Strategic Advisory Group
May 25, 2016

Facilitator: Dr. William Golden

Roll Call of Attendees

Dr. William Golden

- Reviewed minutes from last meeting.
  - Data issues on drug claims hope to be resolved soon
  - 2014 reconciliation now complete
  - Legislature has completed its session.

News and Updates

- Arkansas works program will continue which means that private payers will continue with their QHP program and the QHP medical home program.
- The debate over managed care versus the diamond plan was essentially tabled probably until the 2017 legislative session.
- The governor and the long term care associations have signed an agreement but specific details are yet to be known.
- A reverse site visit is being done in Baltimore regarding DMS’s SIM grant which is coming to a close. They will be asking about Episodes, the Medical Home, plans for sustainability, etc. David Walker, Dr. Golden, several others from DMS, individuals from the health department, and DMS contractors such as GDHS and HP will be attending. DMS will be learning more about where CMS is heading and about the total payment reform package.
- Dr. Golden is on the guiding committee for the Healthcare Learning Network for Payment Reform, a national organization consisting of many individuals. There is a new workgroup being formed on primary care and Dr. Golden will be co-chairing that group. It will consist of 15-17 individuals.

Dr. William Golden

- CPC+ final regulations have been released and, as mentioned before, there will be 20 markets and 5,000 potential practice sites. DMS has been told that each region has to apply on its own. Once the region gets accepted, then practices can apply. Unlike CPC, it is not a regional total cost of care reward process. It is a practice specific reward process. There would have to be at least 150 Medicare patients in the practice to be eligible for the program. More clarification on pooling will be needed. Each of the payers will have to submit an application on their own. CMS appears anxious for Arkansas to be in the market. DMS has also been told that if our market is accepted and a current CPC practice applies, they would have considerable first dibs on being in the 5,000. There may be a limit on the number of practices per region, so if we have more than the limit apply, there might be a lottery in the noncurrent CPC practices who apply if they meet the criteria. The acceptance criteria are still up to CMS although DMS is pushing to have the payers be part of that decision making process. DMS is also learning that a number of markets are having a lot of resistance to applying. DMS has learned that they are requiring that all Medicaid programs apply and if a Medicaid program didn’t apply in that state, the region wouldn’t be eligible. That rule may have been done away, because in some states, the Medicaid program is mostly managed care. For example, New Jersey Medicaid is currently not a CPC participant and probably wouldn’t be in CPC+. DMS is hearing that current CPC markets like Oregon are sufficiently fragmented and that they may not apply. DMS is also hearing of issues...
out of Colorado. DMS has also heard that with Track 1 and 2, there may be some odd waiver requirements for these states to participate. That would be news to DMS because, in many ways, we already have permission in Arkansas to do these kinds of payment reforms. Lech is working with CMS to get the waiver/permission for the medical home program extended and renewed. No major issues have arisen, but DMS wants to stay prompt on the issues. DMS has learned that there are new Medicaid managed care program regulations that are in place that put requirements on reporting data and metrics for Medicaid managed care programs. DMS’s PCMH program is written in to those regulations even though we don’t have managed care. DMS is still working through that as it came as a bit of a surprise since no one at CMMI told DMS about this ruling.

- CPC+ has two tracks. It has a CPC classic and a CPC+ Track 2. As mentioned before, Track 2 features enhanced per member per month fees, reduced fee for service fees, and potentially greater bonus dollars for meeting metrics. CPC+ is primarily for only Medicare. Private payers and Medicaid would have to propose their own frameworks that are consistent with the philosophy of the Medicare CPC+. The CPC+ program would essentially take the bonus money and pay it out up front so there would be a significant amount of PMPM upfront money, similar to how it is now but added to that would be the bonus money. Track 1 would have 2% bonus money and Track 2, over time, would be 4.5-5% bonus money. There would be metrics that practices would have to pass and if those metrics are failed, Medicare or CMS would take the upfront bonus money back. Arkansas DMS has been reluctant to have claw backs. Someone at CMS has advised that loss aversion is a powerful incentive to meet the metrics so that’s why they have gone to the upfront payment with potential paybacks. DMS has some concerns about that plus the metrics have yet to be published and apparently they would be published on an annual basis. If you sign up, it would be a 5 year agreement and you would be looking at metrics that are potentially known but may be changing over time. DMS is unsure if private payers in Arkansas and Medicaid are in favor of the payback angle although DMS does have some enhancement approaches. CPC+ technically is viewing itself not as a total cost of care program but as surrogate measures. The number of patients in your practice is small but you would be getting some utilization measures on that attribution so your hospitalization rate or ER rate would be calculated as metrics that would be part of your requirements in the payback of the bonus money. One might not think the bonus money adds up to much, but if you look at some of the dollars that DMS has paid out on a per member per month basis, it comes close to what DMS has been doing and is actually a fair amount of money. On the upfront PMPM approach, Medicare is looking at a $15 per member per month, or more, payment. It varies depending on the disease severity of the population that is attributed to your practice. They would still be using an attribution model as opposed to a direct assignment model that DMS has used in Medicaid which is now also being used by an increasing number of private payers in our state, which in many ways, increases the number of patients that are attributed to you and gives you higher per member per month dollars for your medical home program. Some markets are upset about the ACO issue. Some are also concerned about FQHCs. At this time, FQHCs are still excluded from participating in CPC+. There have been concerns in many markets about ACOs because a number of state Medicaid programs have extensive use of ACOs. It is DMS’s understand that this is still in play. At this point, it appears that most providers in Arkansas would have to choose between being in a Medicare ACO or participating in CPC+. If you choose to be in a Medicare ACO you wouldn’t be in CPC+, however you could still participate in a Medicaid PCMH or a private payer PCMH because there will be individuals in those programs that are not in CPC+.

