A Comparison of Tier 1 and Tier 3 Medical Homes Under Oklahoma Medicaid Program

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</tr>
</tbody>
</table>
# Table of Contents

ABSTRACT ................................................................................................................................. 3

DESCRIPTION OF WORK........................................................................................................... 5

ACKNOWLEDGEMENTS ............................................................................................................. 7

DISCLOSURES ............................................................................................................................ 8

GLOSSARY OF TERMS ................................................................................................................ 9

INTRODUCTION .......................................................................................................................... 10

METHODS ................................................................................................................................. 13

RESULTS ...................................................................................................................................... 15

DISCUSSION, CONCLUSION, AND SUGGESTIONS FOR FUTURE WORK................................. 17

ITEMIZED RESPONSE TO REVIEWER COMMENTS ..................................................................... 21

SUMMARY ................................................................................................................................... 24

REFERENCES ............................................................................................................................... 26

TABLES AND FIGURES .............................................................................................................. 31
ABSTRACT

Introduction: The patient-centered medical home (PCMH) is a team-based model of care that seeks to improve quality of care and control costs. The Oklahoma Health Care Authority (OHCA) directs Oklahoma’s Medicaid program and contracts with 861 medical home practices across the state in one of three tiers of operational capacity: Tier 1 (Basic), Tier 2 (Advanced) and Tier 3 (Optimal). Only 13.5% (n=116) homes are at the optimal level; the majority (59%, n=508) at the basic level. In this study, we sought to determine the barriers that prevented Tier 1 homes from advancing to Tier 3 level and the incentives that would motivate providers to advance from Tier 1 to 3. Our hypotheses were that Tier 1 medical homes were in smaller practices with limited resources and the providers are not convinced that the expense of advancing from Tier 1 status to Tier 3 status was worth the added value.

Methods: We analyzed OHCA records to compare the 508 Tier 1 (entry-level) with 116 Tier 3 (optimal) medical homes for demographic differences with regards to location: urban or rural, duration as medical home, percentage of contracts that were group contracts, number of providers per group contract, panel age range, panel size, and member-provider ratio. We surveyed all 508 Tier 1 homes with a mail–in survey, and with focused follow up visits to identify the barriers to, and incentives for, upgrading from Tier 1 to Tier 2 or 3.

Results: We found that Tier 1 homes were more likely to be in rural areas, run by solo practitioners, serve exclusively adult panels, have smaller panel sizes, and have higher member-to-provider ratios in comparison with Tier 3 homes. Our survey had a 35% response rate. Results showed that the most difficult changes for Tier 1 homes to implement were providing 4 hours of
after-hours care and a dedicated program for mental illness and substance abuse. The results also showed that the most compelling incentives for encouraging Tier 1 homes to upgrade their tier status were less “red tape” with prior authorizations, higher pay, and help with panel member follow-up.

**Discussion:** Multiple interventions may help medical homes in Oklahoma advance from the basic to the optimal level such as sharing of resources among adjoining practices, expansion of OHCA online resources to help with pre-authorizations and patient follow up, and the generation and transmission of data on the benefits of medical homes.
DESCRIPTION OF WORK

Born and brought up in Oklahoma, I have long been interested in contributing to the health of my state, especially since Oklahoma was near the bottom among American states in various health statistics. When I entered medical school at Harvard in 2012, there was much excitement about the concept of patient-centered medical homes. I was intrigued to learn that Oklahoma Medicaid Program was one of the earliest in the nation to commit to helping providers in the state become patient-centered medical homes. Indeed, the state boasted of 861 patient centered medical home practices that contracted with the state’s Medicaid program. Most medical homes, however, were at Tier 1 (entry-level) status rather than Tier 3 (advanced-level).

Curious to know why medical homes were not advancing to higher levels, I approached the director of the Oklahoma Medicaid program (Dr. Garth Splinter) about conducting a formal study to identify the barriers that medical homes in Oklahoma faced in their advancement and to determine any incentives that might help them advance. Dr. Splinter was excited about the project and suggested that, in addition to providing actionable insights to the Oklahoma Medicaid program, the findings of the study may be useful to other states as well.

Working with Dr. Splinter, I designed a research project in which we would survey all 861 medical homes in Oklahoma for specific metrics thought to be related to the advancement of medical homes. During first year of medical school, I travelled back and forth between Boston and Oklahoma to design our survey instrument and assemble a support team to coordinate logistics for the mail-in survey and follow-up interviews. After the survey was designed, staff at the Oklahoma Medicaid program facilitate the distribution and collection of the surveys.

I then spent a summer working full time on site at the Oklahoma Medicaid program. During this time, I compiled all the survey data and – with the aid of staff at the Oklahoma Medicaid program – analyzed the data. I then drove to multiple select medical homes across the state for follow-up interviews on specific findings.
I prepared a manuscript based on our findings that was published in the Journal of the Oklahoma State Medical Association – the primary journal for Oklahoma healthcare providers. Our findings were also well received at the national conference of the state Medicaid programs. I presented our data at the Soma Weiss Research Day at Harvard Medical School, and at the Students, Residents, & Fellows section of the Massachusetts Medical Society Research Symposium. We won 1st place prizes at both conferences.
ACKNOWLEDGEMENTS

The other authors on the publication were essential to the design and execution of the project. Dr. Ron Arky provided mentorship and guidance at all steps, from supporting my initial proposal through providing insights about the implications of our findings. Dr. Asaf Bitton helped me research and review the literature, formulate hypotheses, design the survey instrument, and edit the manuscript. Dr. Steven Crawford, Chair of the Department of Family Medicine at the University of Oklahoma Health Sciences Center, with the members of the Oklahoma Policy Institute provided essential background data that informed the design of our survey instrument. Ms. Melody Anthony – Director of Provider/Medical Home Services – provided daily guidance on the workings of the Oklahoma Medicaid program and how to conduct the survey and analyze the results. Dr. Splinter was the primary sponsor of the project, provided me the opportunity to intern under him at the Oklahoma Medicaid Program, advised me in the design, analysis and writing of the project, and became a life-long mentor because of this fruitful and enjoyable research experience. Furthermore, we gratefully acknowledge the help of Elizabeth Shoemake with distribution of the survey, Anita Ghosh with research support on the PCMH model, Ryan Morlock with statistical analysis, and Connie Steffie, Jim Cacy and Russell Kohl for reviewing the manuscript.
DISCLOSURES

This thesis is based on work that has been present at the Massachusetts Medical Society 2014 Research Symposium, and at the Harvard Medical School Soma Weiss Research Day 2014.

