Strategic Advisory Group
June 28, 2017

Facilitator: Dr. William Golden

Roll Call of Attendees

Dr. Golden

- There was a regional CPC+ meeting at the end of May. About 300-350 people attended. About 75% of practices attended. Engagement was good. There were many positive reviews.
- CPC+ will be doing a virtual regional meeting on the morning of July 14.
- DMS will be rescheduling our webinar for some time in the summer as the original date conflicted with the regional CPC+ meeting.
- DMS has been looking at the metrics for 2018. More than likely they will stay the same and we will just update the benchmarks.
- Medicaid MMIS will not be changing over until November 2017.
- DMS is now in the process of calculating what the benchmark would be based on 2016 average performance data.
- Data on HIV is being obtained as there are 400-500 patients in the Medicaid system. DMS is trying to find out how many are getting regular visits and proper care. That may be added in as an information metric.
- DMS is working with the other payers in an effort to collaborate what we are all asking for from practices and trying to make the PCMH program as user friendly as possible.
- SHARE moves to the Health Department August 1, 2017.
- DMS is currently working with GDHS to look at the quality of ECQM reporting. We are trying to ensure the validity of the data being sent in.
- CMS just issued an open ended discussion about ECQMs for 2018 so they are aware of key issues.
- DMS understands that a lot of information is being sent out to the practices about CPC+ which may be a bit overwhelming.

Comments/Questions

- Per Anne Santifer, the CPC regional meeting that will take place on July 14 is going to focus heavily on Care Plans. DMS, Blue Cross, and QualChoice will be presenting on Care Plan requirements. There’s also a clinic that has figured out a way to aggregate all of the different Care Plans and they have a template that they will be sharing during the meeting.
- Also per Anne Santifer, after the new MMIS system goes in to place on November 1, there will be a stabilization period to make sure that everything is working correctly before any changes can start happening. The stabilization period will not end until roughly March 2018.

Dr. Golden

- In terms of Care Plans, several reviews have been done. Some training is still needed on how to accurately document Care Plans but there has been steady improvement.
- Per Kim Gillham (AFMC), the Care Plan process has been very thoroughly reviewed. Many practices are really doing well and then there’s a few that are not.
- Per Alicia Berkemeyer (BCBS), they have seen similar issues with the Care Plans and have really been trying to educate the practices on the topic. Alicia asked if the providers on the line had any thoughts or comments on the Care Plan reviews. Dr. Skaug stated that he had none. Alicia
encouraged feedback so the process can possibly be simplified. The payers are trying to figure out ways that the review process can be simplified and make it easier for everyone.

- Dr. Tony Johnson added that maybe it’s time to review some best practices around the country regarding Care Plans and reassess how they are being done in Arkansas.
- Dr. Golden responded that CPC+ is requiring more extensive Care Plans than the PCMH program. He also said that in the beginning of the PCMH program, DMS had tried to figure out the best approach to take regarding Care Plans and ended up only requiring 10% of Care Plans, on the sickest patients that needed the most attention.
- Dr. Bob Hopkins commented that another issue regarding Care Plans is for those practices that use an EMR that’s in an integrated delivery system. Physicians are being asked to assess every one of their problems and many of the problems may be managed by a specialist or may not be active issues. Those pose an additional complexity in developing accurate Care Plans for patients.
- Dr. Golden stated that as long as there is documentation of the problem on the Care Plan and a regular source of management oversight and follow up by a specialist, the Care Plan would be acceptable.
- Dr. William Patton commented that although the concept of the Care Plans is universal to all groups, having a small practice and getting them done is not easy. He went on to say that if any modifications are done on Care Plans, make them a “not one size fits all” but something in between.
- Dr. Johnson said that if you look at the pediatric population, the sick, chronic care kids make up less than 1% of your practice...at the most 1-2%. Then there are a big group of kids that have chronic conditions and are special needs like the Asthma and ADHD, which make up 20-30% of your practice. Dr. Johnson is concerned that the 10% across the board is not highlighting the kids that need more attention.
- Dr. Golden said high risk kids can be considered an asthmatic or diabetic patient. Whereas patients with heart failure, diabetes, or hypertension may be stable but they need attention and something needs to be organized for them.
- Dr. Patton added that he didn’t want to spend a lot of time on kids that really didn’t need the extra care just to meet a 10% number and some of those 1-2% of chronic kids are cost drivers that may be pushing him into the area where he might not gain share and so it would seem to make more sense to focus on those kids that could impact costs.
- Dr. Golden said that on future webinars, there would be examples of good and bad Care Plans and what did and didn’t work and also ways to help simplify the documentation to get a consistent procedure in place.

