Strategic Advisory Group

January 31, 2018

Facilitator: Dr. William Golden (DMS)

Roll Call of Attendees

Dr. Golden

- Public Data on CPC+ Shared Savings has been released and Arkansas was part of two regions that received money. Both Arkansas and Oklahoma performed very well, and other regions have expressed interest in how these two states achieved these performances. On a recent call, Oklahoma talked of their Data System while Arkansas was able to highlight how it Validates its performance activities. Actual validation allows for direct guidance and support for transformation.

There is a difference in how PCMH and CPC+ views Satellite clinics. PCMH allows for satellite sites while CPC+ does not. If someone has multiple sites but only enrolls the core site, CPC+ does not except or recognize these.

Care Coordination Fees: These fees can be charged by any provider who sees the patient. In CPC+ if one of your patients are seen by a specialist and that specialist charges a care coordination fee because they may see them multiple times throughout the year, which could technically require your primary care site to pay back their PBPMs.

Anne Santifer brought of the fact that DMS had received several request from CPC+ clinics asking the amount paid in PBPM’s for 2017. She addressed these request to CPC+ and they noted that the money that a provider receives from Medicaid is NOT part of the money that you have to tie back to CPC+. So just as in PCMH, PBPM’s are not required to be spent in any certain way. Even though these must be reported, no restrictions are placed on how these are spent within you clinic.

- Outlier Metrics: DMS are in the process of submitting Data to CMS for the annual CHIP Measures on how Medicaid performs on metrics like Well Child. Mental Health, Hospitalizations, and ED visits.

Well Child really hasn’t improved all that much, and we are not sure if it might be because of possible unassigned kids. We know that 2016 had many interesting speed bumps that affected Data.

As Data was being broke down by practices, like in every program, we had practice at both performance extremes. It was also noticed that PCMH had some practice that seemed to be just collecting PBPM’s and their Quality Metrics were still lacking.

With this in mind there is a possibility that in the future PCMH may require a minimum in metric performance to maintain their PBPM payments.

Comment

Dr Skaug mentioned that the percentage of well child visits for some practices may have stagnated a bit because of the new MMIS Program. His practice in particular have been following, up to 200 or more children who for several months where not showing on their PCP panels but they saw them anyway. These have just recently began to be added back but there is a concern if these are being counted in the metrics.
Dr Golden assured Dr. Skaug that this is something that is being watched and assigning these beneficiaries to a PCP’s panel is under review. The good news is that although our new system has issues, it doesn’t seem to be to the magnitude as what other states have experienced when theirs was implemented. With this new system we are hoping to make small reforms in 2018 that will make Medical Home Activities and Metrics Stronger as the year progresses. Because of upcoming Implementation in 2017 we had to put on hold many of the changes and improvements and we are now working through that backlog.

- eCQMs: We have extended our deadline to report these to align with CPC+ and these will now be due at the end of February. This should help with not having to report much of the same info at two different times, and hopefully this data can be used this year for accountability. Because of the information and feedback that we were able to provide to CMS concerning eCQMs they have changed the requirements for CPC+. Rather than the required 50th percentile it not the 30th percentile for 2017 which should allow more practices in our state to meet he requirements. CPC+ has also aligned their measures with ours this year in requiring Blood Pressure Control and Diabetes Control as core measures.

- Asthma Metric: There has been concerns surrounding this metric. PCMH has been working with our Data Team and looking at the new requirements. The basic difference between this metric in the past and the New Asthma Measure is that it has become an adherence measure. An adherence measure for a Medicaid Population is very different than that a nonadherence. For 2017 PCMH did not change the thresholds but will carefully rethink these. Anne Santifer mentioned that the analytic team is currently looking into those beneficiaries that have been diagnosed with Asthma in a ED setting, to identify how many times this actually happens and if this might be an adjustment that needs to be addressed.

**Comment**

Dr Shaug addressed one child that he had in his clinic that requires an inhaled steroid 3 months out of the year, normally March through May. The rest of the year the child does well on just his Albuterol without the help of a steroid. Under how this metric is currently stated this child would Fail the metric, yet he feels that they are providing appropriate care and do not want to overdue the medications. He believes that each case is different and in some cases a Chart review may be best.

**Comment**

Dr Golden asked if he would put this in an email so that he might address this concern to CMS and NCQA to see what their response might be.

Dr Patton addressed the concern that with these new Asthma Metric Requirements is affect that it might have on Total Cost Of Care. These inhaled steroids are quiet expensive. His local pharmacist informed him that the cost billed to Medicaid is around $180 per inhaler. Over the course of a year this could increase the cost to that patient to close to $1000, just to meet the metric requirements, when sometimes they really do not need these medications. This may be an in attended consequences that make it hard to hold down cost, especially if the patient really isn’t in that sever category.

