Strategic Advisory Group
April 20, 2016

Facilitator: Dr. William Golden

Roll Call of Attendees

Dr. William Golden
- Reviewed minutes from April meeting.
  - Legislature and Arkansas Works moving along.
  - New release of Medicare CPC+ and what that means:
    It has two tracks. One is standard and what we’ve seen before and the other has more to do with Gain Sharing and Risk Sharing. The old CPC was a regional program which meant that everyone was in one pool. They all gain shared and performed together as a unit. CPC+ will be viewing individual practices. They haven’t published the number of patients required. CMS stated that it’s not a shared savings program but it actually does some utilization metrics. The Maine ACO medical home program was discussed. They have a smaller practice size that they are required to use for shared savings, but it was created for greater population management. They require practices to manage complex mentally ill, home care for disabled, etc. It is more of a global budget kind of approach than just managing primary care. Comparing the two programs is not exact. Discussion with CMS regarding bringing Medicare in to a global budget program for Arkansas is still on the table. That has been put aside until Arkansas Works and other issues are resolved. One proposal to CMS was to expand the medical home program by bringing Medicare in to the medical home program, similar to what CPC and CPC+ does, and then the state would be accountable for global costs of care and deal with the complex mentally ill, the disabled, etc. on a multi-payer basis. Then the state would be the entity accountable for the global costs of care as opposed to local collections of practices. Over the next 60-90 days, there will be more active discussion and work on these issues and DMS hopes to get member feedback on some of it.
- Data Sharing and its importance:
  This issue is going to be a national discussion. The National Learning Action Network is developing several white papers on episodes of care, primary care, and financial incentives which are similar to the principles that have been put in place in Arkansas. LAN also has a data sharing committee that addresses issues regarding the sharing of data. DMS is going to be having our legal department discuss sharing data with 3rd parties within the near future. OHIT and Share offered a demonstration on a software service they are envisioning. Blue Cross Blue Shield and Medicare are also working on creating a more granular dashboard. There are a number of activities in the works to develop greater data sharing and opportunities for the provider community.
- Total cost of care and rewards:
  We are still going through the final reconciliation from 2014. For 2015, DMS is still trying to resolve what the impact of the private option was on the total cost of care thresholds and projections. Because of that, DMS is going to be suppressing total cost of care data on the next report card. It has also been discovered that pharmacy data transferred via MMIS to Magellan, which is now in the HP database, claims data is missing attributions regarding patients, prescribers, and who prescribed drugs. The total
cost of care data is missing several pharmacy claims. The pharmacies were paid but the cost data is lacking. As that is the case, there will be a delay in the report card in an effort to fix data quality and validity.

- **Final determinations:**
  - Several practices were failing their 2014 requirements and had received payment suspension letters. The practices had appeals. DMS recently found out that the administrative law judge at the health department that was going to hear appeals has resigned so that appeal process is now on hold.
  - Validation issues and keeping physicians engaged.

### Comments and Questions
- Dr. Kuo asked if the delay in the first quarter payments and reports was due to the recent data issues. Lech explained that the reports delay is not associated to the data issues. He went on to say that this is the first year that DMS is dealing with reconciliation payments and that is the number 1 reason the reports are being issued late. DMS will be able to maintain the same schedule for quarters 2, 3, and 4 as was done in the past however, it is expected that the reports and payments for the first quarter of 2017 will also be delayed. The reconciliation is taking more time than expected.

### Dr. Golden
- For the first quarter of 2016, DMS was expecting practices to report ECQMs for BMIs, blood pressure, and diabetes. Only 6 practices said that they could not provide the data. On the other hand, a number of practices checked the box saying yes they could provide the data but had numerators and denominators that were zero so the validity of the data is questionable. DMS is doing more of an in-depth review. In the new CPC+ information, there is a tremendous reliance in the proposal for participating practices to report ECQMs. Only a few other states are requiring ECQM reporting, most of which is only preliminary. The new CPC+ may have expectations that have yet to be tested. DMS will be reviewing more in-depth data on this information within the next 30-60 days. At this point, DMS doesn’t expect or want ECQMs as long as a meaningful numerator and denominator report can be obtained. Practices that can’t reliably extract ECQMs during the remediation period will be advised of other ways to extract valid data that gives a sense of their performance. This will also be discussed during the June webinar.

