Strategic Advisory Group  
February 22, 2017

Facilitator: Dr. William Golden

Roll Call of Attendees

Dr. Golden
- CPC+ recently had an informative webinar on Payment Methodology describing how they will be calculating payments.
- CPC+ also announced that they are going to start soliciting for Round 2 for the 2018 CPC+ Program. So far, the existing 14 regions cannot apply for additional practices but up to 10 new regions can apply and those practices that are selected will be randomized into being in CPC+ or being in a control group. More information is needed on this process and will be discussed as it comes out.
- The payer community in Arkansas has been meeting regularly in an effort to align procedures and lesson confusion. Also, been meeting quarterly with payers from other states to exchange ideas and information.
- DMS is still actively looking as to how to enhance and grow our health information exchange. We want to get something that is functional, affordable, and accurate.
- In the new CPC+ document that came out yesterday, they discussed the ECQMs and thresholding those for good performance. The document indicated that it was going to be based on data submitted in 2015.
- DMS is constantly working to make sure that our data is accurate. We have talked with Dr. Skaug about Asthma, we’ve talked to individuals about the 0-15 month metrics, and emails have been exchanged with Dr. Anthony Johnson about cost data. We are cleaning up and moving forward with our final cost adjudications for 2015.
- DMS recently had a webinar to discuss Care Plans. The payers are interested in coming up with a common way to validate Care Plans in an effort to do away with multiple people coming in doing multiple audits.
- DMS is about to release its first Medical Neighborhood Report in the near future.

Alicia Berkemeyer/BCBS
- Hard work is being done to align CPC+ and the state PCMH. Efforts are being made to coordinate measures and reporting processes as much as possible.
- CMS just released a notice to inform BCBS that going forward, if there is not a direct contract with CMS, then CMS cannot include them in any kind of learning sessions or meetings.
- The Lewin Group has been chosen and the subcontractor will be CMS which is great news for Arkansas. That means that Rachel Wallace and her team will continue the work. It appears that there will be limited resources for the 183 practices so the payers are trying to coordinate/collaborate how practices are supported.
- Another challenge is practices that have been participating in the PCMH program for several years vs. new practices in the PCMH program with no experience. The focus being worked on right now is how to start training and how to provide practice support in a variable way.
- In the month of May, the first learning session for CPC+ will kick off.

Comments
- Dr. Maruf added that the regional payers group that was recently started has been very helpful in learning at different levels and she hopes that good lessons will be learned and there will be
good things to share from that. Discussion continues on how to create collaboration among the
payers. Also, QualChoice CPC+ agreements are out and there have been a good responses so far.
The deadline is March 15.

- Dr. Golden added that the common goal among DMS and the payers is for everyone
participating in the program to be successful.
- Dr. Golden asked for comments from the panel on how the CPC+ program is going so far. No
  comments were made.

Shelley Ruth/AFMC

- On February 3 and again on February 9, a webinar was done to educate on Care Plans, the New
  Selection and Submission Processes. After the February 3 webinar there was a bit of an issue.
  AFMC went into the AHIN portal and initiated the random selection of Care Plans and realized
  that the system rendered the numbers incorrectly. It was pulling 20% of all the high priority
  beneficiaries. AFMC contacted AHIN and those were wiped out. Some system recoding was
  done and then on February 13 they were able to reinitiate the random selection. This time it
  rendered the numbers correctly. It selected 20% of the attested Care Plans.
- During the Care Plan webinar, the new process for submitting Care Plans via the AHIN portal was
discussed. Care Plans have been coming in and no issues have arisen with the practices
submitting those to AFMC. The QA specialists will begin reviewing Care Plans next week.
- On February 13, AFMC initiated the new random selection of the 20% of attested Care Plans. A
  notice was then issued out to all of the PCMHs informing everyone that those lists were now
  available in the portal and they could begin submitting their documents. From that date,
  practices were given 2 weeks to return all required documentation. So the deadline to submit
  everything into the portal will be February 28.
- The Care Plan webinar is available on the APII website for viewing.
- At this time, it appears that all of the practices are meeting the 12 month activities. During the
  next meeting, exact numbers will be given.
- AFMC met with BCBS last week regarding Care Plans. Validation and review of Care Plans was
discussed and both AFMC and BCBS are reviewing those in the same manner.

Comments and Questions

- Dr. Zimmerman asked if there had been any trouble with the CPC clinics getting on board with
  submitting the Care Plans as that had not been done in the past.
- Anne Santifer commented that she had heard from some clinics and they seemed to be ok with
  submitting the Care Plans since CPC+ also requires the submission of Care Plans. Also, there was
  some mention that it was difficult to create Care Plans for healthy patients but it was explained
  that for the DMS PCMH program, we only require for the top 10% high priority beneficiaries so
  that seemed to alleviate some of the stress.
- Dr. Zimmerman asked when, as a CPC classic clinic, they required to get on the portal and report
  their Care Plans. She said some thought it was in February 2017 but apparently it is not until
  next year. Anne said that next year was correct.
- Anne went on to advise that on March 1, the Patient Panel List would be loaded on to the AHIN
  portal and, at that time, practices can select who their top 10% high priority beneficiaries are.
  The risk scores are also given at that time. There are no parameters on who practices choose as
  their top 10% from the list. Then throughout the year, practices would complete Care Plans for
  their chosen beneficiaries.
Some changes will be coming up. A practice reached out to DMS regarding the infant wellness metric. For the past few years, DMS has required 4 visits for beneficiaries between the ages of 1-15 months as that is the way the measure is written on the national level. After speaking to one of our providers in Texarkana, more research was done and we noticed that we do things a little different. On the national level most providers bill the first month’s care of the baby under the mom, but in Arkansas providers tend to hold the claims until the babies become eligible. So after some analysis was done, DMS discovered that it would make a significant impact if we were to include that first month of the baby’s life in the metrics. So that metric will be changed for Q2 2017. Instead of being 5 visits within 1-15 months, it will be changed to 5 visits between 0-15 months. This change should make the metric much easier to pass.

