Strategic Advisory Group
July 20, 2016

Facilitator: Dr. William Golden

Roll Call of Attendees

Dr. Golden

• Last meeting was a review of old business. The PCMH webinar on June 24th, which covered MACRA and CPC+, went well.
• At the last meeting, Lech went over procedural happenings and QA updates.
• CPC+ was originally supposed to announce the regions on July 5th but DMS, as well as many others, received an email asking for additional information. The director just wanted an explanation as to how DMS was going to pay for PMPMs for Tracks 1 and 2 differently. DMS had put in the docs that we would align with CMS’s program after the fact. CMS wanted DMS to distinguish between a Track 1 and Track 2 program. Advised CMS that DMS would have to have discussion with our advisory group before anything would be certain. The DMS team came up with a plan and sent it to CMS. They replied back indicating that what was sent was acceptable. CMS originally approved the existing program waiver but with the new changes, it may have to be reapproved by a different silo of CMS. Also, it will have to go through DMS’s state promulgation process. DMS suggested that beginning in 2017, we would have a Track 1 program for Medicaid PCMH and that would be open to practices with a minimum of 150 Medicaid patients. That would be in keeping with Track 1 of the Medicare CPC+ program. However, that Track 1 group will only get 2/3 of the current risk adjusted PMPMs, but they will have to pass reduced practice performance measures and quality measures. The expectation is that Track 1 would not be eligible for shared savings, but DMS would put in to place some kind of quality metrics/performance measures for a PMPM bonus. DMS will basically make the current PCMH program Track 2. It would be open to practices with 300 Medicaid beneficiaries and shared savings would exist as currently outlined. For 2017, the PMPMs would be just as they are now. In 2018, DMS would increase the PMPMs to 120%, about $1 per member per month. Of course that’s pending budget approval. It’s basically saying that in Track 1, you would get a 67% rate and Track 2 would get 120% rate. That’s the framework thus far and adjustments will be made as necessary. If you are a pediatrics practice you could be in Track 2 Medicaid PCMH which means that if you are in the program now, you could stay in it if you are in good standing. If you choose to be in Medicare Track 2, you have to be in DMS’s Track 2 program. You could not be in Track 1 Medicaid and Track 2 Medicare. If for some reason a PCMH program in Arkansas applied to be in Medicare Track 2 and was not accepted because of limitations in size or numbers, you can still be in DMS’s Track 2 program. Being rejected for Track 2 Medicare does not omit you from being in Track 2 Medicaid PCMH. Again, if you are not doing well with Medicare CPC+ requirements, it does not mean you would be thrown out of Medicaid PCMH. You would just have to meet DMS’s requirements.

Questions and Discussion

• Dr. William Hawkins: If you are in CPC+ Track 2 but do not have enough Medicaid beneficiaries to be in Track 2, how will that be handled? Dr. Golden advised that more information would need to be obtained on that subject as it has not been worked through at this time.
• Dr. Stacey Zimmerman: Why not keep the minimum Medicaid beneficiaries at 150 for both Track 1 and Track 2? Dr. Golden advised that it gets in to issues of shared savings, metrics, and requirements so DMS wanted to keep it as is. Also, this is a way of bringing in new practices and
smaller practices. Dr. Zimmerman stated that she was worried about a number of practices being excluded from Track 2 because they don’t have the 300.

- Dr. Dennis Kuo: With regards to Track 2, is there any discussion on the table about reduced fee for service payments? Dr. Golden advised that DMS told Medicare that since Medicaid is already on a reduced fee schedule, DMS did not think it would be appropriate to reduce the fee schedule as a discount. Dr. Golden added that he did not get a push-back on that subject.

- Dr. Golden advised that if there were no other questions/comments/feedback from the advisory group, he would tell CMS, after the meeting, that the plan was reviewed and the basic framework was viewed and no objections were raised to the plan about the PMPM differential. At this point, it appears that CMS’s biggest concern was the PMPM differential and with that core issue being addressed, DMS will be able to move forward with the framework. Once CMS receives the required information from DMS, it is assumed that they will respond rather quickly so the application process can begin.

- Blue Cross Blue Shield also had a phone call with CMS regarding CPC+. Numbers were discussed but CMS did not request any additional information. There was a verbal commitment that BCBS would adjust their numbers to the best of their ability.

- Alicia Berkemeyer (BCBS) stated that their call was very similar to the call that Dr. Golden had with CMS. She said that when BCBS was in Washington for the initial application, CMS had stressed the importance of commitment and support for the 2 Tracks. All the payers in Arkansas received similar emails about giving more details on how much would be paid on Track 2 and how they (the payers) were going to support that. BCBS expressed to CMS that they were very committed to supporting the track. Per Alicia, all indication is that everything is looking good for Arkansas and that CMS is still impressed by the work that has been done in Arkansas.