This thesis is an expansion on work that has been previously published in: Kumar JI, Anthony M, Crawford SA, Arky RA, Bitton A, Splinter GL. A comparison of Tier 1 and Tier 3 medical homes under Oklahoma Medicaid program. J Okla State Med Assoc. 2014 Apr;107(4):157-61.
GLOSSARY OF TERMS

AAP - American Academy of Pediatrics
AHRQ – Agency for Healthcare Research and Quality
EHR – Electronic health records
NCQA – National Committee for Quality Assurance
OHCA – Oklahoma Health Care Authority, the Medicaid program of the state of Oklahoma
PCMH – Patient-centered medical home
PMPM – Per member per month
INTRODUCTION

The Medical Home

The patient-centered medical home (PCMH) is a team-based model of comprehensive and coordinated primary care (1-5). By providing patients expanded access to a single provider who knows their unique history along with a team of staff to provide care, the PCMH model seeks to improve quality of care and control costs by ensuring necessary preventive care, minimizing duplication of laboratory and imaging studies, and possibly reducing expensive emergency department visits and hospital admissions.

The PCMH concept was first published in 1967 by the American Academy of Pediatrics (AAP) with the aim to coordinate care for children with special needs (6). It was expanded in 2002 by the Future of Family Medicine Project to cover every American citizen (7). Advanced models of PCMHs were developed by the American College of Physicians in 2005 (8) and the IBM Corporation in 2006 (9). Joint principles of PCMHs were released in 2007 by the AAP, the American Academy of Family Physicians, the American College of Physicians and the American Osteopathic Association (10). The National Committee for Quality Assurance (NCQA) recommended a uniform national standard for PCMHs in 2008 (revised in 2011) that is being adopted progressively across the nation (11, 12). Other accreditation agencies and states have followed with their own medical home standards.

At the time of this study, formal data on the benefits of PCMHs were beginning to appear. The US Department of Health and Human Services’ Agency for Healthcare Research and Quality (AHRQ) reviewed all studies published between January 2000 through September 2010 and...
recommended more evaluations to refine the PCMH model (4). A review of the literature on PCMHs in PubMed, the Cumulative Index to Nursing & Allied Health Literature, and the Cochrane Database of Systematic Disorders concluded that PCMHs improved patient and staff experience and reduced emergency room visits (5).

**Oklahoma’s Medicaid Program**

The Oklahoma Medicaid program has been a leader in the nation in establishing medical homes (13-15). The Oklahoma Health Care Authority, the state agency that administers Oklahoma’s Medicaid program, began one of a few state-wide programs in the nation to convert existing primary care practices to recognized patient-centered medical homes in January 2009. In May 2013, there were 861 medical home sites serving 537,293 patients covered by Oklahoma Medicaid (13). In 2013, 3 tiers of medical homes were recognized in the program as follows:

**Tier 1: Entry-Level Medical Home (n = 508):**

12 total requirements including coordinated primary care, immunizations, member-specific charting, medications list, tests-tracking, referral-tracking, proactive member and specialist contact, member education, direct provider-member communication, open scheduling, electronic communication with OHCA, and 24/7 telephone coverage (Figure 4).

**Tier 2: Advanced Medical Home (n = 237):**

All 12 Tier 1 requirements plus 4 additional requirements consisting of: full time (30 hr./week) practice, use of electronic resources from OHCA for patient tracking, hospital follow-up and enhanced provider-patient communication, plus 3 of the following 6 criteria: healthcare team,
post-visit follow up, adoption of evidence-based practice guidelines, medication reconciliation, mental health screening, and more than 4 hours per week after-hours service (Figure 5).

**Tier 3: Optimal Medical Home (n = 116):**

All 12 Tier 1 and all 10 Tier 2 requirements plus 1 additional requirement of using a health assessment tool to characterize patient needs and risk utilizing any OHCA recommended format such as an AAP approved standardized developmental screening tool, the SoonerCare Health Assessment form, or a disease-specific screening tool (Figure 6).

Oklahoma Medicaid had 3 main payment mechanisms for PCMHs:

Per member, per month (PMPM) care-coordination fees (tiered according to the achievement of the PCMH model; Tier 1: $ 3.58 (Children only), $ 4.33 (children and adults), $ 5.02 (adults only); Tier 2: $ 4.65 (Children only), $ 5.64 (children and adults), $ 6.53 (adults only); and Tier 3: $ 6.19 (Children only), $ 7.50 (children and adults), $ 8.69 (adults only)

b) Fee-for-service payments for office visits and procedures with additional payments for after-hour visits

c) Performance-based payments for specific targets, including breast cancer screening, cervical cancer screening, emergency room visits, and generic prescribing

In this study, we sought to determine the demographic characteristics that are associated with Tier 1 and Tier 3 homes and identify the barriers and incentives that may affect the advancement of Tier 1 homes to Tier 3 homes.
METHODS