**Alicia Berkemeyer (BCBS)**

- The payers are continuing to meet in an effort to align the QHP work and the CPC+ work as much as possible in an effort to be consistent across the state. In the past, there was a CPC stakeholder group and that will be changing and expanding. In the past, CMS funded the facilitator for that, but that funding is no longer available. The payers have been talking with the Hospital Association and they may be hosting that at their facility. There will be an effort to turn that group into more of an Arkansas Payment Improvement stakeholder group as opposed to just CPC for the PCMH, Episodes, CPC+, and payment transformation programs across the state. The core members will be the people that started with CPC. One thing missing is that a couple of patients that were on that have passed away. Alicia requested that if anyone had any patients that would be good for the Arkansas Stakeholder Initiative or if you or someone you know would be interested in participating on that stakeholder group, there’s 4 meetings per year.
- Anne Santifer commented that those names can be sent to Julie Pair and she will make sure the stakeholder group gets them.
**Dr. Lubna Maruf (QualChoice)**

- QualChoice is just getting started on their Care Plan reviews. Going forward they will be following the same guidelines for Care Plans as Medicaid and Blue Cross. Also, QualChoice is hearing all of the concerns and confusion from practices and although no changes may be able to be made at this time, it is helpful to hear the issues so they can align more with other payers. QualChoice tries to collaborate as much as possible but there will always be some variations. The feedback and opinions are greatly valued.

**Kim Gillham (AFMC)**

- The AFMC QA team has completed the validation efforts for the 2016 12 and 13 month activities. On the 12 month activities, there were 137 PCMHs eligible for the validation. Of those, 101 (74%) have successfully completed the 12 month activities and 36 (26%) failed to complete the 12 month activities and are currently in remediation. The primary reason for failure of the 12 month activities is related to Activity O: Care Plans. The top 3 reasons for Care Plan failure were lack of assessment of problems, not all problems being addressed, and lack of follow up.

- On June 19, all of the PCMHs were issued a notice of validation results for the 12 month activities. Those that received a notice of failure have 15 days from the date of receiving the notice to complete a Quality Improvement Plan (QIP) and return it to the QA team. The practices also have a 45 day, from the date of the notice, remediation period to correct deficiencies. The deadline to remediate the performance is August 3. For remediation of Care Plans, after August 3, the QA team will contact practices and request a list of High Priority Beneficiaries (HPB) seen in the practice within the last 4 weeks. QA will ask the practice to submit a Care Plan for each HPB for review of current Care Plans and determine if performance has improved.

- In regard to the 13 month activities, again there were 137 PCMHs eligible for validation. Of those, 133 (97%) have successfully completed the 13 month validation and 4 (3%) failed to complete the 13 month activities and are currently in remediation. The practices were notified at the same time the 12 month validation results were issued. Those placed in remediation have the same time period to remediate performance as stated for the 12 month activities. After the remediation period deadline, QA will conduct an onsite validation visit to check for performance improvement.

- Some may notice on the 2nd Quarter PCMH Reports, which posted on the AHIN portal on June 19, a red X under the activities. Please be aware that the report was sent to production prior to all validation efforts being complete; primarily the Care Plan validation. The 3rd quarter reports will accurately reflect all activity validation results.

- Next week the team will begin pulling the 2017 six month activity attestations from the AHIN provider portal and reviewing for completion. Onsite validation visits for the 2017 six month activities are expected to begin mid-July.

- There are currently 4 (3%) PCMHs being recommended for suspension from the PCMH program. These PCMHs are recommended for suspension based on their performance remediation for the 2015 practice support metrics. On June 27, 2016 these practices were issued a Notice of Practice Support Metrics Deficiency explaining their deficiency in meeting set targets for 2015 performance year for the four practice support metrics. The four practice support metrics were:
  - Metric A: Percentage of High Priority Beneficiaries with a Care Plan in the medical record; the target is 80%.
  - Metric B: Percentage of practice’s HPBs seen by their attributed PCP at least twice in the past 12 months; the target is 75%.
  - Metric C: Percentage of beneficiaries who had an acute inpatient hospital stay and were seen by a healthcare provider within 10 days of discharge; target is 40%
• Metric D: Percentage of emergency visits categorized as non-emergent by the NYU ED algorithm; target is 33%. (It is worth noting that all PCMHs met this metric.)

• According to Section 242.000 of the 2015 PCMH Provider Manual, practices must meet a majority of the practice support metrics in order to receive practice support.

• To determine if performance of the metrics improved, AFMC used data collected and reported for the Q2 2017 PCMH report that posted to the AHIN portal on June 19. This allowed for all claims to be filed for the 2015 performance period.

