Facilitator: Dr. William Golden

Roll Call of Attendees

Dr. Golden

- Since the last call, DMS had a meeting with Dr. Hawkins regarding Care Plans and how they integrate.
- Also spoke to a PCMH clinic about the 0-15 months well child visits which DMS is continuing to look into. Had an email conversation with the NCQA and they clarified what counts for the well child visits. DMS will continue to look into the issue but there is a good chance that calculations will be changed to include the 0-1 month timeframe as long as standards are met. This change would be helpful to several PCMH clinics.
- Spoke with Dr. Skaug about asthma and exercise-induced asthma. Also spoke to NCQA about the topic. Their response was somewhat unsatisfactory so DMS will examine whether NCQA metrics will be modified to reflect the information discussed with Dr. Skaug. More information will be given at a later date.
- The first version of the Medical Home Report has been sent out to the hospitals and ERs. There has been minimal response back. Per James Gallaher, the publishing of the report will be done in mid to late February and it will be available on the portal. Direct mail will be sent to facilities until the new direct interchange provider portal is up at HPE. This will be recent data/the most current data available.
- Also, a draft is being worked on that will give each PCMH a profile of their use of some controlled substances. It will show the rates of Opioid use and rates of Opioid/Benzos use combined. The rates are lower than expected. The framework will be developed with other payers in hopes that they can develop something similar. That will be on the portal and not a public document. The framework and more information will be shared during the next SAG call.
- There are other Medical Neighborhood Reports in the works but DMS wants to see how the first one goes before proceeding with others. Per James Gallaher, other reports to possibly be developed will be Hysterectomy, UTI Presentation, and the EDs. Per Dr. Golden, Mammography and the total cost of the episode, how different centers use biopsies, and recall rates might be of interest as well.
- DMS is still awaiting announcements about CPC+ coaching. There are regular meetings going on with the payers and the state to get ready for common metrics. DMS has made a commitment to keep be as aligned as possible with CPC+.
- CPC+ enrollments are moving forward. Per Anne Santifer, there are 183 practices that have been accepted into the CPC+ program. There are 192 practices as well as 919 PCPs enrolled in the state PCMH program for 2017. This year’s enrollment process was a bit different as information was requested on satellite locations as well. There are 168 satellite locations attached to those 192 practices.
- Per Anne Santifer, in December 2016 some of the private payers and Medicaid staff traveled to Fayetteville, AR. to meet up with other states participating in the CPC+ program. Arkansas participants met with Kansas and Oklahoma participants. It turned out to be a really informative meeting which went really well. There will continue to be quarterly meetings with those states as a sort of an informal regional CPC+ group.
- Dr. Golden said that there are a few national efforts trying to get the regions to work together. The spinoff of the HCP LAN has been a practice action group that will hand off the white paper
entitled “Primary Care Reform.” They will be organizing regional medical homes activities. CMS also has some national regional activities. Oklahoma is now statewide and they now have very active activities. Kansas, more so the Kansas City area, and across the Missouri/Kansas border are both very robust. Tennessee, which has been adopting the Arkansas payment reform model, is in there as well. Arkansas has 183 practices in CPC+, Oklahoma has about 180, and Tennessee has about 45. Michigan, which has had a Blue Cross Medical Home Program for several years, has 300-400 practices in CPC+. Nevertheless, Arkansas is still one of the bigger states to be enrolled in the CPC+ program. They will be reopening CPC+ at the end of the year to several states but Arkansas will not be included in that reopening.

Comments/Questions

- DJ Lewis had seen that BCBS’s application was on their website but was unsure of how to access some of the other applications such as QualChoice and other payers that have applications for CPC+. Anne Santifer commented that she would get that information and send it to Mr. Lewis.
- Bryan Meldrum, Arkansas Health and Wellness, said that they will be auto-enrolling. He also added that they continue to work on their metrics and getting everything aligned as much as possible. Per Brian, they’ll really be starting on their new program at the beginning of the second quarter in 2017.