He also expressed concern as allude to earlier that this in one of the only metrics where the diagnoses can be made by a non PCMH, meaning the ER Visits.
• Dr Golden pointed out that inhaled steroids and anti-inflammatories are interesting areas. There are some Asthmas that are seriously under treated and the kids need the inhaled steroids and then they would need less Beta Agonists inhalers and some may not need them at all. This is a tough area for a physician. If a child has persistent asthma, chronic coughing, we don’t want to under treat them either. This in some cases are judgement calls but there may be more kids who probably need inhaled steroids that may not be getting them, than those who are getting them and don’t really need them or getting extras.
Research was done that showed that 5% of kids with Asthma represented 30% of our ED visits and about 35% of our hospitalizations. This is an area where we need to concentrate on that 5% that ae the high frequency ER, Hospital visitors. Those are the ones who really need the steroids.
As continual feedback, findings, and decisions are made in the future, these will be shared with the group.
• Regional Meetings: Future Regional Meetings are being planned. If there are topics that you would like to see addressed in future CPC+ Regional Meetings please make these know by email.
• Anne Santifer addressed that all payers are meeting on a monthly basis and Care Plans and been and area addressed. It seems that Care Plans, although there are a few still not there, are now on more of a maintenance mode. The payers are evaluating how they might change up Care Plan reviews and Validations requirements going forward. Those that are doing well year in and year out not have to provide as much and more time be spent on those who might not be doing as well.
• PCMH Webinar is being planned for March and if there are any topics that need to be addressed please notify someone from the PCMH team. Anne Santifer, Shannon Langhorn, Larry Ballard or Julie Pair.
• Dr Golden pointed out that as MMIS matures there will be new Medical Neighborhood Reports that will be developed. Some area being looked at is revisiting the classic ER report to the hospitals and giving more data to the PCMH’s, like how ER’s handle psychiatric care and how follow ups happen. This should be helpful for both PASSE and the PCMH’s
• When the First Quarter Reports are finally released our first Medical Neighborhood Report will be released dealing with Opioids. These reports will be release twice a year.

Comment
Dr Patton asked of Anne Santifer, has PCMH completed the cost review that they have been waiting on, if so what are the findings? When will this information be available? When will First Quarter Reports come out, and when can they expect First Quarter PBPM payments?

• Anne; as we know with the New MMIS implementation there are some areas that are working well, such as Paying Claims, but there are behind the scene areas that are just not quite ready yet. There is a lot of data being transferred from the old system to the new system. Once we started receiving the 7 years of historical data we found that there was missing information, so there have been patch files that are being sent. We have to make sure that we have ALL the information we need to populate reports, payments, and finish 2016 cost analysis. It is moving along, unfortunately a little slower that we would like. Because of this we do not have dates yet for reports, payments or when share savings for 2016 will be completed. This will not be available until we have a fully developed data warehouse. One area of missing data has been that of provider ID’s, which impacts a lot of our metrics. We had claims without providers ID’s attached which caused problems. We hope to have better deadline dated to share in March.
Dr Hawkins asked since we are doing all these changes to the system if it might be possible to providing more detail on our payments. They receive checks to a clinic without the breakdown of responsible parties. He was wondering if we could add a provider column to these. These are issues that they have with Manage Care Fees with PCMH and CPC+

- Sheryl Hurt mentioned that this is an issue that is currently being looked into.

Shelly Ruth: Quality Assurance Update
- December 31, 2017 marked the deadline for all PCMH’s to have completed the 12 month Activities for the 2017 performance period. In addition to completing the attestation in the AHIN portal the PCMH should have also selected at least 80% of High Priority Beneficiaries as having first and second Care Plans. This is the second part of Activity I. January 5, 2018 QA was able to determine which of the PCMH’s had completed this. A total of 6 PCMH’s were not able to attest to the 80% and those were asked to submit a Quality Improvement Plan. These QIP’s have been reviewed and these PCMH’s have been placed in Remediation until April 10, 2018. After this date QA will review some of the current care plans from each of these PCMH’s. There are 2 PCMHs that did not attest to anything for 12 month Activities and these have been suspended. Review of Care Plans have begun and this year Medicaid has adopted a Validation process similar to that of BCBS and will be using a validation score card. Each element of a care plan is worth so many points. As of today the total number of Care Plans that will be reviewed is 4612. QA Team has also begun onsite validation visits.

Alicia Berkemeyer Blue Cross Blue Shield QHP Updates
- Today is the deadline for BCBS concerning Care Plans as well as submissions of eCQMs
- In addition to Multi-Stakeholder meetings they have also engaged the stakeholders to create workgroups. These workgroups have 2 primary focuses right now, Behavioral Health, and Patient Engagement.
- The Multi-Payers group feel that it is important to step back and share their story. Arkansas has done an outstanding job and has received Shared Savings 2 years in a roll with Medicare. Other states are interested in how this as occurred and what is Arkansas doing differently. So there is a workgroup that is focused on reporting and collaborating and telling the story for Arkansas.

Anne Santifer PCMH Update
- Enrollment for 2018 went well. PCMH picked up about 30 new practices. Attribution requirement eligibility was lowered to 150 to allow for smaller practices to enroll. We had 12 smaller practices that join. For 2018 we have 206 PCMH’s, with Satellite clinics this makes up a total of 394 practice sites throughout Arkansas

Comment
- Dr Gray Wheeler gave an Arkansas Health Department Registry update. 191 PCMH’s now have Registry ID’s. About half of these are providing VFC’s (Vaccines for Children) services to
children. 100% of those providing this service are reporting to the Registry. Of the remaining PCMHs, 30% are reporting to WebIZ, and the other 20% have never made contact with WebIZ.