To compare the demographic characteristics of the practices between tier 1 and tier 3 medical homes, we analyzed OHCA records for demographic data on the 861 PCMHs and compared tier 1 (n = 508) with tier 3 (n = 116) homes with regards to the following variables:

a) Location: urban or rural.
b) Duration as medical home
c) Percentage of contracts that are group contracts
d) Number of providers per group contract
e) Panel age range
f) Panel size
g) Member-provider ratio

To determine barriers faced by medical homes in advancing from Tier 1 to Tier 3, a survey was mailed to each of the 508 Tier 1 medical homes (Figure 7). Practice providers were asked how difficult it would be for providers to make the following changes:

1) Maintain a full-time practice with at least 30 office hours.
2) Increase access to care and provider-member communication.
3) Provide post-visit follow up for panel members.
4) Implement a screening, intervention and referral program for mental illness and substance abuse.
5) Offer 4 hours of after-hours care.
For statistical analysis, a two-proportion z test was used for percentages and a two-sample t test was used for averages. Assumptions were random sampling, independence, and that all cell counts were 5 or greater. 95% confidence intervals and p values were calculated using standard normal distribution tables. All averages were found to have unequal variances between Tier 1 and Tier 3 data ranges (p = < 0.05).

The survey also asked providers whether any of the following would incentivize them to advance from Tier 1 to Tier 2 or Tier 3:

1) More PCPs/staff
2) Higher pay
3) OHCA help with panel member follow up
4) Less “red tape” from OHCA
5) Help with Electronic Health Record
6) Evidence for efficacy of Patient-Centered Medical Home model
7) Patient request

The survey instrument invited optional write-in comments. Following the survey, personal interviews were conducted on-site at Tier 1 and Tier 2 homes to clarify provider responses to survey questions.
RESULTS

At the time of this study, Oklahoma Medicaid had 861 medical homes (Tier 1, 508; Tier 2, 237; Tier 3, 116). Medical home contracts were issued to either a group of providers or individual providers. A provider could hold only one individual contract but be part of multiple group contracts. Contracts were classified as rural or urban based on the population of their county of practice: counties with a population of greater than 50,000 are classified as urban and others as rural. Duration of medical home was counted in months since the beginning of the original contract. Each medical home catered to a preselected range of patient ages.

Demographic data was available on all medical homes (Table 1). The data revealed that Tier 1 providers tend to be placed in rural counties, contract as individual providers, and the groups they do participate in are significantly smaller than those of Tier 3 providers. They tend to limit their practice to adult patient panels more frequently, their panels tend to be smaller, and they have a higher member-to-provider ratio.

A written survey was sent by mail to all 508 Tier 1 medical homes to determine the barriers and incentives for advancement to Tier 3. 177 surveys were returned (35% response rate), with 17 of those incomplete and excluded from analysis, leaving 160 completed and viable for analysis. In section A, respondents were asked to rate changes on a scale of difficulty from 1 (least difficult) to 5 (most difficult). In section B, respondents were asked to rate incentives on a scale of importance from 1 (least important) to 5 (most important). The data from the Tier 1 survey are shown in Table 2 and Figures 1 and 2. The strongest incentives for providers to move from Tier 1 to Tier 3 were less “red tape” from OHCA, a higher pay rate, and more help in panel member
follow up. Personal interviews with providers in the field revealed that the specific item of “red tape” most providers found most burdensome was preauthorization for imaging studies and medications. A total of 45 written comments were received. The comments indicated that 16 providers were interested in upgrading their tier status but 29 were not. A total of 25 providers stated that the current work load was keeping the providers and the clinic staff fully occupied and they did not have the resources to add more services or staff. Others cited extra cost [2 providers], patient non-compliance [1 provider], and not being convinced of the need to change tier [5 providers].

Two site visits were conducted at specific Tier 1 Medical Homes to follow up on survey comments and better understand the circumstances and challenges of the providers and their staff. Reflections and findings from these visits are summarized in Figure 3.
DISCUSSION, CONCLUSION, AND SUGGESTIONS FOR FUTURE WORK

The Patient Protection and Affordable Care Act of 2010 encouraged the adoption of the medical home model to provide patient-friendly, cost-effective, coordinated care (16). The Oklahoma Medicaid program had been a national leader in setting up medical homes and has pioneered several improvements of the PCMH model including tiered payment of PMPM care-coordination fees, and assistance to providers with acquisition of, and staff training with, electronic health records (EHR, 6-8). In 2013, an impressive number of 861 medical homes across the state were currently contracted with OHCA. However, only 13.5% (n=116) of the homes were at the optimal tier 3 level. The majority (59%, n=508) were at Tier 1 and 27.5% (n=237) were in Tier 2.

To capture the full benefits of the medical home model, it is important for the Oklahoma Medicaid program to help advance the tier 1 and tier 2 homes to the optimal tier 3 level. This study provides useful information for planning that effort. We found that most tier 1 homes were in smaller practices with limited resources. A significant number of medical homes were reluctant to advance to tier 3 medical homes, mostly because the providers and the office staff were already fully stretched with the current load of patient services and lack the resources to add additional staff. The requirements these providers find most difficult to satisfy were the 4 hours per week of after-hours care and the setting up of a screening, intervention and referral program for mental illness and substance abuse. OHCA should continue to devise creative solutions to overcome these barriers. Solutions could include increasing co-pays for after-hour services to pay for the additional staff needed and increasing efficiency by allowing multiple practices to offer a joint after-hours program.
Some providers were not convinced about the benefits to patients of higher tier medical homes. OHCA continues to collect and analyze data on the benefits of the medical home model in Oklahoma. Further studies could include differentiating the impact on patients’ health and cost outcomes provided by the different tier of medical homes. In surveys and interviews with Tier 1 providers, billing denial was raised as a common concern (see Figure 3). Further investigation could be performed to assess the most common causes of denied billing.