Shelley Ruth/AFMC

- At the last meeting, the change to the submission of Care Plans was briefly discussed for the 2017 performance year. Testing of the new process has taken place and it appears that everything is working properly. A webinar on the step-by-step process of how Care Plans will be submitted to AFMC for review via the AHIN portal will tentatively be set for February 3 at 12 p.m. A formal e-blast will be sent out once the date is confirmed. Also, AFMC is working getting CME credits. Per Anne Santifer, some of the common issues and misconceptions regarding Care Plans will be addressed as well.
- Shelley gave an update on the current QA process. For the 6 month activities, everyone passed. Right now there are 138 PCMHs that are eligible for validation. AFMC is starting to work on the 12 month validation. The QA staff will be contacting practices over the next several weeks to set up appointment times to come out and do the validation of the 12 month activities. Again, they will start with validating Care Plans so after the webinar, they will start their requests for submission of Care Plans. Submission will be done via the AHIN portal. Practices will have 2 weeks to submit Care Plans to AFMC which is a greater amount of time than what had been given in the past, which was 72 hours.
- Anne mentioned that there had been some confusion on the AHIN portal at the end of 2016 as the interface had changed to display 2017 information so there is now a “toggle button” to toggle between 2016 performance and 2017 performance.
- Shelley added that if you have not been in the AHIN portal in a while it would be a good idea to go to the portal and make sure your log-in and password are working correctly. Per Anne, if you don’t log-in for 6 months, your log-in is deleted.
- Josh Heimburg asked about what percentage of Care Plans would be audited. Shelley advised that it is 20% of the Care Plans that have been attested to. Anne Santifer advised Josh that if time issues arise, email PCMH and we can work together to resolve the problem.

Dr. Golden

- DMS has been working on the new metrics for 2017. A few things will be changing but a summary will be sent out.
• On the informational materials, in the past there had been discussion about sending you who has been in the ER 12 or more times. That number is now being reduced to 6 so you can see your high frequency patients. In general, ER visits have been going down.
• Discussion regarding the 0-15 months’ visits has led to a change to 5 visits, which is a significant drop, and the criteria will be liberalized so it should be easier to count some of the visits especially the ones that occur in the first month of life. DMS will also be looking into enrollment periods and transfers to make sure that it’s a fair metric and not somebody that you inherit in the middle the time period as well.
• DMS will be doing more informational research on cervical cancer screening, colorectal cancer, mammography, and the CT scan/lower back pain studies. More information will be given once it is obtained.
• DMS continues to look at EHR data extraction and validation. Dr. Golden recently attended an ONC conference on the data validation process and learned that most states are not data validating by submissions.
• For 2017, DMS has changed from a quality metric to activities list about the follow-up after an inpatient stay. It is not an office visit but just documentation of contact to make sure there was appropriate follow-up and assessment of the needs of the patient after the acute care activities.
• There have been many discussions regarding changes to the PCMH program. DMS has been modifying our program to reflect the new CPC+ activities in an effort to stay in unison to avoid as much confusion as possible.
• Dr. Lonnie Robinson added that from the AAFP side, they greatly appreciate the effort to harmonize quality metrics because it just makes things easier.
• Per Dr. Golden, OHIT will become part of the Department of Health this year.
• The metrics from 2015 are currently being calculated to be put into place for the 2017 standards. The criteria for passing quality metrics will be somewhat similar. A few will go up and a few will go down. The activity metric for well child visits will go down slightly because they went down in 2015. The number of PCP visits for high priority patients will go up slightly because the metric improved somewhat in 2015 and most practices are meeting it. The infant wellness for 5 visits will go down slightly because DMS has increased the standard but at the same time DMS is also liberalizing the criteria for the data. The asthma metric has changed because it is a new national metric so that number will also go down. In the past it was about 85% and will probably drop to about 47-50% because the metric itself has changed. ADHD will be about the same. The URI metric standard will be a bit tighter, but again, most practices are passing that. It’s an outlier metric so you only have to have under 60% of your patients having an antibiotic for a viral URI. The A1C metric will go up slightly to 78%. Diabetics on statins will go up to about 50%. The Xanax measure will go down slightly. More information will be distributed as the numbers solidify.
• DMS has not heard of any major issues from CMS.
• DMS is hoping to get the co-location of psychiatric care and primary care operational by late 2017, assuming the MMIS update in May goes well. Updates will be distributed as they happen.
• Dr. Golden encouraged practices to send emails to DMS if any problems arise.
• Dr. Maruf added that QualChoice is working to get everything in place for CPC+.
• Dr. Anthony Johnson asked about Shared Savings and said they had received the breakdown of costs. He felt that the breakdown they received did not correlate with the report on AHIN. He asked for a more granular report. Anne added that DMS is working on a more in-depth Total Cost of Care explanation and hopes to present it during a webinar in the near future. She added that final determinations on Shared Savings will be made at the end of April 2017 so it’s not final yet if you didn’t receive the preliminary Shared Savings. Reconciliation and recalculations are currently being done on 2015 and DMS should have the first report out on April 18 and Shared...
Savings will go out on April 28. Dr. Golden added that in 2015 DMS changed the number of diagnoses for risk adjusting your practice site. So there are some practices that will end up with higher expected costs and some practices will have lower expected costs and those changes may just now be showing in the TCOC for the practices.

- Meeting was closed.