validation process.
24. Does the 30 day follow up ADHD visit apply if the medication dosage is changed or if another prescription is added?

We only count the Index Prescription Start Date (IPSD) if there is a 120 day gap with no ADHD medications. Adding/changing an ADHD medication within 120 days of a previously dispensed ADHD medication will not start an IPSD.

25. If a patient is off ADD medication for the summer and resumes the medication when school starts back, do we need to treat that patient as an Initial visit with f/u in 30 days?
Only if there is a medication break for more than 120 days

26. If a PCMH clinic has more than one provider and Provider A passes 1 of 2 care plans, but Provider B doesn't pass 1 of 2, does the PCMH fail?

All providers must pass the care plan review.

HIGH PRIORITY BENEFICIARY

27. When is the AHIN portal updated to reflect the patients that have been dismissed or have fallen off of the providers/PCMH's caseload?

The AHIN portal is used for PCMH practices to maintain and update their HPB and beneficiary listings. This information is updated quarterly but can only be updated with the most current information received from the DCO offices.

Reports

28. Can PCP providers obtain performance data on the subspecialists that make up their medical neighborhood?

Not at this time, but it continues to be the goal of our program.