Patient-Centered Medical Home Advisory Council Meeting Minutes

Meeting Time and Location: April 16, 2019 from 1-3:30 pm
PA Child Welfare Center, Winding Hill Road, Mechanicsburg, Pa

Attendees: Dr. David Kelley, CMO of the Office of Medical Assistance Programs
Laurie Rock, Bureau Director, Bureau of Managed Care Operations
Pauline Saunders, Manager, Bureau of Managed Care Operations
Nancy Stadler, Manager of Quality, Office of Mental Health and Substance Abuse
Kara Eshenaur, HSPS Supervisor, Bureau of Managed Care Operations
Tracy Carney, Senior Recovery Specialist, Community Care Behavioral Health
Steve Carson RN, Vice President of Clinical Integration, Temple University Health System
Dr. Nicholas Degregorio, Senior Medical Director, UPMC for You
Dr. Christopher Echterling, Medical Director of Vulnerable Populations, Wellspan Health
Dr. Robert Edwards, Vice Chairman of Clinical Affairs, Magee-Women's Hospital of UPMC
Kim Fedor COO/BSN, East Liberty Family Care Center
Dr. Eric Gertner, Medical Director of PCMH and Practice Transformation, LHVN
Lynn Phillips DNP, Lehigh Valley Practice Associates
Joanne Sciandra RN, Associate Vice President of Population Management, Geisinger Health Plan
Dr. Linda Thomas-Hemak, President and CEO, Wright Medical Center
Dr. Renee Turchi, Division Chief Pediatrics, St. Christopher's Hospital for Children
Dr. William Warning, Director Crozer-Keystone Residency Program, Crozer-Keystone Health System
Lloyd Wertz MS, VP of Policy and Program Development, Family Training and Advocacy Center
Dr. Matthew Herford, CMO, Community Care Behavioral Health
Dr. Brian Young, Medical Director Care Transformation, Lancaster General Health
Dr. Chris Tjoa, Deputy CMO, Community Behavioral Health

Minutes

1. Implementation of the PCMH Model through HealthChoices Exhibit DDD:
    - It's important to note that this payment/care model is not designed to touch all PCPs; it is targeting high Medicaid volume sites that care for the most complex Medicaid members.
    - As of March 31, 2019: 1,223 unique PCMH practices have been contracted with; 650,489 Medicaid members are being served by those PCMH providers; 32,022 of those members are in the top 5% of medical costs; 64,716 of those members have been diagnosed with a SPMI; and $13,534,142 have been paid to the PCMH practices.
    - Starting in 2019, we are asking PCMH providers to screen for Social Determinants of Health (SDoH). We are undergoing an information gathering effort currently to find software vendors that can assist in the collection of information and referral to community resources.
    - While more information will be sent out later this year to clarify DHS's position, we are asking that PCMH providers make at least one screening a year. If screening is positive, then additional screens should be done at subsequent visits. Additionally, DHS is not asking providers to obtain new screening tools; it will be sufficient at this point to use what is already in place. Guidance will be provided at the regional PCMH learning network meetings.
    - There are a lot of integrated practices now in certain areas of the state. We are encouraging our MCOs to think in terms of having a more integrated model by using therapists, LSWs, and consultative psychiatrists. CMS came out with three supportive CPT care codes for use in this model.

Questions and Answers

- Have you found that MCOs were able to spend most of the funding earmarked for the PCMH model? Yes, most money has been spent. In fact, DHS doubled the funding after the first year.
- Is the mandate really to screen 100 percent of patients for SDoH? These are goals. While DHS would like for you to think in terms of doing it for all patients, we understand that there are workflow and time challenges that prevent that.
- Will providers be able to connect with the state's chosen SDoH vendor through the same contract? That has yet to be determined but will be considered. Again, at this time, we are gathering extensive amounts of information so that we know what is available and what we want prior to issuing an RFP.

Suggestions and Comments from the Council

- The Wright Center has purchased two kiosks for use in SDoH screening and patients can mostly enter the data themselves. St. Christopher's uses iPads that patients use while waiting to be seen. Both methods of SDoH collection have maximized patient visit time.
- Tools for screening should be uniform across the state and shared/discussed at the Learning Collaborative Network meetings.
- The Commonwealth should work to streamline data collection, especially for data points that are already collected through other programs.
- There are concerns related to HIPAA that the Commonwealth should resolve.
- Evidence shows that members benefit from having embedded social workers or case managers in practices. However, it's really hard to differentiate between MCOs/payors while caring for patients. At one provider site in the Philadelphia area, all MCOs are paying into one pot to hire a Community Health Worker (CHW) to make connections for patients. This model is referred to as "Payor Agnostic." Having a Payor Agnostic CHW eases the burden on providers and allows the member to get the best available care. This model should be spread across the state.
- CBCM funding should be infused into the PCMH model to make PCMH model more community-facing.
- For small practices, interconnectivity is largely a myth and smaller providers are being told by some HIOs that they cannot contract with smaller providers.
- The use of ICD-10 codes should automatically trigger a referral for case management at the MCO level. Requiring the provider to call the MCO in addition to using proper SDoH codes is an added burden.

