Spring 2017 Meeting Minutes

HIV CM Stakeholder Meeting			
Meeting Date/Time:	5/4/2017 1:00 – 2:24 PM EDT	**Location/Conf. info:**	Kirby Bldg. CR 297
Facilitator(s):	Cassandra McFadden, Ashley Batchelor and Renee Stapleton	**Scribe:**	Renee Stapleton

Meeting Objectives and Agenda	
Objective(s):	
Agenda Topics:	
01	Introductions and Housekeeping Reminders
02	Information for all Medicaid Providers on upcoming items of note
03	Policy Updates
04	Audit
05	Next Stakeholder Meeting (August 2017)

Agenda Topic Discussion Notes	
01	**Introductions and Housekeeping Reminders** 1. The DMA contact information (HIV_CaseMgt@dhhs.nc.gov) for questions or concerns was shared 2. Reminder to review Medicaid Bulletins regularly for important information, located at: https://dma.ncdhhs.gov/2017-medicaid-bulletin-and-index.
02	**Information for all Medicaid Providers on upcoming items of note.** 1. Fingerprint-based Criminal Background Checks may be required of Medicaid Providers. a. Implementation 7/30/2017 but is retroactive back to 8/1/2015. i. This applies to Providers who are classified as high risk or any person with a 5% or more direct or indirect ownership interest in the organization. Providers will be notified in NCTracks if they must comply. 2. NC Health Information Exchange Authority (NCHIEA)/NC HealthConnex a. The law requires that as of February 1, 2018, all Medicaid Providers must be connected and submitting data to NC HealthConnex to continue to receive payments for Medicaid services. i. "Connected" means that information pertaining to services paid for by Medicaid is sent to the NC HealthConnex at least twice daily – either through a direct connection to NC HealthConnex or via a hubPolicy Updates. ii. Providers may visit the website at www.nchealthconnex.gov for questions, concerns, or feedback.
03	**Policy Timeline** 1. The current HIV CM Clinical Coverage Policy No 12B is in the process of being amended to address Stakeholder concern and changes in the program since last policy amendment. a. Policy is scheduled to be revised and through internal review and processes, to be posted beginning July 1, 2017 for 45 days of public comment. b. Expected effective date for updated policy is Sept 1, 2017.

Accreditation

1. Accreditation will remain a requirement
    a. DMA is expected to add 2 new accreditation options to policy; Accreditation Commission for Health Care (ACHC) [www.achc.org] and The Joint Commission [www.jointcommission.org].
2. It remains the Providers' responsibility to research and review appropriate options for their situation.
3. A request was made to add further accreditation options
4. The response was that any additional accreditation bodies found may be forwarded to DMA for consideration in the next few weeks. After the policy update is completed, additional accreditation options will not be considered.

CCNC's Role

1. CCNC is charged with the coordination of the beneficiary's overall healthcare.
2. The Primary Care Doctor's (PCP) role and responsibility is to manage the overall care for the beneficiary. This relationship should not to replace specialists such as Infectious Disease (ID) Dr.
    a. Per Stakeholder feedback, beneficiary's in this population rarely contact their PCP and request a referral to HIV Case Management, adding additional CCNC / HIV CM / PCP coordination challenges.
    b. Since a PCP is not always identified up front, the PCP may be hesitant to provide authorization for a patient they have not seen.
3. Per Policy, Providers must share information monthly with the PCP / CCNC with which beneficiary is linked.
    a. This information often comes from the ID to the Provider and the Provider forwards it to the PCP. Can be shared by fax, portal uploads or via phone, as a Provider choses.
    b. Written Physician orders are often coming from the ID, not the PCP.
    c. Discussed origin of referrals as pertains to physician authorization.
        i. Providers in attendance shared that most new clients come from word of mouth with approximately 20% of referrals from Testing centers or ID Dr's, not from a PCP or DSS.
    d. Providers should encourage the relationship of the beneficiary and the Primary Care Physician (PCP).
        i. * Uncompensated time – Since Providers cannot bill Medicaid before receipt of the signed authorization, Providers report they provide uncompensated service to help clients through initial crisis. Additionally, Providers are not protected for work completed if beneficiary "Agency shops" since they cannot enter any documentation into NCTracks until after receipt of the authorization.
        ii. Difficulty obtaining Carolina Access number in a timely manner.
            1. Stakeholder suggestion made that unmanaged units be added as a billing option to compensate Providers for work done before authorization is received.
4. The goal is to enable the Providers to serve their clients in a way that is compliant, but streamlined and not overly burdensome.

	a. DMA encourages feedback from Providers on the communication process and any obstacles encountered. b. DMA is working to revise and clarify language in the policy regarding requirements of each party and process around the sharing of data. c. Stakeholder shared that after going through a process of approval she was granted access to CCNC's information system (CCPGM) to review all beneficiary's activity as well as verify the beneficiary's assigned PCP. DMA will work with CCNC to share process of accessing CCNC Provider Portal if available.
	Training 1. Basic Training will remain a requirement and DMA is seeking ways to provide this resource. a. DMA is considering several options to streamline this process. i. A request was made to consider Provider led training for their own staff i.e., train the trainer format. Rationale is that new hires must have the education and experience to be considered for their role, and the Provider has a vested interest in appropriate staff training since oversights could lead to paybacks. 1. The response was that this option would be considered. 2. Continuing Education Unit requirements (CEU) a. Providers suggested the annually required 20 hours of CEUs is too high. i. Rationale behind this request is it doesn't mirror other policy i.e. Ryan White only requires 6.5 hours and Providers are already completing uncompensated work*. Providers indicated that it is too expensive to pay each employee for 20 hours of unreimbursed training and seems unnecessary since the HIV CM's are already qualified by education and experience. 1. DMA will review this requirement, but this was not a topic that was previously under consideration. ii. Another comment on required training was received regarding the process of finding appropriate training which includes completing the approval form, receiving approval, attending training and documenting attendance. This was found to be cumbersome and time-consuming. In addition, it is reported that a trainee does not always receive the expected certificate at completion to prove attendance for audit purposes. 1. Response is that the training process is currently under review. Possible options include DMA provided resource links to a few common training sites and/or changing the process to allow submission of all completed trainings on an annual basis rather than using a pre-approval request of process for each training event. DMA is reviewing the current process and are considering several options.
04	**Audit** 1. The audit will be based on the current HIV CM Clinical Coverage Policy No 12B and will be based on the 2016 audit year.

	2. A certification extension letter will be sent to extend the current certification beyond the current June 30th deadline. This will allow DMA time to craft appropriate processes. 3. The following is a list of Provider requests and suggestions: a. Providers requested more follow up after the audit for continuous improvement. Providers would like more than an audit finding letter; they wanted a conversation about the outcome and possible to see the actual audit tool scores to look for training opportunities. b. Providers requested permission to review the audit tool ahead of time to prepare and ensure they were complying with policy. i. Response is that they have the policy and the tool is based on the policy. c. Providers suggest including an overall grade or percentage on the audit so they could compare their outcomes year over year. d. Providers requested clear, specific actions needed to return to compliance. e. DMA continues to work on the on-site audit process and will share information in upcoming meetings.
05	**Next Stakeholder Meeting (August 2017)**