Comments
• Dr. Joe Thompson asked if participation in CPC+ offers protection from MACRA participation requirements. Dr. Golden advised that it wouldn’t protect against all of the MACRA requirements but should protect against some of the core MACRA components. It would give a lot of bonus and special dispensation. There should be informational webinars on the topic in the near future.

• Dr. Stacy Zimmerman commented that physicians shouldn’t be penalized for patients that won’t be compliant and come in for wellness visits or regular appointments. She went on to say that some accountability should be aimed toward the patients to promote compliance.

Dr. William Golden

• The loss motivation approach is not being embraced in Arkansas and this is something that is coming directly from CMS. The CPC material is still in regulation and Dr. Golden suggested that Stacy have the Arkansas Medical Society write a letter of comment to CMS in the regulation commentary period on that area as there are some problematic issues. DMS has expressed some concern to the CPC leadership, but again, this is a CMS/Medicare direction so hearing from a physician through their medical society would be very important. CPC+ is separate from MACRA and each has their own set of rules. CPC+ will give upfront bonus money that can be taken back. MACRA has its own plus and minus bonuses and has penalties and is separate from CPC+. Both programs’ regulations are currently open for comments. CPC+ is a separate program and was designed to extend CPC. That is not part of a law but part of a Medicare/Medicaid innovation program initiative. It is separate from the laws and regulations governing MACRA. MACRA covers everybody in Medicare all over the country. It replaced SGR. So any doctor in the U.S. billing Medicare is subject to MACRA and that is replacing the SGR. The regs are the interpretations of how the bill was written. CPC+ applies only to the regions selected to be in CPC+ and the practices who apply so that’s a whole separate program with a separate set of rules. CPC+ may be more flexible in changing its rules than MACRA. If you are CPC+ you may be shielded from some of the MACRA regulations. The Arkansas private payers and Arkansas Medicaid program are designing its own rules and regulations. DMS does have to modify our medical home program to at least fit some of the philosophic angles on what CPC+ has written to be. DMS will be putting in place some sort of upside and downside risks to match it. DMS has been told that we don’t have to do that up front but we have to do that over the CPC+ 5 year time period. But DMS can do it to meet our needs and how we view our interactions with physicians so we may have some flexibility. Again, it gets in to the issues we’ve had regarding practice size, total cost of care, and surrogate measures. If Medicare is only going to require 150 people per practice DMS may be looking at different ways of judicating costs of care and it might change what shared savings looks like or what the downside risk looks like. DMS may want to evolve our program. While Arkansas has been a template for reform, we are seeing a whole national movement for other ways of doing business. Arkansas is currently a national leader and we want to stay that way.

• Dr. Randall Hundley added that MACRA is still open for comments and encouraged physicians to do so. He also stated that under the MACRA legislation, in order to qualify as an advanced alternative payment model clinic or group, which has tremendous advantages, there has to be some risk component to the provider. He thought it was a brilliant move that CPC+ basically said we will pay you the quality bonus up front but let that comprise the risk part of the model. He felt that there are tremendous benefits to being an AAPM in terms of getting extra points for MACRA. Assuming it doesn’t change, the plus for the practices is if you take the quality money and set it aside, you would have it in case money needed to be paid back.

