Strategic Advisory Group
April 26, 2017

Facilitator: Dr. William Golden

Roll Call of Attendees

Dr. Golden
- The PCMH webinar was held on April 14. There were 350 open phone lines.
- DMS is working to align the PCMH program with the CPC+ program as much as possible. There will be a CPC+ regional meeting on May 26 at the Benton Community Center. There will be national and regional webinars to provide education. The CPC+ Connect website is also a valuable source of information from CMS.
- Dr. Golden advised the group to review the CPC+ benchmark targets which qualify practices for Shared Savings as well as the Quality Bonuses. The Medicaid PCMH Program bases its thresholds on state averages of PCMHs whereas the CPC+ benchmarks are based on submission data for PQRS from 2015. DMS has shared those numbers with the Oklahoma CPC+ team and private payers for review.
- DMS is meeting with the CPC+ payers in Oklahoma on a quarterly basis in an effort to share information and outreach strategies. DMS is also trying to get the Kansas City region to join that quarterly meeting.
- The leader for CPC+, Laura Sessums, is still in place at CMS as the transition to the new administration takes place. Also, the leader for CMMI, Dr. Stephen Cha, is still at CMS.
- DMS is still getting feedback from the AFMC Outreach Team as well as others about issues regarding data sharing/ECQMs. Dr. Golden encouraged the group to be vocal about data collecting issues as well as any other issues that may arise. DMS had hopes that the 2015 Meaningful Use Standards would make data extraction easier but it appears that is not the case.
- DXC, formerly HPE, is the data vendor now with the new health information system which will spinoff at the end of May.
- The PASSE Program, Provider-owned Arkansas State Savings Entity, is going to be soliciting bids over the summer for Level 2/Level 3 high risk patients for the behavioral health and disabled populations. Level 1 behavioral health patients will have the option to voluntarily opt out of traditional Medicaid and go into the PASSE. Because of the changes due to contractual activities, Episodes of Care for Behavioral Health will likely significantly changed, if not eliminated.
- DMS is working closely with the Department of Health in the transition of OHIT. There will be work done on a common HIE framework, potentially with the Michigan Health Information Exchange, to make data extraction easier and more user friendly. The first target may the Health and Immunization Registries. This will be a work in progress for the next several months.
- Dr. Maruf commented that QualChoice is moving along with CPC+ and a lot of work is going on at this time.
- Dr. Johnson asked if there was a timeline when the description of the new Behavioral Health and DD contracts will be going out. Anne advised that if a physician wants to be a PASSE, he/she can send in a letter of intent to CMS. The deadline for those letters is May 15. The PASSE would be the managed care entity that would handle behavioral health Level 2 and 3 beneficiaries. Dr. Johnson asked if there was a definition of was DD is at this point. Anne said she was unsure and would get back to him, but the DD population would be included in the PASSE if they are a Level 2 or 3 beneficiary. Dr. Golden added that the final legislation passed outlined the timelines and a copy of that would be emailed to SAG members after the meeting.
Dr. Hopkins stated that many of the Title 5 people had been working on complex issues regarding transitions of those beneficiaries into the adult world and was wondering if any information was known about that along with the DD issue. Anne stated that once the assessment comes out, DMS would have a better idea of which Tier and which program would handle them. If they are in Tier 1, they will remain in PCMH. If they are in Tier 2 or 3, they would be managed by the PASSE so all medical costs would be managed by the PASSE and that person would be excluded from PCMH.

Dr. Golden stated that there will be another legislative session coming up that deals specifically with healthcare and Arkansas Works so there is potential for changes in eligibility, changes on who is in which program, changes in co-pays, etc. Anne added that there would be changes in PCMH as well because if Tier 2 and 3 beneficiaries are not being seen, adjustments would have to be made to the Total Cost of Care. She said that changes would also be done regarding Chiropractors as they no longer require a PCP referral.