### Comment and Questions
- Dr. Jim Salmon commented about an EMR committee that is working to form templates for doctors to have all the required data entered in one place in order to help with extractions. Dr. Golden requested that Dr. Salmon advise DMS of any progress or barriers in an effort to find model solutions to prevent overspending.

### Dr. Golden
- CPC+ will be open to as many as 20 markets, currently there are only 7, and as many as 5000 practices. Regions apply to be regional but then practices apply as practices to be part of the program. It is a Medicare program unlike CPC, which is a multi-payer program. CPC practices that are now getting Medicaid PMPMs as part of CPC would have to transition to the Medicaid PCMH program. In the future CPC will be a Medicare-only program very closely connected to what PCMH is to Medicaid as well PCMH is for the private payers. To apply as a market, the payers will have to agree to some principles, most of which are already in place for CPC track 1.
CPC track 2 is more complex in the area of pay outs. Blue Cross in Arkansas has discussed with DMS the idea of implementing CPC track 2 in the future but a specific timeframe is unknown. Qualchoice has had some changes regarding being involved with Medicare Advantage that have changed their business plan. United has pulled out some exchange markets. As CPC+ is a Medicare program, pediatric practices would be unable to enroll in CPC+ but practices that are not in CPC now can apply if they have Medicare patients. Markets that are CPC practices or that are in CMMI practices, Arkansas being in both, will be highly sought after to be participants. Medicaid PCMH practices that have Medicare patients would likely be easily accepted in CPC+ because a lot of the requirements are part of the DMS’s PCMH program. As part of CPC+ track 2 there is an agreement to have a reduced stream of payments and the prospect of a bonus payment as long as metrics are met but there is a threat of recoupment if metrics are not met. Practices cannot be dually enrolled in a Medicare ACO and CPC+. CPC+ will still use an attribution method.

- Alicia Berkemeyer stated that the CPC initiative, in one year, had brought about $16 million to Arkansas for practice transformation and has done some good things. She added that the state had hoped to get to one PCMH program but after evaluating information, Arkansas would probably have to have 2 with the 2 track opportunity and CMS choosing those practices for the next 5 year initiative. There will be some specialties, such as pediatricians, that will not be chosen by Medicare so the state will need to continue down the road of 2 different programs. As multi-payers, we also need to take in to consideration how we can align the two programs to be as consistent as possible in the future.

- CMS had come to DMS about a global budget program. The head of the CMMI is interested in talking with DMS about doing something as an alternative to CPC+ where we take the CPC+ concepts and blend it in to the global budget. They are willing to work with Arkansas. This would require the governor to sign a multi-year deal but it is unknown if the legislature would be accepting of the deal.

- The legislature currently has 2 proposals pending. The first being a managed care plan for behavioral health and disabilities. Then there is the Diamond Care Plan. They are still in the early stages due to Arkansas Works and other fiscal issues. The Diamond Care Plan, in some ways, footsteps the global budget ideas that Medicare or CMS has proposed and put in place in Maryland and some other states. Adding managed care to the mix might complicate having a global budget plan. Whereas the Diamond Care Plan might be more adaptable with the global budget to put everything in to one program. At the minimum, we have 2 plans, medical homes and CPC+.

- Per Alecia, both the CPC and the SIM want participation from Arkansas so they are very willing to work with Arkansas. Another thing to note on the CPC+ is that we as payers here in Arkansas will be coming together this week to try to collaborate and see how we move forward on an application for our state to be chosen and then the practice deadline for practices to apply will be in October so our timeline is very short.

- Dr. Lonnie Robinson stated that the changes will require lots of change in providers’ business practices, conserving dollars already received, and planning ahead for possible recoupment. Dr. Robinson asked if the PCMH program would run in parallel with the Medicare portion of CPC+ and that there would not be two different medical homes projects.

- Dr. Golden stressed that there will be only one Medicaid PCMH. The Medicaid PCMH, similar to QHP PCMH, will meet the expectations for an application procedure for CPC+. DMS is working to make the program as administratively simple as possible.
Medicare recently launched a new hip and knee episode nationally in 75 counties, 3 of those being in Arkansas. The hospital, not the doctor, would be the PAP. Arkansas had already had an episode of care for hip and knee since 2012 and seems to be pretty comfortable with it. One article mentioned stated that about the 75 counties doing hip and knee episodes and 60% of the hospitals there were potentially going to participate in the gain sharing/shared savings program for hips and knees replied and reported that they were unprepared and didn’t feel they would be able to be competitive in an episode of care because they had “never thought about how to manage or coordinate care to deal with things like total spend and readmissions.” Arkansas has really benefited in early preparation.

