Healthcare Quality and Payment Policy Advisory Committee (HQPPAC)
Meeting minutes – November 6, 2015 10:00 a.m. – 12:00 noon

The meeting was called to order by Mark White DHS Deputy Director at 10:11 a.m. After a welcome from Mark introductions were made around the room.

Committee Members Present:
Vicki Pennington          David Norsworthy          David Deaton
Dr. Joanna Thomas        Dr. Bradley Bibb        Dr. John Henderson
Mr. Joel Pritchett          Dr. Jason Richey        Dawn Stehle

Committee Members Absent:
Brant Joyner

DHS Staff in attendance:
Dr. William Golden       Lee Clark              David Walker
Mark White               Jacqueline Gorton

Non-Committee members present:
Jodianne Tritt, AHA       Senator Missy Irvin    Andy Davis, AR Democrat
Gazette

Housekeeping Details:
Lee Clark discussed the travel expense reimbursement forms and network access authorization forms with committee members.

Opening remarks made by Senator Missy Irvin:
Sen. Irvin expressed her appreciation and willingness of members to serve. She was sponsor of the bill that created Act 1266. She encouraged members to look toward high quality, patient safety, effective payment reform; and patient centered physician services. She voiced a need for strong honest dialogue and said that DHS represents your interests. The goal is transparency, input, and dialogue. Committee members were encouraged to read the Stephen Group Report, making reference to Richard Kellogg of Stephen Group and his comments regarding Vermont’s change to the reimbursement rate of vaginal births to that of C-sections which reduced C-section rate 21 percent.
Mark White led a discussion of the purpose and charge and focused on 3 things:

- Overview of Committee’s purpose and the responsibilities outlined in Act 1266
- Overview of FOIA [booklets handed out to each committee member]
- Initial discussions and decisions regarding how the committee will operate

The Act required the committee be convened within 30 days of appointments. Final appointments to core membership completed last month which is why the committee had not met until now.

At least 45 days before DHS proposes a rule it must come before the committee. The committee’s purpose is to advise and assist the Department when it proposes rules related to the development of episodes of care. If the rule pertains to a provider category not represented by committee membership, the committee must reach out to that provider association and seek input.

Once DHS submits a proposed rule, the committee has 30 days to issue a written advisory opinion to DHS. If DHS does not follow advice, it must prepare a written report explaining why. If the committee does not issue the written opinion, DHS may go ahead with promulgation of the rule.

FOIA discussion – referred them to the booklet. Emphasized committee documents in their possession are public record, subject to public release. This includes written correspondence, reports, handwritten notes, and emails. He gave a couple of examples of how this would apply. Also emphasized committee meetings are open to the public and must be announced in advance. Applies to both formal and informal meetings. Anytime two or more members discuss committee business, even informally, it can be determined to be a ‘meeting’ under FOIA and therefore could be an illegal meeting if advance notice is not given to the public. He provided the committee some examples of what constituted a meeting and therefore potentially subject to FOIA.

No hard and fast rules on what is or is not a meeting under FOIA. He referred them to the handout and a contact phone number for the Attorney General should they have questions.
Clarification requested by David Deaton: If he discusses issues with a provider in his hospital is that subject to FOIA?

Mark White’s answer – it is not a meeting if the physician is not a member of the committee, but if notes are taken they are subject to FOIA and therefore available to the public. Emails about committee business are subject to FOIA.

Phone calls could be subject to FOIA if 2 or more committee members are conferencing and discussing committee business.

Question by Joel Pritchett – Is asking questions to DHS staff subject to FOIA?

Mark White’s answer – No, but the staff emails are subject to FOIA as a routine matter as a state employee.

Mark facilitated discussion regarding Committee Procedures: DHS will provide proposed rule to committee members and post to the committee’s special website.

Suggestions: 1) that committee authorizes DHS to call a meeting in consultation with the committee chair at such time DHS has a rule to propose to committee for their review. 2) committee could have a regularly scheduled meeting perhaps monthly or quarterly; 3) DHS can send the rule to the members and then call a meeting only if a member requests to hold one.; 4) leave decision to have a meeting to the discretion of the chair.

Committee decision regarding meeting: leave it to the chair’s discretion. Settled on 10 a.m. as the start time and on Friday as a good day of the week.

Mark facilitated discussion regarding the Written Committee Advisory Opinion: Approval of the written opinion must be in a formal meeting.

Alternatives presented:
- Chair or another designated member could draft the opinion during the meeting and then the committee can vote to approve it in that same meeting. It could be handwritten or a member might bring a laptop.
- A member could be designated to draft opinion and then bring it back to a second meeting for formal approval
- DHS staff could maintain minutes of your meetings and record your wishes during the meeting. The meeting minutes would not become official until the committee approved them in a subsequent meeting.