• Upon review of the data, it was determined that the four PCMHs continued not meeting set targets for the metrics:
  o Two continued to not meet the metric for the 10 day follow up after an inpatient stay (Metric C) and Care Plans (Metric A).
  o One continued to not meet the targets for PCP visits at least twice a year (Metric B) and the day follow-up after an inpatient stay (Metric C).
  o One continued to not meet the target for PCP visits at least twice a year (Metric B) and Care Plans (Metric A).

• On June 19, Shelley Ruth sent “Recommendation for Suspension” notices to DMS for the four PCMHs.

Anne Santifer (DMS)

• Preliminary Shared Savings are not going to be paid out this year due to the MMIS conversion. They will not be paid in October 2017 but will be caught up in April 2018 pending the new system is working accordingly.

• Usually Q3 is when the Preliminary Shared Savings decisions are made but DMS is not going to be able to display a Total Cost of Care (TCOC) during the Q3 report. But, depending on the new system, it will pick back up in Q4 of 2017 or Q1 of 2018.

• Josh Heimburg, Arkansas Children’s Hospital, asked if there would be anything taken into account for Medicaid patients who were enrolled, lost enrollment, then were reenrolled when calculating Shared Savings. Anne asked if he was talking about the drop in children in 2016 and Josh stated that he was. Anne said she believed there was a plan being put into place for that issue. She said that if there is not a PMPM payment for at least 6 months then the person does not get counted, not only in the costs but also in the metrics. DMS is working out a plan to pay those practices separate from what the PMPM for PCMH is because the only way to include all those kids is to rerun the entire 2016 algorithm. The problem with doing that is it would cause a lot of practices to fail certain metrics because they were not able to do the Preventative Care on many of those kids. DMS also saw that a large number of those kids never regained Medicaid eligibility. DMS is working on a plan to give those practices affected payments independent from PCMH to help out.

• Josh went on to ask if it was the claims that originated in 2016 that make up TCOC or claims that were processed in 2016 that make up TCOC. Anne replied that DMS looks for the date of service so a date of service for 2016 would be counted in the 2016 TCOC.

• Dr. Johnson commented that the practices are continuing to see and care for reinstated Medicaid kids but are not getting paid for it.

• Anne stated that DMS would have to explore different options to find a solution to a difficult problem.

• Per Anne, Dr. Greg Bledsoe, Arkansas Surgeon General, is going to be heading PCMH committee. This will be a small group of physicians that are enrolled in PCMH. Dr. Bradley Bibb is co-chairing that committee with Dr. Bledsoe. There was a meeting last week and a few select physicians have been chosen to be part of the group. They will be receiving an invitation very soon. There are lots of changes in place for the next few years and DMS needs feedback from the providers’ point of view. This will be a workgroup of 10-11 physicians that will meet once a quarter. Some things to
be discussed will be Care Plans, more Medical Neighborhood reports, Metrics, Behavioral Health Transformation, Health Information Technology, etc.

- DMS paid about 20 clinics Shared Savings for 2015. After those payments were made, several practices contacted DMS for reconsiderations of their metrics on things that are not usually picked up during claims that required some paper documentation that the service was rendered. PCMH has been working through those and everyone has been given until Friday of this week to turn in any additional documentation. It appears that about 30 additional clinics will be receiving Shared Savings for a total of 50 for 2015 and for a total payout of about $8.1 million.

Comments/Questions

- Dr. Patton stated that in several of the upcoming meetings around the state, he would like to hear some discussion on the new challenges to control costs to be eligible for shared savings. He stated that his costs are consistently rising and would like to know what other practices are doing to keep costs down or get more information from DMS as to how to cut costs.

- Dr. Golden said DMS would be looking at the cost thresholds as the program has matured and DMS has in the works an analysis of the 2015 costs and the changes, which will be shared later. One of the things that happened in 2015 was a substantial and dramatic increase in pharmacy costs. The pharmacy program has changed how it pays and that number has stabilized and even gone down. Pharmacy costs was a big driver in 2015. DMS is not basing this on a comparative of everyone else. DMS set benchmarks several years ago and then had an inflation accelerator year over year. It’s not a normative process but it was based on the cost numbers that were from 2014 with an annual inflation rate built in to the expected thresholds. But DMS will be looking in to the assumptions built in to that over the few months.

- Anne agreed with Dr. Patton’s concerns. She said that she had asked our analytics team to break that down to see exactly what is driving the costs up. There should be a meeting on the issue this week as they were given a deadline of June 30. Anne said she wanted to look at what changed between 2015 and 2016 and what made the costs go up. There may have been an issue with the ICD-9 conversion in 2016. As soon as any results are discovered, they will be shared.

- Meeting was closed.