Dr. Lonnie Robinson expressed concern that physicians are currently in PCMH program and also in a Medicare shared savings ACO. He stated that he was aware that CMS will only allow participation in one model regarding ACO and CPC+ so if the PCMH program moved under the CPC+ umbrella and that were our only means of participating in a medical home what does that mean for the future of MSSP ACOs that are currently in stages. Most providers making the transition to value based care are going to want 100% of their contract in a value based reimbursement pool. What does that mean if we can’t participate in both an ACO and a medical home if that came to be a reality of that transition? Dr. Golden stated that if you are currently in an ACO, you are excluded from this. Also, CMS will be giving additional guidance on this in the future after gathering more data. Some of that will be determined by our local market. Right now, nothing is set in stone.

Dr. Lubna Maruf, Qualchoice, stated that they are looking at several options and want something more standardized and uniform instead of having differing sub-sets of programs.

Alecia Burkemeyer

- No QHP updates that we haven’t already discussed.

Lech Matusezewski

- The reconciliation update is for the 2014 performance period. DMS had 37 practices that were participating in shared savings and some preliminary shared savings payments were made in October and now we are scheduled to do the final reconciliation of the shared savings at the end of April. Out of 37 practices, in October, DMS made payments to 19 practices. In addition to those practices, 11 practices will also receive payments as they were not eligible at the time of the October payments but have since corrected and met requirements. In the end, 7 practices will not be receiving any payments. Prior to the shared savings discussion, DMS was asked to make sure the way that we calculated shared savings is such that there will be little to no recoupments. That goal is being fulfilled. No final amounts will be shared at this time in order to assure further accuracy. Our partners’, HP and GDHS, work was instrumental in computation of the shared savings. Also, DMS has submitted extensive documentation to CMS that reflects the program’s performance throughout 2014 as this is the most current data. This is associated with the extension of the PCMH program beyond 2016. We have not heard from CMS as to what the next steps will be.

Dr. Golden

- The payouts and shared savings went to a lot of practices. One of the things that DMS designed in to the initiation of PCMH program was to have success from the beginning. One of the things built in to the CPC/Medicare program was shared savings was issued if there were dollars saved
after accounting for the PMPMs. That, very often, ended up with minimal shared savings being offered plus it was on a regional basis which made it harder for individual practices to be winners. Our program was pool practice based but we also discounted the recoupment of the PMPMs for the first year so our shared savings dollars only accounted for 50% of the PMPM dollars and that’s going to be changed in 2015. More of the PMPM dollars will be counted for in the global shared savings equation so it’s a little harder in 2015 to achieve shared savings however the practices will have more experience in doing management. DMS wanted to make sure that during the first year of transition there were some gains. The second year, the PMPMs will be more fully accounted for as we account for the cost of managing the patients. Also before releasing the final numbers, DMS wants to make sure that our data is accurate so questions from the Legislature or other officials can be answered correctly and a full explanation of the impact of the program, how it operated, and what it meant to the overall budget of the Medicaid program plus the benefits to the practices. Dr. Kuo asked if the projected payout date for the shared savings would change or was it still scheduled for April 28. He also wanted to know if the shared savings payout would likely be smaller going forward because of the equation of the shared savings, PMPMs, and the budget evolving. Dr. Golden advised that a favorable PMPM differential would be in the range of $2/member per month and some of the shared savings were much higher than that. Plus you’ve had the experience of a year beginning to do population health management so there may be a modest change. And DMS is still planning on April 28th for the payout.

**Angela Lattrell**

- Reports will reflect the total cost of care and will be displayed in Q2 which will be a reflection of Q1 reporting. Working with practice transformation vendors to communicate that out to the practices and the HPE customer service call center will be answering questions as well if practices call about that.

**Comments**

- Dr. Golden asked for further questions and comments. Lech added that quarter one reports had been successfully loaded to the portal so providers will be able to view them. No other questions/comments were made. Meeting was closed.