Committee consensus:
Committee should deliberate and come to a consensus during the scheduled meeting with facilitation by chair and DHS can take the written minutes back to the chair for approval.

Preparation of Meeting minutes: DHS will take minutes in writing and via recording. Minutes will be posted on agency website and on DHS internal network and such links will be provided to the committee members. END.

Lee Clark stated that DHS would post electronic files of the materials used today in the meeting. Dawn Stehle informed the committee that even though the Act was passed in 2013 and no committee members were appointed until recently, DHS has followed the spirit of the act and posted materials electronically for 45 days. Those past materials are also available to anyone interested.

**Election of Chair and Vice Chair**
Mark White opened the floor to nominations for Committee Chair. David Norsworthy nominated Dr. Bradley Bibb. Nominations ceased. A motion was made and seconded; all in favor – unanimous. None opposed. Chair position offered to Dr. Bibb; he accepted. Dr. Bibb deferred to Mark White to continue carrying out the agenda.

Mark White opened the floor to nominations for Committee vice chair. Joel Pritchett asks for clarification to identify the current DMS Director. Dawn Stehle identifies herself as director of DMS. Mr. Pritchett inquires if it is acceptable to nominate Dawn as vice chair. Mark White indicates no objection.

Formal nomination made by Joel Pritchett for Dawn Stehle as vice chair. Nominations ceased. A motion was made and seconded; all in favor – unanimous. None opposed. Vice chair position offered to Dawn Stehle, she accepted. Also
clarified that Dawn Stehle is a permanent member of the committee as the Director of DMS.

**Drawing of lots for 1 and 2 year terms: - facilitated by Lee Clark**
Clarification question posed by Joel Pritchett – will the new speaker be able to appoint new members next year?

Mark White answer: No, current member would have to be removed for cause or serve out their term. Then the new speaker could appoint a replacement.

Lee Clark provided lot draws for Dr. Brad Bibb, newly elected Committee Chair. The first draws were from the 7 core voting members.

2 year terms:
Vacancy – representative of 100+ bed hospital [appointed by Senate]  
Dr. Brad Bibb Dr. John Henderson

1 year terms:  
Dr. Joanna Thomas Dr. Jason Richey David Deaton

The next lot draw was from the 5 additional members representing LTSS:

2 year terms:
Vacant – Arkansas Assisted Living Association [appointed by the Speaker]  
David Norsworthy Joel Pritchett

1 year terms:  
Vicki Pennington Brant Joyner – who is absent from today’s meeting.

**Dr. Golden’s Presentation – Overview of Episodes**
Referenced his slide presentation – The agency was charged by the governor in 2011 to look for a more value-oriented approach for paying providers and to identify ways to bend the cost curve. Dr. Golden emphasized that the goal of payment improvement initiative was not to cut costs, but the bend the cost curve and to be better stewards of funds. The Governor also challenged the private insurance community which expressed concerns about rising copays, deductibles, and premiums. During development of APII, DHS staff traveled around the state
holding town hall meetings, meetings with statewide professional societies, AARP groups and others to gather input on ways to create a sustainable healthcare system. The goal was to ensure healthcare delivery access and emphasize quality within the financial resources available.

By the summer of 2012, the system design included input from work done in conjunction with BCBS, QualChoice and other payers. Several ideas were presented to stakeholders during these visits around the state.

1) Managed Care – stakeholders clearly indicated they did not want this.

2) Bundled payments – Payers could write a big check and give it to somebody (provider) as a prospective DRG-like payment for a specific predetermined set of medical procedures (i.e., joint replacement). Then that somebody would get everyone together who helped provide the service and figure out who got paid what. A prospective single payment was not a popular option either. No legal way for the receiving provider to distribute the money among all other providers participating in the medical procedure and no way to determine how the money would be split. The practice structure in Arkansas is not based on large multi-specialty practices like Geisinger in Pennsylvania, for example. We recognized that if we mandated a single payment it would take providers years to figure out their legal relationships and how to divide up the money.

3) Mandated single payment – professional associations did not want to be the negotiator about payment distribution.

4) Identified need for a consultant. Interviewed 3-4 groups; some of which provided off the shelf cookie cutter versions. One, McKinsey, provided DHS with an out-of-the-box design, with flexibility and creativity. The consensus was to work with McKinsey.

So we have episodes, no one had not done this before. Solution was implementable, but it was not the final solution. DHS and McKinsey created a system – version 1.0 – designed to change the conversation and create a dialogue about stewardship, quality, data, etc. It wouldn’t be perfect but it was a place to start.

