Activity L: After Care Summary

1. The 2017 PCMH Addendum refers to this activity related only to high priority beneficiaries. The portal has similar verbiage. However, on page 19 of the addendum manual in the details of the activity – it does not say high priority patients only – it refers to “patients.” Can you verify if this activity only applies to HPBs or all Medicaid beneficiaries?

   • Activity L applies specifically to high priority beneficiaries (HPBs).

2. The addendum manual is very specific in the time the after visit summary should be delivered when it is delivered by mail (3 days) or handed to the patient (prior to leaving the clinic); however, there is not a time frame for pushing that information to the portal. How long does a clinic have to push the after visit summary to the portal?

   • Clinics should follow the same specifications as listed in the addendum, 3 days.

3. If a clinic has a policy that all visit summaries are provided on the patient portal, and that a patient must login to the system to retrieve the summary, does that suffice for this activity?

   • Clinics will attest to this activity in the AHIN portal. Currently, there is not a percentage required to meet in order to pass, therefore, the beneficiary not logging in to the portal would not cause a negative impact for the provider.

4. If a patient declines an after visit summary and they do not have portal access, and it is against clinic policy to mail PHI, does the clinic have to document the patient declined receiving after-visit summaries.

   • There is not a percentage required to meet this activity. It would however be good to capture for your records.

5. What will be required for validation of this activity?

   • The detailed description of this activity in the 2017 PCMH Addendum states: Practices are to document completion of this activity via the provider portal and attest that the described activity has been completed, and that proper evidence of such can be provided upon request

   A clinic will likely have different processes, as the patient’s preference on how to receive this information will differ. Clinics will need a documented process of each delivery method. The clinic will have to decide what works best for them to capture this information and have it available upon request for validation.
Activity E: PDMP

1. Is it expected that a provider has to check the PDMP system before EVERY controlled substance is written? Or that it is checked whenever there is a concern/new patient they are not familiar with?
   - The addendum states that they have to enroll in the PDMP, and describe the method used to monitor if a process is in place. So, if the providers have an internal process that they follow before prescribing, new patients, etc. it should be documented in the portal for attestation. If they do NOT have a process in place, then they would just attest that ALL providers are enrolled in PDMP.

2. How will the clinic be validated for “monitoring the provider checks the system before prescribing a controlled substance”? Is the provider expected to make a notation in the EMR that they have checked the PDMP system and therefore the office note will be supporting documentation for validation?
   - The addendum does not state that the provider has to check the PDMP before prescribing. The documentation of the process will suffice.

GENERAL

1. What are CPC + clinics required to attest to for the Arkansas Medicaid PCMH program?
   - All clinics enrolled in the Arkansas Medicaid PCMH program for the 2017 performance period must comply with the requirements of section 220.000 of the PCMH manual to receive PBPM. All Medicaid PCMH practices must report activities on the portal and accountability for practice support as outlined in section 242.000 of the PCMH manual. Metrics for shared savings will also have to be met as described in section 243.000.

2. Is NICU cost included in the TCOC?
   - NICU facility costs are excluded, however, provider NICU costs are included.

3. Some EMR vendors have not resolved the ability for some PCMH’s to pull CQM reports. Will the practice fail if they are unable to run this report?
   - At this time, Medicaid will place the practice(s) in remediation for 90 days, if they indicate on the attestation that they are unable to pull eCQM data. We will request that they send us a QIP that clearly explains the issue and when they expect the issue to be resolved. At the end of the 90 day remediation period we will evaluate the current status of the resolution.

4. When will Risk Sharing begin for the Arkansas Medicaid PCMH program?
   - Risk sharing is currently not a piece of the PCHM program. It is unknown at this time if it will be in the future.

February 2017

1. Can you please provide a simpler version to help with understanding of Metric 11?
• Here are a couple of ways to look at the metric:
  o From a truly metric perspective (what is the metric doing):
    The metric is Oral Diabetic Agent (ODA). In a sense, the metric is looking at diabetic patients who are currently on Oral Diabetic medications. Once they start taking the Oral Diabetic medications, for the rest of the performance period, do they stay with the same Oral Diabetic class ODA medication for at least 80% of the time.
  o From a clinical perspective:
    Typically, with someone just diagnosed, they will start with one drug (monotherapy). They will be monitored and if the sugars are not controlled, they will then move to combination therapy. Therefore, we are looking at all phases of diabetics (new and old) so we need to look for those on monotherapy and stable or those that have moved to combination therapy. This is measuring the Diabetic Patients receiving monotherapy or combination therapy to control diabetes.

March 2017

1. I want to exclude and/or choose a beneficiary as a HPB, however, they are not on my beneficiary list to choose. Why?
   • The list of beneficiaries was generated on 12/2/16, as this is the first step to processing all data for the PCMH performance period. The list was uploaded to AHIN the 1st of March, so it’s possible that you will have beneficiaries assigned to you now, that wasn’t assigned to you when the report was generated.

2. What activities will be validated for clinics at the satellite level?
   • Satellite clinics will be validated on ALL activities.