Another change is for diabetics that had an eye exam within the last 2 years. The measure written by NCQA can be interpreted in several different ways. DMS’s analytics department contacted NCQA for some clarification and they basically said it was up to DMS to interpret it however we feel it works best for Arkansas. DMS decided to keep it as simple as possible. The denominator is the patient is a diabetic. The numerator is a patient who had an eye exam with a PCP/Eye Specialist/etc. Then we are also looking for those who had a negative result:

Did they have an exam? Yes, you get credit.
Did they have an exam and get a negative code value set? Yes, you will get credit for that too.

So the eye exam metric will also be a lot easier to pass this year. DMS debated changing the targets but decided to leave them as is for now but next year we’ll probably see a big increase on those targets.

Dr. Golden added that there are some bills on Total Cost of Care in the Legislature. One of them is about going to the Chiropractor without referral. DMS will track all of those. When the Legislature makes decisions on something that removes referral requirements, DMS will make some adjustments in the TCOC burden for PCMH.

Anne added that DMS is monitoring the bills closely and changes will be made as needed.

Dr. Hawkins asked for the eye exam explanation once more and Anne reiterated.

Dr. Golden added that most of the exams would be done by the eye specialist. It’s not a chart item but an administrative data point so if the patient visited an Ophthalmologist, an Optometrist, etc. that billing code would suffice to satisfy the measure. The codes are also being expanded.

Dr. Hundley asked if there was a code, for the PCP, to be submitted that the eye exam had been done and would that that code submission meet the HEDIS metric for an eye exam? Anne said that the DMS analytics team would have to do more research on the issue but she was told that basically with any provider DMS would accept it. Dr. Golden added that most of the guidelines promote from an eye professional as the average PCP office doesn’t meet the standards for a retinal evaluation.

Dr. Hopkins added that, as standard routine, most of the PCPs wouldn’t have the appropriate documentation or code submission for that element.

Dr. Hundley went on to say that most PCPs feel like a dilated exam is really necessary and whether a non-eye professional is comfortable doing that is an issue.

Anne went on to discuss Q2 reports. Upon requests from practices, there are going to be some cosmetic changes on the reports. There will be a new graph for costs. There will be a new report guide on the APII website to aid in understanding the new cost graphs. Also, the risk score is being expanded from 1 decimal point to 3.

PBPMs will go out on February 27.

The high priority beneficiary list will be posted on AHIN on March 1.
• Q1 Reports will come out on April 18.
• Shared Savings payments for 2015 will be paid out on April 28.
• Anne said that DMS is currently in the middle of a new Medicaid billing software change which will be a positive thing. For Q2, there may be very few changes seen but DMS IT are starting to shut down the current MMIS system so we will be getting all of the information out of it before the complete shutdown. Information for Q3 and Q4 is somewhat uncertain at this time. If all goes well, the new system should be up and working over Memorial Weekend.

James Gallaher/DMS
• Next week the first Medical Neighborhood Report will be released. Some of the PCMHs have noticed a new button on their reports page on the AHIN portal. This is related to URI antibiotic rates in the ED. Per James, other report topics will be worked on in the future.

Dr. Golden
• Dr. Skaug had previously mentioned exercise induced asthma being an exception to the asthma rule. After doing research and looking over data, DMS found that it’s not an exclusion as it has minimal impact on the metrics.
• Per Anne, research was done on the topic and out of all the PCMHs and all the beneficiaries enrolled in PCMHs, there was only 1 that had the code of exercise induced asthma. So as there is no significant impact, no changes will be made at this time.
• Dr. Zimmerman added that a lot of pediatricians code for cough variant asthma because their EHR doesn’t provide a valid code for exercise induced asthma so the data and research may be off. Anne said that DMS would look into that issue.

Comments
• Alicia Berkemeyer said the Care Management Portal has been released to the market and they are working on starting with the CPC/PCMH practices for training. If a clinic has not received training and is interested in that, please contact BCBS.
• Alicia also mentioned that many are already aware of the CPC shared savings for 2015. BCBS has released the fully insured payment. They are in the process of delivering the self-funded payment. In addition to that, BCBS is preparing a 2015 value based performance report card for the CPC practices. The physicians will receive a notice of their value based payment they received for being part of the program.
• Dr. Golden encouraged comments and input at any time for the betterment of the program.
• Meeting was closed.