We started with the premise that providers would continue to deliver services as they always did. DHS would gather data about the care delivered by the providers
and the cost of that care. A review of the data would identify an ‘accountable party’ responsible for the total cost of care of the patient journey.

The patient journey would then be risk adjusted to then create a profile based on average costs of the care provided by each individual medical provider allowing for a normative process to compare providers. By sharing this data with providers, it would be the first time providers would see this type of data. DHS worked with other payers to provide a common framework and common data. He referred to slides in his presentation that showed sample provider reports and cost details included in the reports. This episode design process and report framework allowed providers to access data regarding the entire patient journey, pulling in data regarding complications and other undisclosed services. It provided a picture of the entire continuum of care for comparison purposes.

In addition to data, Dr. Golden spoke about the perspective that comes with data comparison. He gave an example of a meeting held several years ago when he discussed mammography rates in the state. The rates were about 50% at that time. Most in the audience thought that was a pretty good achievement…until there were told that that rate placed Arkansas 49th in the country. To compare performance indicates where you really are.

DHS held town hall meetings, webinars, utilized UAMS telemedicine system through AHEC remote site access, involved clinical experts to answer questions and gather input.

This process resulted in the initial 6 episodes launched in 2012. Dr. Golden mentioned practice variation in URI; involvement of clinical experts in the design of these episodes; and he referenced tonsillectomy physicians determining that while they had similar outcomes and costs, they all did it differently. The model was a comparative model of risk adjusted cost and it recognized that not every case would be the same. He mentioned a desire to change how we incentivize care. When presented to providers, the better physicians recognized it as a novel idea and liked the fact that they could actually be rewarded for doing a better job at a lower cost.

Other states such as Oregon, Minnesota, and Massachusetts were looking into Value Based Purchasing. CMS identified Arkansas as a Model Testing State and in
2013 awarded the agency funds to pursue a plan to develop and launch episodes. The grant funds supported incentives for better outcomes and lower costs – agreeing to a 50% share rate for both risk and gain with our providers. The Arkansas model is now being used in Tennessee and Ohio.

Reports provide data to providers, and providers very quickly could see how their patients spent or utilized health care dollars compared to their peers. This started a dialogue about data and how to look differently at the data you do have.

**Follow up comments by Senator Missy Irvin and Dr. Golden**

Senator Irvin cited one ENT who was not happy and expressing concern about being held accountable for costs about which they have no control – hospital contracts, for example [these related to Arkansas BCBS]. Physicians cannot control patients’ compliance/non-compliance. She encouraged committee members to reach out to their constituents for input.

Dr. Golden stressed that Medicaid normalizes per diems for all hospitals. Episodes and the data reports have created a healthy dialogue between providers resulting in constructive outcomes and modifications. He stressed that the system allows for medical judgment and is not proscriptive.

No additional comments or questions.

Mark White facilitated meeting wrap up:
Referred committee members to the forms in their binders – travel reimbursement, W-9s and DHS security access forms.

Opened the floor to questions:
A committee member asked DHS to send out a roster of contact information, along with electronic files of today’s materials and the links to access materials from the website.

Dr. Joanna Thomas asked about quarterly meetings for meeting cohesion and she would like to have updates and progress on EOC. The motion was to have at least quarterly meetings or as often as the chair sees fit. Motion seconded, voted on. All in favor; none opposed.
David Norsworthy asked about EOC plans for the future – Dawn Stehle stated there are 14 EOC live at this time with approximately 10 upcoming. DHS will provide both lists to the committee members. She reiterated the agency’s commitment to CMS for SIM grant funding.

Questions posed about what happens at end of grant funding? Dawn Stehle stated no ongoing obligation for state staff and resources. Once the grant period ends in September 2016, with the exception of the ongoing payment for per member per month for PCMH, potential gain sharing payments for episodes, we do not anticipate having ongoing state costs after federal grant funds ends.

Vicki Pennington shared information regarding impact of Medicare episodic payments on the home care service delivery; it helped providers tighten up costs.

Mark asked for final comments or questions. A question was raised about how the two voting groups – the 7 core and the 5 additional LTSS members – functioned as a whole. Mark indicated that for purposes of organization it is one committee. The 5 additional LTSS members would only vote if there is an episode that relates to long term care. They can participate in the discussion, but cannot vote on episode policy issues that are not LTSS related.

Meeting adjourned at 11:52 a.m.

Jacqueline Gorton
Episode Design and Delivery Project Manager
Healthcare Innovation/DMS