- Mike Motley (ACHI) stated that his organization had helped Health Scope, who represent multiple self-insured carriers in the state, apply. Health Scope has been wanting to participate in Arkansas’s Payment Improvement Initiative for some time. The CPC+ program is a chance for them to come in with the other payers. Health Scope also had a phone call similar to what Dr. Golden described. The CPC+ team wanted clarification on the PMPM differentials and their commitment to share data with the providers and make that available, which is also something that other payers have already been doing, but with Health Scope being somewhat new needed to commit to that.

- Brian, Arkansas Health and Wellness (AHW), stated that they also had a call and helped CMS understand their situation which was as a new entrance as a QHP and the fact that their run history began with the exchange so it was very difficult for AHW to gear up to a Track 1 and Track 2 shared savings without any history, but CMS was very understanding about that. AHW assured CMS of their commitment and informed them that they had been an ongoing participant in in the conversation and collaboration. Overall, the conversation was positive.

- As mentioned in prior meetings, Dr. Golden is participating in a work group about payment reform for primary care for the Learning Action Network. The group has a representative from Humana. At last week’s meeting, Dr. Golden was told that Humana has elected to not participate in any CPC+ region.

- DMS has worked with AFMC to do a survey of all the medical homes about their capacities to do ECQMs for hypertension control, diabetes control, and BMI recording and to learn of any barriers that may persist. Better results were received than had been anticipated. It appears that there a minimal amount of vendors that are not prepared to support practices in this. There are a number of practices that thought they had software vendor problems but in discussions with AFMC, and in coordination with their vendor, turned out that there were some perceived barriers that were not real barriers and could be easily fixed. There were a few practices that had software that was working fine for some practices but, because of contract or update
issues, was not working for their practice. There were also a large number of practices that had no barriers at all. Roughly 75-80% of practices were reasonably functional and ready to go. Another 15% has some achievable barriers to be fixed. And roughly 5% had some significant vendor issues. These numbers were a lot better than had been initially anticipated. AFMC agreed with Dr. Golden’s statement. This information will be shared with ONC.

- Dr. Golden asked for comments and questions regarding ECQMs and EMRs. No comments or questions were asked.

**Alicia Berkemeyer**

- While BCBS was in Washington speaking with CMS about CPC+, BCBS expressed their wish, if selected as a CPC+ region, to have all the practices, not only in the current CPC but also in the state PCMH program, to be considered and included. There was discussion regarding pediatrics and not having a population of Medicare beneficiaries. BCBS asked for those clinics to at least be recognized in the program then you wouldn’t have members to attribute. So a part of all BCBS applications consistently for all payers in the state included a list of all the CPC and state PCMH practices and their MPIs and information asking that if our application is considered as a market to please consider those practices. There will be 5,000 chosen so with the 20 markets. It is uncertain of how that will fall in to place.
- BCBS has asked United if they had applied and at this time they have not, but they will have an opportunity to apply at the end once markets have been chosen.
- Things are going well from the QHP standpoint. They continue to meet on a regular basis.

**Lech Matuszewski**

- There will be a few proposed changes to the PCMH manual. Mostly it involves clarification based on questions DMS has received from practices.
  - One of the changes that DMS has clarified is how the practices who were previously suspended from the program may return to the program. They would need to submit a new enrollment application and at that time our QA team will verify whether or not they have met previously failed activities.
  - Another change is that during the enrollment process, DMS will require identification of multiple sites. If a PCMH is performing out of more than one location, the primary site and satellite sites must be disclosed on the application. That will also help the QA team verify whether all sites are meeting PCMH requirements.
  - An exception in the current manual has been removed. It is in regards to the provision where the individual practices which have 5,000 beneficiaries and are unable to meet that requirement at the end of the performance period, they will be moved to the default pool. Under the current manual, this provision did not apply to voluntary pools but that exception has been removed for 2017. As of 2017, an involuntary pool that does not meet the 5,000 beneficiary requirements toward the end of the performance period will be moved to the default pool. It is the same rule for both individual practices and voluntary pools.
  - Clarification has been addressed regarding the preliminary shared savings payments. A standard has been developed that eligibility for shared savings is fixed based on quarter 3 results. Basically if you meet eligibility for shared savings in quarter 3 of this year, you are considered eligible for shared savings. That is with the exception to the total cost of care. After receiving additional claims or changes in economic performance, those will be reflected on the final reconciliation; however adverse changes with regard to quality metrics or attribution numbers will not affect eligibility for final reconciliation. At the same time, if some practices did not qualify for shared savings in quarter 3, then
subsequently improve their performance between quarter 3 and the final reconciliation, those will be recognized in their favor.

- There is also more explanation on “zeroed out reports.” There are situations when there are credentialing problems. Those are affecting both the license issues as well as the stream of PCCM claims. Licensing is the responsibility of the providers. DMS is not in the position to fix licensing issues. Providers get notice from DMS via a zeroed out report which shows no attribution. The provider may still be considered to be in PCMH but they will have no beneficiaries and the zeroed out report is a notice to the provider that there is an issue that he/she needs to fix.

- A section was deleted regarding the CPC classic program. The current system issues payments for Medicaid panels in CPC but that will not happen in CPC+ so that section of the manual was removed.