• Dr. Golden added that CPC+ Track 2 would be setting a visit fee that would be discounted because they would be giving you up front extra money as well. They will be taking your basic Medicare average fee and putting a bonus on top of that. So you will receive an enhanced fee
on top of PMPMs that would then be discounted. Plus, on the MACRA regs, if you are in a risk sharing program in Medicare, which CPC+ would be, in about 3 or 4 years, you would not be in the MACRA plus or minus 5% or 10% that everyone else is in, but you would be getting an upfront 5% bump on all of your fees per year. That’s a compounding 5% increase for several years. That would be a significant advantage to a practice site in a Medicare program if you qualify for that. That would be a non-metric driven 5% bump per year purely based on your participation in an upside downside risk program. At this time, DMS doesn’t know the metrics that practices would have to pass or how they move from year to year. DMS does know that if you are in CPC Track 1, it’s limited to a 2% risk and a 4% risk in Track 2. It’s not on your total book business. It would be on the PMPMs that you are receiving. So it would be a limited dollar pool that would be at risk. DMS will give more information as it is received.

- Regarding CPC+ proposals as a payer group, Dr. Hundley stated that the payers have come together in an attempt to align their applications. Each payer that wants to participate has to apply separately. There are things they can and cannot discuss. They are trying to align the overall global objectives. They would like to align on the quality metrics so you don’t have one set for CPC and another set for PCMH, etc.
- Dr. Golden added that a colleague in Colorado was interested in sharing their application with Arkansas so we would have another state’s prospective on troubleshooting barriers. Colorado is also a CPC market.
- Dr. Golden commented that DMS has until June 8 to submit material for CPC+.
- The PCMH webinar will be on June 24 at noon. There will be a lot of discussion on CPC+ and PCMH.
- Electronic Health Records update. DMS is working with AFMC to gather information on what practices can and can’t do for meeting the metrics for BMI, diabetes control, hypertension control. DMS should have a complete report in the next week or two. Documentation has been acquired from roughly 60 practices sites. This is an effort to learn, help the practices, and let the national programs be aware of the barriers because CPC+ is going to be reliant on ECQMs. DMS has heard that Epic has been reluctant to support ECQMs that have been listed in CPC+. That information has been sent to ONC. DMS is still trying to find out what the barriers are and doesn’t want physicians dropping out because of not being able to meet the metrics for 2016. The failure to meet the metric at the end of March only triggers a remediation period. The remediation period is an opportunity to help DMS understand problems occurring and how we can help the practices. DMS will share the information received with the SAG members and it will also be on the PCMH webinar. Dr. Golden advised that if barriers arise, the PCMH program can be contacted through our help desk through Mir Ali and his email is Mir.Ali@dhs.arkansas.gov. Physicians can also contact AFMC, field reps, and coaches for help.
- DMS has activities going on with OHIT.
- Medicaid and Blue Cross Blue Shield are working together to enhance its MMIS systems and using MMIS dollars to enhance our dashboards and granularity and creating better registries for data. More information will be given in the near future.
- DMS has been looking at models in other states, particularly Oklahoma, to potentially develop software opportunities in granularity.
- CPC+ will be offering DMS information on ways of collecting and sharing data.
- DMS is looking down the road at potentially looking at different kinds of program activity metrics such as patient centered reporting that we can do on a cost effective basis.
- Dr. Kuo will be leaving Arkansas at the end of July and will be moving to Buffalo. He will be the Chief of General Pediatrics at Children’s Hospital. We wish him the best.

Angela Littrell/HP
- PMPMs for Q2 went out on May 23 and they anticipate Q2 reports going out at the end of June.
**Marlo Harris/GDHS**

- GDHS is also looking at the end of June to release reports. For the pharmacy report, the previous quarter's data will be used due to recent data issues.

**Dr. William Golden**

- Several states may not be able to apply for CPC+ due to the inability to build data infrastructure in a quick and timely way to respond to CPC+ requirements.
- Dr. Lonnie Robinson added that the discussion about MACRA reveals some of the complexities that all of the physicians will be facing.
- Dr. Robinson went on to say that The Arkansas Academy of Family Physicians is having their 2016 Annual Scientific Assembly August 3-6. As part of the preassembly program, they will have their national advocacy vice president speaking on MACRA as a preassembly educational opportunity at 1-3:30 p.m. on August 3. Dr. Robinson will be speaking during the meeting, on August 6 at 9:45 a.m., and will be covering a lot of information about CPC+. For more information, you can email Dr. Robinson or check the academy website at [http://www.arkansasafp.org/cme-programs/2015-annual-scientific-assembly/](http://www.arkansasafp.org/cme-programs/2015-annual-scientific-assembly/).
- Dr. Golden commented that for CPC+, the payers have to apply as a region by June 8, if the application is accepted, it is then opened up for practices to apply, and each practice has to apply on its own. You will choose Track 1 or 2. They want to get this started quickly so payments can start going out in December so CPC practices don’t have a gap.

**Michelle Young-Hobbs**

- Michelle confirmed that practice applications are due July 15, 2016 thru Sept 1, 2016.

**Alicia Berkemeyer**

- Blue Cross Blue Shield will be sending out applications to their CPC/PCMH practices to help them get started.

Meeting was closed.