3. Enrollment in the Arkansas Prescription Monitoring Program (PDMP): All PCPs must enroll in PDMP. Report method(s) used to monitor controlled substance prescriptions using PDMP. What documentation is needed for validation purposes?
   • PCMH practices will need to provide a screenshot regarding enrollment for each provider.

April 2017

1. Our April report has a red X by our 12-month metrics that were due by December 31, 2016. We attested to our metrics by the deadline, so why is there a red X?
   • The legend to the practice support report key shows that a red circle with an “X” indicates that it’s either not submitted or under validation. If you submitted your activity requirements and you have an “X”, it is likely because validation is not complete.

2. Activity E: Does the doctor need to be in Arkansas Prescription Drug Monitoring Program (PDMP)?
- Yes, your provider(s) have to be enrolled in the Arkansas Prescription Monitoring Program - Activity E: Enrollment in the Arkansas Prescription Monitoring Program (PDMP): All PCPs must enroll in PDMP. Report method(s) used to monitor controlled substance prescriptions using PDMP.

3. Are the following included in our Total Cost Of Care (TCOC)?
   - CHMS (Child Health Management Services)
     - CHMS is not included in the TCOC if they are rendering provider.
   - DDTCS (Developmental Day Treatment Clinic Services)
     - DDTCS is not included in the TCOC if they are the rendering provider.
   - First Connections Program (Often referred to as Early Intervention)
     - First Connections/Early Interventions programs are not included in the TCOC if they are the rendering provider.
   - RSPMI (Rehabilitative Services for Persons with Mental Illness)
     - RSPMI services are included in the TCOC if they are the rendering provider.

May and June 2017

How long does it take for an “inactive” or “assigned to another PCP” Medicaid beneficiary to fall off of my quarterly PCMH report?

- The PCMH beneficiary list on AHIN updates quarterly. Depending on when the beneficiary was removed, it can take up to two quarters for the report to reflect the dismissal. In the meantime, checking eligibility to ensure the beneficiary has been removed from the caseload is encouraged. Be sure to follow proper dismissal process per the Medicaid manual or contact your AFMC Provider Representative.
- The “history” button on the AHIN portal can be used to review the beneficiaries that have been added or deleted from the caseload specific to each quarter.

Please clarify the following information on the report: “historical risk-adjusted per beneficiary per year cost is below your 2015 trend benchmark” – does a green check mark appear when the clinic is below their benchmark and have met the 2% minimum savings requirement?

- A green check mark does not mean the 2% savings was met.

How are risk scores calculated and what is the range?
Why does my 2017 PCMH report released on April 17, 2017 indicate that 12 month attestation was not submitted?

- The red circle with an “x” symbol indicates that either attestation wasn’t received, or validation is not complete. The next quarter’s report will accurately reflect if validation passed or failed.

We note that the intake period is modified to be the first 11 months of the performance period. Does the age range modify to: Six as of January 1 of the measurement year to 12 years as of November 30 of the measurement year or does this remain as stated in the HEDIS 2016 specifications?

- The first scenario is used, January – November 30\textsuperscript{th}, and is not based off the HEDIS 2016 specifications for age ranges. Also, the beneficiary needs to be 6 by January 1\textsuperscript{st} or <13 by November 30.

Activity N: Are behavioral health facility stays and overnight observations included in the metric?

- Observation bed status is an outpatient designation; therefore, it is not included. Behavioral Health facility stays are not included as well.

2017 Asthma Metric: How does Medicaid know if the beneficiary's asthma is persistent or intermittent?

How will you know if medications are being prescribed and actually filled appropriately for the controller medications for 50% of their treatment?

- Both are claims driven and the denominator looks at 2 years of data, current performance year and the previous year. Data meeting the criteria in both years, not just current, helps to define persistent asthma.

To be considered in the denominator a member has at least one of the following criteria during both the measurement year and the year prior.

- At least one ED visit with a principal diagnosis of asthma
- At least one acute inpatient encounter with a principal diagnosis of asthma
- At least four outpatient visits or observation visits on different dates of service, with any diagnosis of asthma, **and** at least two asthma medication-dispensing events. Visits type need not be the same for the four visits.
- At least **Four** asthma medication-dispensing events.

**For the Numerator for 2017**
- Member is on a controller medication at least 50% for their treatment period of measurement year.

It is important also to understand the exclusions in this metric: Anyone who had a diagnosis or the following value sets since 2010 to December 31st of the measurement year will be excluded.

- Emphysema Value Set
- Other Emphysema Value Set
- COPD Value Set
- Obstructive Chronic Bronchitis Value Set
- Chronic Respiratory Conditions due to Fumes/Vapors Value Set
- Cystic Fibrosis Value Set
- Acute Respiratory Failure Value Set

**Members who had NO asthma Controller medications dispensed during the measurement year are also excluded.**

To be included in the denominator for this Metric not only do you have to have one of the criteria, both current and previous year, but the beneficiary also has to have a controller medication dispensed during current year.

**Please Note: The Asthma Controller exclusion is new to 2017. It was not part of any previous years.**