The survey of Tier 1 homes identified that in addition to a higher pay rate, the providers would be most incentivized to advance to Tier 3 if they had a more efficient system to obtain prior authorization and more help in panel member follow up post-hospitalization. OHCA could consider exempting Tier 3 homes from routine pre-authorizations, and advertising or expanding its existing online services to help with prior authorization and panel member follow up.

Since the time of this study in 2013, studies have continued to be conducted on the usefulness and impact of patient-centered medical homes. The Patient-Centered Primary Care Collaborative publishes an annual report reviewing the evidence of impact of PCMHs and has recently expanded the scope of their reports to cover the effects of various initiatives dedicated to the transformation of primary care practices with the overarching goals of reducing costs, improving quality, reducing utilization of complex medical care, and improving the experience of patients and providers. The most recent report released in July 2017 reviewed 45 peer-reviewed reports as well as government evaluations at the state and national levels published between November 1st, 2015 and February 28, 2017 (17).
Overall, they found that PCMHs have demonstrated improved outcomes in each of the parameters of quality, cost and utilization but not uniformly (17). Meaningful transformation is occurring but with considerable variations in quality, cost and utilization outcomes. All studies that reported the patient experience found that PCMHs increased patient satisfaction (26, 27, 28). The positive impact of transitioning to a PCMH model appears to take time to develop. A survey of multiple studies suggests that significant positive impact tends to be quantifiable after about four years (18, 19, 20, 21, 22, 23, 24, 25). Decreases in cost seemed to generally accrue to those with advanced PCMH status or those with higher number of patients with complex medical conditions (17). The Comprehensive Primary Care Initiative (CPCI), a Medicare innovation program, showed only modest cost savings that did not offset the care management fees paid per beneficiary per month (PBPM) but individual state programs in Oregon and Colorado did show cost savings (17).

Regarding utilization, there is a consistent increase in utilization of primary care and frequency of outpatient visits associated with the PCMH model (29, 30, 31, 32). However, the correlations between the increase in primary care utilization and the desired decrease in other utilization – particularly emergency room visits and hospitalizations – are unclear. Studies report conflicting results, with some finding decrease ER visits (29) and others finding increased ER visits (30). At least four studies that looked at ER visits in isolation – without connecting them to trends in primary care usage – showed decreased utilization (19, 20, 33, 34).
Importantly, within the last several years, the classic Triple Aim of reducing costs, improving outcomes, and improving patient experiences has been expanded to the Quadruple Aim, adding the provider experience (40). The current body of literature linking PCMHs to provider experience is limited. However, positive team culture has been demonstrated to reduce physician burnout, and the PCMH model has been linked to more positive team culture (41, 42).

Moving forward, continued surveying and study of PCMHs is required to understand the impact of the model and guide further improvement. However, since the time of this study, the PCMH has been joined by an increasingly diverse array of transformative primary care practices, all seeking to achieve the common goals of reducing costs, increasing quality, reducing complex and urgent utilization, and improving patient and provider experience. Robust primary care has been well established as effectively contributing to progress towards all these goals (35, 36, 37, 38, 39). As the existing models – including the PCMH – continue to be refined and new models continue to be developed, thorough study of the impacts of these models will guide state and national efforts to select and promote the most valuable practices.
ITEMIZED RESPONSE TO REVIEWER COMMENTS

1. I think you take as given that there is clear utility in moving from Tier 1 to Tier 2 or Tier 3 status. I think this remains an open question. In fact, meeting the technical specifications required might not truly result in a new model of primary care, and achieving such a new model might not be perfectly correlated with PCMH status. I think a much more involved and detailed discussion of the prior literature of PCMH evaluations would better inform this research while also providing a bit more of an even approach. I think you adopt a normative view that more PCMH is better, when in fact that may or may not be the case when we remain mired in an FFS world that is poorly designed to support primary care.

Response: Multiple studies have demonstrated that improved primary care function contributes to positive progress towards the Quadruple Aim of increased quality, lower costs, and positive patient and provider experiences (35, 36, 37, 38, 39). Insofar as the PCMH model contributes to enhanced primary care, there is a hope that this model will also yield positive outcomes along all four elements of the Aim but so far the results have been somewhat mixed. A recent comprehensive review of the latest literature on the PCMH model by the Patient-Centered Primary Care Collaborative found that “the PCMH delivers improved outcomes in quality, cost and utilization but not uniformly” (17). An expanded discussion of the latest findings regarding each element of the Aim has been added to the discussion.

2. Please go into some more detail on the accreditation process—is this done by the state or NCQA? How much does it cost? What are the requirements?
Response: The accreditation process for all PCMH’s in the state of Oklahoma is conducted by the Oklahoma Health Care Authority, the state agency that directs Oklahoma’s Medicaid program. The medical home program is branded as SoonerCare Choice PCMH program, and providers can apply directly to the agency for a contract. To successfully become accredited, a provider must show evidence that they are fulfilling the requirements for their desired Tier status of medical home (see Introduction for detailed requirements. One accepted into the SoonerCare Choice PCMH program, is required to complete self-evaluation forms outlining their qualification status per requirements (See Figures 5-7). Using these evaluation forms, a provider may also apply for an increase in Tier status once per year. The OHCA staff then follows up with providers on an individual basis to verify their qualifying criteria. The cost of this process is included in the salary costs of the agency members that coordinate the program.

3. In the methods you state that all PCMHs were surveyed, but results are presented just on Tier 1s. Please elaborate and say what was done. If others were presented, I would suggest including those data.

Response: All Tier 1 providers only were surveyed. The focus of this study was identifying barriers that prevented Tier 1 providers from advancing to higher Tiers, and to determine whether certain incentives might facilitate this advancement. Therefore, the survey instrument (See Figure 8) was distributed to all 508 Tier 1 Medical Homes only. Another survey and study
could be performed to assess the 237 Tier 2 Medical Homes for what might help their advancement to Tier 3, and what allowed them to advance from Tier 1 to Tier 2.