Shelley Ruth

- The QA team has finished up most of the 12 and 13 month validations. It appears that everyone is doing really well. Shelley’s team is mostly done with the Care Plan reviews so those have gone to the AFMC physician for another review.
- The process for reviewing the Care Plans is as follows:
  - Once AFMC receives the Care Plan, a QA specialist reviews the document. If they feel that not all required elements are included in that document, then it will go to another QA specialist for review.
  - After that, it will go to an AFMC physician for another review. If they feel the Care Plan does not meet requirements, the document is then sent to Dr. Golden to review.
Shelley wanted to stress that the reviews are very in-depth. Once all of the reviews have been completed, notifications will be sent out regarding the Care Plan review and the rest of the 12 month validation results. AFMC wanted to group all of the 12 month activities in to one notification in an effort to reduce confusion.
- If a Care Plan does not meet the requirements, there will be a remediation process. Remediation will be 45 days from the date of the notification that is received. Once that notification is received, the practice will have 15 days to complete a Quality Improvement Plan and send that plan back to the QA department. The remediation process will go as it did last year. At the end of those 45 days, a QA specialist will contact the practice and ask for a list of their high priority beneficiaries that have been seen in the practice in the last 4 weeks. From that list, 2 beneficiaries per provider will be randomly selected and ask that a current Care Plan be submitted for review. That current Care Plan will not need to include an update because AFMC realizes that the patient may have only been seen one time in that 4 weeks. But the other elements will be required to be included in the Care Plan. Once that Care Plan is submitted for review, it will go thru the same process as when a Care Plan is initially submitted.
- Dr. Golden added that DMS really wants to work with/help those that are trying to be successful at the Care Plans.
- There was a webinar in February 2017 on Care Plans and also discussed them during the April 2017 webinar. During those webinars, various examples of Care Plans were shown.
- Most of the problems seen on the Care Plans is seen on the Assessment. The documentation of the status of the problem and an assessment is required. Care Plans are coming in with a one word assessment. More information needs to be documented on the Care Plans. It can be brief but needs to be specific.
- Dr. Maruf added that they are just now requiring the Care Plans so they have not got to the point of reviewing them at this time. They hope to get in line with the other payers and have a similar process.
• Dr. Golden added that a uniform submission process and assessment process is the ultimate goal. That way, practices would only have to submit once through a portal and each payer would only have to review their patients’ material. DMS is trying to make it as least burdensome as possible. DMS hopes to make it as parallel to CPC+ as possible.

Anne Santifer
• Shared Savings letters for the 2015 performance year went out on April 14. DMS has heard that some practices did not receive their letters so that is being researched and those will be sent out electronically today. If a letter was not received, please contact PCMH@AFMC.org.
• Shared Savings will be paid out on April 28. There was a total of 22 practices that received Shared Savings which totaled almost $4.7 million. There are also several practices that have filed for Reconsiderations so additional payments will probably be paid out sometime this summer.
• DMS encourages all practices to go through their patient panel at least once a year to do some clean up.

Comments and Questions
• Anne advised that if there were any issues with vendors to please let us know by emailing Julie Pair.
• Per Dr. Golden, the payers are still meeting weekly to discuss ideas. Also, the lead for the CPC+ regional activities participates in that meeting. There is also a representative from the Dallas regional office.
• Anne advised that due to the MMIS conversion, DMS will be unable to start Track 1 in 2018. That is currently on hold at this time.
• Per Anne, DMS still plans on trying to reduce our enrollment numbers from 300 to 150. That is being worked on in hopes of implementation in January 2018. It would be under the current PCMH Program so those with less than 300 would be able to participate.
• A Stakeholder meeting is being planned so if you were part of the CPCi Stakeholder meeting, someone will be reaching out to you regarding the upcoming meeting. DMS also suggested some new names as potential invitees. The Hospital Association has agreed to facilitate and host that meeting.
• As far as HPE changing to DXC, all of their emails still work. There will be a transitional period of about a year and a half.
• Anne encouraged anyone having trouble with reports to reach out to AFMC for assistance. AFMC is always available to answer any questions that may arise.
• Dr. Robinson asked about concerns regarding Quality Measures for CPC+. Dr. Golden responded that CPC+ gives bonus dollars up from with the theory that loss aversion is a more powerful motivator than a theoretical gain attainment. So in Track 2, you will be given close to $5 PMPM ($2.50 for Quality and $2.50 for Resource Management). The Resource Management is based on ER visits and either admissions or bed days. In CPC Classic, the bonus dollars were based on performance of the entire region, which was a bit of a barrier, as opposed to CPC+ where the bonuses are based on per practice performance. Dr. Golden went on to give examples and information about CPC+ Quality Measures and data. Also for more information, videos covering the program will be emailed to the group.
• Dr. Robinson stated that there had been discussion with community physicians about the Diabetic Eye Exam measure and how that will be very difficult to meet and a lot of practices will just give up as there they will feel that there is no way to meet it.
• Dr. Golden said that there would need to be more discussion with CMS on this issue.
• The meeting was closed.