- Payments during the Appeals process have been changed. Currently we still pay PMPMs while the practices are going through the appeals process, but this will stop once a practice requests a hearing. If a practice prevails during the hearing process then they would receive all of the withheld PMPMs.

- As mentioned previously, DMS is still waiting on final decisions from CPC+ regarding our application. Once that is approved and finalized, manual changes will again need to be made. At the current time, the manual only covers Track 2. Rules regarding Track 1 will have to be created and added to the manual.

- The enrollment webinar has been delayed until DMS is given the final enrollment rules.

**Comments and Questions**

- Dr. Kuo: Are the recent decline in metrics due to enrollment issues or was there some other issue? Lech replied that the decision about the 3rd quarter was minimally affected by eligibility determinations and that past issues should be fixed.

**Dr. Golden**

- Future Practice Activities: Some of the current information is potentially subject to change due to CPC+ determinations. The document outlining future practice activities will be emailed to the group after the meeting. DMS wanted to add a few ideas in terms of practice support activities.
  - One being the capacity to have communications from patients. This would consist of email messaging. CPC+ may require a portal program for patients to see their records. DMS feels that would be somewhat of a reach for our smaller practices so instead we will have a requirement that there be some capacity for email or electronic communication from patients to the practices and back.
  - DMS also wants every practice in PCMH to be part of the Narcotic Data Registry and to be enrolled in the health department’s narcotic monitoring program. That may soon be a requirement of the medical board as well. DMS will monitor the care plan eligibility and see what CPC+ requires, but we may increase the percentage of patients that need care plans.
  - DMS wants to address patient literacy. There are patient literacy tools available that are very helpful and can be administered in the waiting room. DMS will share that tool with the practices.
  - DMS is going to require that practices receive patient feedback. This could be an advisory council, some sort of survey tool in the waiting room, or a suggestion box in the check-out area where patients can anonymously give feedback regarding their visit. It
would just be some sort of tool to receive input from patients as to how the practice is doing.

- DMS wants practices to give patients some sort of written health care instructions for high priority beneficiaries. There needs to be some sort of written information given to the patients about their visit either electronically after the fact or some written information given to the patients upon check-out about their care and follow-up.
- Documentation in the EMRs that medications were reconciled.
- Something will probably be added about the Medical Neighborhood and getting referrals from doctors, but at this point nothing is concrete on that.

- Again, these are subject to change but DMS feels these will align with CPC+ requirements. A written document will be sent to the group afterwards and feedback will be appreciated. There will be further discussions in August.
- A spreadsheet of documentation showing performance by emergency rooms for giving antibiotics to people with nonspecific URIs was recently sent out via email. It consisted of a spreadsheet that showed the practice variation and the number of patients being billed for nonspecific URIs by individual ERs and their rates of filling antibiotic prescriptions. It ranged from 80-90% down to 10-15% or less. There was one large ER with over 200 visits that only gave out antibiotics 20% of the time. There was also large volume ERs that gave them out 70% of the time. DMS’s plan is to use this report, and other URI events like strep throat and sinusitis, to help develop a report that identifies those ERs by name. The email sent was a blinded copy and DMS will be sharing that data with the Medical Society, the Hospital Association, and the ER Doctor Association. Our plan would be to provide medical homes a report that identifies, by name, each of the sites of the ERs who did the prescribing. This will be used as a prototype for future transparent performance data to be shared with the medical home community and to identify their medical neighborhood performance. This is given for information and as an example that we are moving forward to use this as an alpha test of the concept and get everyone ready for greater transparency in the future.
- Dr. Lonnie Robinson added that Urgent Cares should be included in that evaluation as there is currently no accountability for ERs or Urgent Cares. He went on to say that doctors often hold their ground on antibiotics used and then the patient leaves and goes to the ER or Urgent Care and receive the antibiotics they want.
- Dr. Golden added that Urgent Cares would be included although some are not easily identifiable.
- Dr. Stacey Zimmerman asked about possibly setting a metric goal for the ERs.
- Dr. Golden responded that these numbers are part of the EOC for URI. Since ERs are part of the EOC they are at financial risk for their prescribing patterns.
- Dr. Golden added that antibiotic prescriptions for colds continue to decrease and it’s been a major success. It has gone from a statewide average of about 50% down to 37% and it continues to decrease.
- Dr. Lonnie Robinson commented about PMPM claw backs from patients losing eligibility. He disagreed with claw backs from patients losing their eligibility as the physicians still had to do care plans, etc. for the beneficiary. Lech responded that his comments would be taken into consideration as to how to handle the situation. Dr. Golden added that the issue would be discussed within the organization and possible solutions would be addressed.
- Dr. Anthony Johnson added that the physicians are continuing to see the patients and give medical care in hopes of them getting reinstated.
- Dr. Golden again advised that DMS would discuss the issue and get back with them.
• Dr. Golden wished Dr. Kuo a farewell as he is moving to New York. Also, thanked him for his contributions to PCMH in the state.
• Meeting was closed.