4. The site visit data could prove very illuminating and is not in the current article or results. I would suggest more fully developing these methods and adding these results to the thesis. I also suspect this could result in an additional manuscript if done well.

Response: Two extensive site visits were performed to targeted Tier 1 PCMHs to follow up on survey results and conduct more extensive investigation by means of interview to understand the challenges of Tier 1 providers. Key insights reflected those found in written responses to the survey data (see Results section), and the summarized content from the site visits is now included (Figure 3). Follow-up site visits to providers that have since moved from Tier 1 to Tier 3 or have continued to experience difficulty with advancement may provide further useful insights.
SUMMARY

The patient-centered medical home (PCMH) is a team-based model of care that seeks to improve quality of care and control costs. Since its development, it has become relatively widespread, though questions remain regarding its impact.

The Oklahoma Health Care Authority (OHCA) directs Oklahoma’s Medicaid program and contracts with 861 medical home practices across the state in one of three tiers of operational capacity: Tier 1 (Basic), Tier 2 (Advanced) and Tier 3 (Optimal). In this study, we sought to determine the barriers that prevented Tier 1 homes from advancing to Tier 3 level and the incentives that would motivate providers to advance from Tier 1 to 3.

We found that the most difficult changes for Tier 1 homes to implement were providing 4 hours of after-hours care and a dedicated program for mental illness and substance abuse, and the most compelling incentives for encouraging Tier 1 homes to upgrade their tier status were less “red tape” with prior authorizations, higher pay, and help with panel member follow-up.

Multiple interventions may help medical homes in Oklahoma advance from the basic to the optimal level such as sharing of resources among adjoining practices, expansion of OHCA online resources to help with pre-authorizations and patient follow up, and the generation and transmission of data on the benefits of medical homes.

Since the time of this study, the PCMH model continues to be refined, and has been joined by a growing body of primary care practice transformation models all seeking to advance on common
objectives. Continued study of the PCMH and other models will inform best practices in primary care that may help improve health systems.
REFERENCES


TABLES AND FIGURES

Table 1. Characteristics of Tier 1 and 3 Medical Homes
Table 2. Survey of Tier 1 Medical Homes
Figure 1. Barriers to Advancement of Tier 1 Medical Homes
Figure 2. Incentives for Advancement of Tier 1 Medical Homes
Figure 3. Feedback from Site Visits
Figure 4. Tier 1 Self Evaluation Form 2013
Figure 5. Tier 2 Self Evaluation Form 2013
Figure 6. Tier 3 Self Evaluation Form 2012
Figure 7. Survey Instrument
Figure 1. Barriers to Advancement of Tier 1 Medical Homes
Scale: 1 (lowest) - 5 (highest)

- Full-time practice with &ge; 30 office hours
- Increase access and communication
- Provide post-visit follow up for panel members
- Implement a mental health program
- Offer 4 hours of after-hours care
Figure 2. Incentives for Advancement of Tier 1 Medical Homes
Scale: 1 (lowest) - 5 (highest)

- More PCPs/staff
- Higher pay
- OHCA help with panel member follow-up
- Less red tape from OHCA
- Help with Electronic Health Records
- Evidence for efficacy of PCMH Model
- Patient Request
Figure 3. Feedback from Site visits

1. Providers, especially those with large patient panels, find the increased payments with higher tier PCMH rating adds substantially to practice income.

2. Providers do not like pre-authorizations and justifications for procedures and medications. Billing denial was also a major concern. OHCA staff think that they have tried to best streamline need for documentation. But, some documentation is needed prevent fraud and waste, especially with tight budgets.

3. Electronic Medical Record, a mandatory requirement for enrollment in the PCMH program is an issue with positive and negative aspects. The positives are improved efficiency is patient data retrieval and efficiency of claims processing. The negatives about EMR are the cost, the slowness of work flow, need to learn keyboarding, and interruption of face to face time with patients. Some local hospitals were helping with purchase of EMR systems. The newer providers, who were more comfortable, have more positive opinion of the EMR than their older colleagues.

4. Patient compliance was a substantial issue reducing practice efficiency from no-shows and increasing overall healthcare costs from medication non-compliance. Continuing patient education efforts are needed.

5. OHCA is a large agency and needs more interdepartmental alignment to reduce confusion for providers.
Figure 4. Tier 1 Self-Evaluation Form

Tier One Entry-Level Medical Home
Self-Evaluation Form 2013

Provider Name: ____________________________________________
Provider ID: ____________________________  NPI: ____________________________
Address: __________________________________________________
Phone: ________________________________  FAX: ____________________________
Practice Type: ______________________________________________ (i.e. FP, Peds, GP, etc)
Medical Home requested panel capacity: ____________________________
Number of hours per week PROVIDER is available for appointments: Must be at least 20 hours per week _________

Please describe below how PROVIDER meets the requirements defined below.

1. PROVIDER supplies all medically necessary primary and preventive services for panel members. Yes_____

2. PROVIDER is a VFC participant (if PROVIDER sees members less than 18 of age for primary care).
   Provider provides all scheduled immunizations to appropriate panel members, records all immunizations in the Oklahoma State Immunization Information System (OSIIS) and adheres to all requirements of the VFC program: Yes_____
   Provider does not see children_____
   VFC ID#__________________________ OSIIS ID#__________________________

3. PROVIDER organizes clinical data in a paper or electronic format as a patient specific charting system for individual panel members. A patient-specific charting system is defined as charting tools that organize and document the following clinical information in the medical record:
   a. Problem lists
   b. Lists of over-the-counter medications, supplements and alternative therapies
   c. Lists of prescribed medications including both chronic and short-term
   d. Structured template for age-appropriate risk factors (minimum of 3)
   e. Structured templates for narrative progress notes.
   Yes_____