2. <u>Centers of Excellence (COEs):</u>

- Using COEs has shown to increase the number of people who say engaged with treatment as compared to "standard" practices.
- As of October 31, 2018: 19,887 unique individuals with OUD have been in contact with one of the Commonwealth's 45 COEs; 17,587 unique individuals had a level of care assessment completed; and 16,975 unique individuals initiated treatment.
- Today, more than 70 percent of Medicaid patients diagnosed with OUD receive treatment and 62 percent remain in treatment for more than 30 days.
- The care team consists primarily of peer recovery specialists, nurses, and social workers. A $277.22 per member, per month payment is made for these care management services. To qualify for payment, the member must be seen at least once in a calendar month by the COE.

Questions and Answers:

- Is this payment made each time a member visits the COE? No, it's made on a monthly basis, regardless of the number of visits the member has. The rate was built assuming that ongoing care management services would be provided.
- We are a PAC-MAT provider and want to treat pregnant women but are concerned about double-dipping if the member is being seen by the COE. A decision has to be made as to who will provide care management. If the member was already engaged with a COE, let them continue. Some COEs do specialize as perinatal health homes.

3. Community Care Behavioral Health Clinics (CCBHCs):

- The single CCBHC slide in the PPT does not demonstrate the intensity of work that has been put into this program. Hundreds of providers applied to participate in the program and we currently have seven sites.
- Data for year one of the grant is being collected now and will be reported.
- The two-year demonstration will end on 6/30.

4. Health Homes for those individuals living with Persistent Serious Mental Illness PSMI):

- One of our BH MCOs applied for a PCORI grant and set-up 11 Health Homes. The Health Homes were designed to enhance the capacity of BH providers by implementing a wellness coaching model that uses self-management toolkits, coordinating care with wellness nurses, peer specialists, and case managers, and by using targeted interventions. The targeted interventions were use of a member registry and case consultation. Both Provider-Supported and Self-Directed arms of interventions led to improvement in patient-activation, with Provider-Supported leading to more stable improvement.
- Use of Health Homes decreased total spending by 15 percent (including cost of the nurse) when compared with a comparison group, and inpatient utilization decreased by 2 points.
- Health Homes also led to increased self-perceived mental health wellness and increased knowledge of physical health conditions in engaged members.
- 5. Medication Therapy Management:
- All of our MCOs have some form of MTM program in place. Some use in-house pharmacists to reconcile medications, while others have pharmacists embedded in practices.

Questions and Answers:

- Is there any talk about MTM services being reimbursable? No. Some MCOs have contracted with a set of pharmacies who perform a broader array of services including MTM. We have encouraged the MCOs to reach out to higher volume practices and share pharmacy data or place an embedded pharmacist into the practice.

6. Telemedicine:

- Use of telemedicine has increased steadily since 2011: visit counts have increased to over 61,000 visits in 2018. In 2011, 1,718 telemedicine visits were PH-based; that number increased to 17,669 in 2018. In 2011, 3,624 telemedicine visits were BH-based; that number increased to 43,467 in 2018.
- There has been a large push of telemedicine use on the BH side, particularly in pediatrics.
- DHS encourages leveraging telemedicine with MTM in an effort to combat the opioid epidemic.
- DHS keeps providers aware of changes in telemedicine payment policies through publication of bulletins. OMHSAS is currently updating their bulletin on BH telemedicine.

7. General Suggestions and Comments from the Council:

- DHS should be flexible on FQHC reimbursement rules. DHS should consider allowing non-licensed providers (e.g. Community health Workers) to be able to bill PPS payments for their services. Does it really require a Master's in Social Work to find someone food?
- Providers should be incorporated into the planning process for the PCMH Learning Collaborative Networks.
- Overall, the PCMH Learning Collaborative Network sessions are very helpful, especially when DHS has a presence there.
- DHS should be more prescriptive about how the PCMH program should work and outline operations. There seems to be some miscommunication between MCOs and providers.
- PCMH reporting should be more uniform across payors.
- There was talk that some of these programs will no longer be funded. Is that true? PCMH, CBCM, and the Provider P4P continue to be funded, but DHS encourages large practices to move to a value-based arrangement with the MCOs. Value-based, or risk-sharing, arrangements will allow MCOs to share patient data with the providers to better focus care.