4. PROVIDER maintains and updates the member’s medication list maintained in the chart and also reviews all other medications a member is taking during each office visit.
   Yes______
5. PROVIDER maintains a system to track diagnostic tests and provide follow-up on test results. Provider also uses a tickler system to remind/notify panel members about follow-up test as needed via written logs/paper based documents or electronic reports. Provider has written procedures that outlines diagnostic test tracking procedures, in addition to detailing designated staff that maintain and oversee this process. 
Yes______ Please explain provider’s process:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

6. PROVIDER maintains a system to track referrals including self-referrals communicated to provider by member. Provider notifies panel members when specialty appointment is made by the PCP. Provider documents attempts to obtain a copy of the specialist provider’s consult and finding (this does not include self-referred services). Only one documented attempt to obtain records is expected. This requirement can be fulfilled by written request on the referral form, by mail or telephone contact. Provider has written procedures that outline designated staff that maintain and oversee this process. 
Yes______ Please explain Provider’s process:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

7. PROVIDER supplies care coordination and continuity of care through proactive contact with panel members and encourages family participation in coordination of care. Provider coordinates the delivery of primary care services with all specialists, case manager, and community-based provider (such as school based clinics, WIC, and Children’s First program) involved with the member including, but not limited to consultations and referrals. 
Yes______ Please provide an example:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
8. PROVIDER supplies patient/family education and support utilizing varying forms of educational materials, appropriate for individual patient needs/medical conditions to improve understanding of the medical care provided. An example would include patient information handouts, which can be found on the OHCA website.
Yes____ What type of educational support is used by provider?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
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________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

9. PROVIDER obtains a hard copy of the mutual agreement on the role of medical home between the provider and the patient. The defined roles should be explained within the context of all of the joint principles that reflect a patient centered medical home. The copy signed by the PCP and member is maintained in the patient’s record. Yes____

10. PROVIDER uses scheduling processes to promote continuity with clinicians including (but not limited to) open scheduling and maintaining open appointment slots to accommodate work-in, routine and urgent appointments. (Open scheduling is defined as the practice of having open appointments slots available in the morning and afternoon for same day/urgent care appointments available to SoonerCare members). Provider implements training and written triage procedures for the scheduling staff.
Yes_____ Please explain provider’s process:
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11. PROVIDER accepts electronic communication from the OHCA in lieu of written notification.
Yes_____

E-Mail address for communications: __________________________________________
12. PROVIDER supplies voice-to-voice telephone coverage to panel members, 24 hours a day, seven days a week, where a patient can speak directly with a licensed health care professional. All calls are triaged and forwarded to the PCP or on-call provider when necessary (use of the OHCA Patient Advice Line does not meet this requirement). This coverage includes an after-hours and weekend/vacation number to call that connects to a person or message that can be returned within one half hour. Provider maintains a formal professional agreement with the on-call PCP or provider and notification is shared relating to panel members’ needs and issues.

Yes______

Briefly describe how this process is performed in provider’s office:

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Person completing this form______________________________________________

Date Completed__________________________

Contact Telephone Number________________________

Medical Director or SoonerCare Choice Provider
Signature_________________________________
Figure 5. Tier 2 Self-Evaluation Form

Tier Two Advanced Medical Home
Self-Evaluation Form 2013

Provider Name: _____________________________________________
Provider ID: __________________________ NPI: ______________________
Address: ____________________________________________________
Phone: __________________________ FAX: ______________________
Practice Type: ________________________________________________
(i.e. FP, Peds, GP, etc)
Medical Home requested panel capacity: __________________________
Number of hours per week PROVIDER is available for appointments: Must be at least 30 hours per week ________
Approximate percent of PROVIDER’s hours stated above that are spent caring for patients that are SoonerCare members: ________

Please describe below how PROVIDER meets the requirements defined below.

1. PROVIDER supplies all medically necessary primary and preventive services for panel members. Yes________

2. PROVIDER is a VFC participant (if PROVIDER sees members less than 18 of age for primary care).
   Provider provides all scheduled immunizations to appropriate panel members, records all immunizations in the Oklahoma State Immunization Information System (OSIIS) and adheres to all requirements of the VFC program: Yes_______
   Provider does not see children_______
   VFC ID#________________________ OSIIS ID#_______________________

3. PROVIDER organizes clinical data in a paper or electronic format as a patient specific charting system for individual panel members. A patient-specific charting system is defined as charting tools that organize and document the following clinical information in the medical record:
   a. Problem lists
   b. Lists of over-the-counter medications, supplements and alternative therapies
   c. Lists of prescribed medications including both chronic and short-term
   d. Structured template for age-appropriate risk factors (minimum of 3)
   e. Structured templates for narrative progress notes.
   Yes_______

1
4. PROVIDER maintains and updates the member’s medication list maintained in the chart and also reviews all other medications a member is taking during each office visit.  
   Yes______

5. PROVIDER maintains a system to track diagnostic tests and provide follow-up on test results. Provider also uses a tickler system to remind/notify panel members about follow-up test as needed via written logs/paper based documents or electronic reports. Provider has written procedures that outlines diagnostic test tracking procedures, in addition to detailing designated staff that maintain and oversee this process.  
   Yes_____ Please explain provider’s process:
   ___________________________________________________________
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6. PROVIDER maintains a system to track referrals including self-referrals communicated to provider by member. Provider notifies panel members when specialty appointment is made by the PCP. Provider documents attempts to obtain a copy of the specialist provider’s consult and finding (this does not include self-referred services). Only one documented attempt to obtain records is expected. This requirement can be fulfilled by written request on the referral form, by mail or telephone contact. Provider has written procedures that outline designated staff that maintain and oversee this process.  
   Yes______ Please explain provider’s process:
   ___________________________________________________________
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7. PROVIDER supplies care coordination and continuity of care through proactive contact with panel members and encourages family participation in coordination of care. Provider coordinates the delivery of primary care services with all specialists, case manager, and community-based provider (such as school based clinics, WIC, and Children’s First program) involved with the member including, but not limited to consultations and referrals.  
   Yes______ Please provide an example:
   ___________________________________________________________
   ___________________________________________________________
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   ___________________________________________________________
8. PROVIDER supplies patient/family education and support utilizing varying forms of educational materials, appropriate for individual patient needs/medical conditions to improve understanding of the medical care provided. An example would include patient information handouts, which can be found on the OHCA website. Yes______ What type of educational support is used by provider?

________________________________________________________________________
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9. PROVIDER obtains a hard copy of the mutual agreement on the role of medical home between the provider and the patient. The defined roles should be explained within the context of all of the joint principles that reflect a patient centered medical home. The copy signed by the PCP and member is maintained in the patient’s record. Yes______

10. PROVIDER uses scheduling processes to promote continuity with clinicians including (but not limited to) open scheduling and maintaining open appointment slots to accommodate work-in, routine and urgent appointments. (Open scheduling is defined as the practice of having open appointments slots available in the morning and afternoon for same day/urgent care appointments available to SoonerCare members). Provider implements training and written triage procedures for the scheduling staff. Yes______ Briefly describe how this process is performed in provider’s office:

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11. PROVIDER accepts electronic communication from the OHCA in lieu of written notification. Yes______

E-Mail address for communications: ________________________________
12. PROVIDER supplies voice-to-voice telephone coverage to panel members, 24 hours a day, seven days a week, where a patient can speak directly with a licensed health care professional. All calls are triaged and forwarded to the PCP or on-call provider when necessary (use of the OHCA Patient Advice Line does not meet this requirement). This coverage includes an after-hours and weekend/vacation number to call that connects to a person or message that can be returned within one half hour. Provider maintains a formal professional agreement with the on-call PCP or provider and notification is shared relating to panel members’ needs and issues.

Yes______ Briefly describe how this process is performed in provider’s office:

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13. PROVIDER maintains a full time practice with established office hours to see patients a total of at least thirty (30) hours scheduled hours.

Yes______ List hours by day offered in provider’s office:

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14. PROVIDER uses data received from OHCA (i.e. rosters, patient utilization profiles, immunization reports, etc.) and/or information obtained from secure website (eligibility, last dates of EPSDT/mammogram/pap, etc.) to identify and track panel members both inside and outside of the PCP practice.

Yes______ Briefly describe how this process is performed in provider’s office:

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15. PROVIDER coordinates care and follow-up for panel members who receive care in inpatient and outpatient facilities. Information can be obtained from the member, OHCA or the facility. This information should be maintained in the medical record. Upon notification of member activity, the provider attempts to contact member and schedule a follow up appointment. Inpatient and outpatient activity should be documented on the problem list.  
Yes_____ Briefly describe how this process is performed in provider’s office:  
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16. PROVIDER implements processes to promote access to care and provider-member communication. PCP or office staff communicates directly with panel members through a variety of methods (email, scheduled and unscheduled postal mailings, etc.)  
Yes_____ Briefly describe how this process is performed in provider’s office:  
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**Optional (PROVIDER must choose three additional components)**

17. PROVIDER develops a healthcare team that provides ongoing support, oversight and guidance of all medical care received by the member. This requirement includes documentation of contact with specialist and other health care disciplines that provide care for the member outside of the PCP office. The team may include doctors, nurses and other office staff.  
Yes_____ Briefly describe how this process will be performed in provider’s office:  
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18. PROVIDER supplies post-visit follow up for panel members. (Examples may include outreach calls to members for the monitoring of new medications, ongoing weight and blood sugar checks, blood pressure monitoring, etc.)
Yes______ Briefly describe how this process will be performed in provider’s office:
________________________________________________________________________
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19. PROVIDER implements specific evidence-based clinical practice guidelines for preventive and chronic care as defined by the appropriate specialty category, i.e. AAP, AAFP, etc.
Yes______ Briefly describe how this process will be performed and what guidelines will be utilized in provider’s office:
________________________________________________________________________
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20. PROVIDER implements a medication reconciliation procedure to avoid interactions or duplications. Examples may include using e-Pocrates, e-Prescribing, SoonerScribe Pro-DUR software, screening for drug interactions, etc.
Yes______ Briefly describe how this process will be performed in provider’s office (please include software program used if applicable):
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21. PROVIDER uses behavioral health screening, brief intervention and referral to treatment for appropriate members requiring treatment. Through the usage of these procedures, the provider will expedite treatment with the goal of improving outcomes for panel members suffering from mental illness and/or alcohol or substance abuse. Yes______ Briefly describe how this process will be performed and what guidelines will be utilized in provider’s office:
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22. PROVIDER offers at least 4 hours of after hours care to SoonerCare members. (After hours care is defined as appointments, scheduled or work-ins, readily available to SoonerCare members outside the hours of 8 a.m. - 5 p.m. Monday – Friday). This requirement is per location regardless of number of providers. Solo practitioners can arrange after hours coverage through another approved choice provider location. Multiple locations can submit for a single location to provide after hours coverage. These requests will be reviewed and decided on a case-by-case basis. Provider maintains vacation coverage in the same manner. Yes______ Briefly describe how this process will be performed in provider’s office:
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Person completing this form______________________________________
Date Completed__________________________________________
Contact Telephone Number____________________________________
Medical Director or SoonerCare Choice Provider
Signature____________________________________________________
Tier Three Optimal Medical Home
Self-Evaluation Form 2012

Provider Name: ______________________________________________
Provider ID: ____________________  
NPI: ________________________
Address: ________________________________
Phone: _________________________  
FAX: ______________________
Practice Type: _______________________________________________
(i.e. FP, Peds, GP, etc)
Medical Home requested panel capacity: ___________________________
Number of hours per week PROVIDER is available for appointments: Must be at least 30 hours per week ________
Approximate percent of PROVIDER’s hours stated above that are spent caring for patients that are SoonerCare members: ________

Please describe below how PROVIDER meets the requirements defined below.

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   Provider does not see children______
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   c. Lists of prescribed medications including both chronic and short-term
   d. Structured template for age-appropriate risk factors (minimum of 3)
   e. Structured templates for narrative progress notes.
   Yes______
4. PROVIDER maintains and updates the member’s medication list maintained in the chart and also reviews all other medications a member is taking during each office visit. Yes______

5. PROVIDER maintains a system to track diagnostic tests and provide follow-up on test results. Provider also uses a tickler system to remind/notify panel members about follow-up test as needed via written logs/paper based documents or electronic reports. Provider has written procedures that outlines diagnostic test tracking procedures, in addition to detailing designated staff that maintain and oversee this process. Yes______ Please explain provider’s process:
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E-Mail address for communications: ________________________________

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Yes______ Briefly describe how this process is performed and what guidelines will be utilized in provider’s office:
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Yes______ Briefly describe how this process is performed in provider’s office:
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23. PROVIDER uses health assessment tools to characterize patient needs and risk utilizing any OHCA recommended format, (examples include AAP approved standardized developmental screening tool, SoonerCare Health Assessment form, disease-specific screening tool, etc.). Tools may be publicly available, purchased or created by the OHCA and available on the website.

Yes______ Please explain provider’s process:
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Tier Three Optional. These are not required but are recommended if applicable

24. PROVIDER uses a secure electronic interactive web site to maximize communication with panel members/families this will allow patients to request appointments, referrals, test results, and prescription refills; as well as allow the practice to contact patients to schedule follow-up appointments, relay test results, inform patients of preventive care needs, instruct on medication, etc.
Yes_____ Briefly describe how this process is performed in provider’s office:
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25. PROVIDER utilizes integrated care plans for panel members who are co-managed with specialist(s)/other healthcare disciplines, and maintains a central record or database that contains all pertinent information.
Yes_____ Briefly describe how this process is performed in provider’s office:
________________________________________________________________________
________________________________________________________________________
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26. PROVIDER regularly measures their performance for quality improvement, using national benchmarks for comparison. Provider takes necessary actions to continuously improve services/processes and reports that information to the OHCA regularly.
Yes_____ Briefly describe how this process is performed in provider’s office:
________________________________________________________________________
________________________________________________________________________
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________________________________________________________________________

Person completing this form__________________________________________
Date Completed_____________________________________________________
Contact Telephone Number__________________________________________
Medical Director or SoonerCare Choice Provider
Signature ________________________________
Patient-Centered Medical Home (PCMH) Tiered Status Survey

***Please direct this form to the staff member who oversees the SoonerCare contract***

You have received this survey because you are a contracted SoonerCare primary care provider and a tier 1 Patient-Centered Medical Home. OHCA is interested in understanding the barriers faced by Tier 1 homes from advancing to Tier 2 or Tier 3 homes.

Please complete this form and **fax** to 405-530-7137, Attn. Elizabeth Shoemake, or return by **mail** in the self-addressed stamped envelope, or **scan** and e-mail to ProvServicesAdmins@okhca.org by June 17th, 2013. Please include a copy of the original cover letter with your survey. You may attach additional pages to this survey to thoroughly explain your answers. Thank you very much.

i. Provider Name: _____________________________________________________________

ii. SoonerCare Choice Provider ID number: _________________________________________

iii. How many physicians and other health care professionals (Pas, ARNPs) are in your practice?

   MDs _____; DOs _____; PAs _____; Nurses _____; Other _____

iv. Please describe your practice location.

   Rural (pop. <1,500) _____; Town (1500 < pop. < 25,000) _____; City (pop. > 25,000) _____

<table>
<thead>
<tr>
<th>Section A. How difficult would it be for you to make the following changes?</th>
<th>Section B. What would incentivize you to advance from Tier 1 to Tier 2 or Tier 3?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please rate on a scale of 1 (easiest) to 5 (most difficult).</td>
<td>Please rate on a scale of 1 (least important) to 5 (most important).</td>
</tr>
<tr>
<td>1. Maintain a full time practice with at least 30 office hours.</td>
<td>1. More PCPs/staff</td>
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<tr>
<td>Easiest 1 2 3 4 5 Most Difficult</td>
<td>Least 1 2 3 4 5 Most</td>
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<tr>
<td>2. Increase access to care and provider-member communication.</td>
<td>2. Higher pay</td>
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<tr>
<td>Easiest 1 2 3 4 5 Most Difficult</td>
<td>Least 1 2 3 4 5 Most</td>
</tr>
<tr>
<td>3. Provide post-visit follow up for panel members.</td>
<td>3. OHCA help with panel member follow up</td>
</tr>
<tr>
<td>Easiest 1 2 3 4 5 Most Difficult</td>
<td>Least 1 2 3 4 5 Most</td>
</tr>
<tr>
<td>4. Implement a screening, intervention and referral program for mental illness and substance abuse.</td>
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</tr>
<tr>
<td>Easiest 1 2 3 4 5 Most Difficult</td>
<td>4. Less red tape from OHCA</td>
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<tr>
<td>5. Offer 4 hours of after-hours care.</td>
<td>Least 1 2 3 4 5 Most</td>
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<tr>
<td>Easiest 1 2 3 4 5 Most Difficult</td>
<td>5. Help with Electronic Health Record</td>
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<td>Least 1 2 3 4 5 Most</td>
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<td>6. Evidence for efficacy of Patient-Centered Medical Home Model</td>
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<td>Least 1 2 3 4 5 Most</td>
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<td></td>
<td>7. Patient request</td>
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<td></td>
<td>Least 1 2 3 4 5 Most</td>
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</table>

Comments:

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