PCMH Review + 2017 Updates

October 28, 2016
PCMH Webinar - Agenda

- CPCi – Comprehensive Primary Care initiative
- eCQM survey
- HCP-LAN draft report
- 2015 Medicaid shared savings results
- 2017 updates
  - 2017 practice support activities
  - 2017 quality metrics
  - Quarterly report changes
  - Activity validation update
  - 2017 enrollment update/deadline
- SAG openings
CPCi
Comprehensive Primary Care Initiative
PCMH Webinar: CPCi – Comprehensive Primary Care Initiative

Comprehensive Primary Care Initiative
2015 Shared Savings and Quality Fact Sheet: ARKANSAS

This fact sheet presents the shared savings and quality results for the 2015 performance year and includes key figures for your region. You can find more resources and the shared savings technical methodology on our website: https://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/

Gross Savings
$20.6 M (4.3%)

Net Savings
$11.5 M (2.4%)

Shared Savings
$780 K

Gross savings is the difference between actual Part A and B expenditures for attributed Medicare beneficiaries and the region’s expenditure target for 2015. Net savings incorporates Medicare care management fees (avg. $15 per beneficiary per month) in the actual expenditures.

Baseline Expenditures (PBPM)
$742

2014 2015

Growth Rate* 3.5% 0.4%
Risk Adj. Ratio* 0.99 0.99
Case-Mix (% Aged) 80% 83%

2014 Target Expenditures (PBPM)
$760

2014 Actual Expenditures (PBPM)
$768

2015 Target Expenditures (PBPM)
$782

2015 Actual Expenditures (PBPM)
$763

56 out of 58 practices in Arkansas met quality requirements to be eligible to receive any shared savings earned by the region. CMS shared $739,443 with the region, with an average of $13,204 per practice.
eCQM Survey
### Table 8: 2015 Benchmarks by Measure Based on PQRS GPRO QRDA III Data

<table>
<thead>
<tr>
<th>CMS Measure Number &amp; Version</th>
<th>NQF Measure Number</th>
<th>Measure Name</th>
<th>Benchmark Values by Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>165v3</td>
<td>0018</td>
<td>Controlling High Blood Pressure</td>
<td>54.24</td>
</tr>
<tr>
<td>138v3</td>
<td>0028</td>
<td>Tobacco Use; Screening, and Cessation Intervention</td>
<td>70.10</td>
</tr>
<tr>
<td>125v3</td>
<td>0031</td>
<td>Breast Cancer Screening</td>
<td>3.42</td>
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<tr>
<td>130v3</td>
<td>0034</td>
<td>Colorectal Cancer Screening</td>
<td>2.19</td>
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<tr>
<td>147v4</td>
<td>0041</td>
<td>Preventive Care and Screening: Influenza Immunization</td>
<td>5.78</td>
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<tr>
<td>163v3</td>
<td>0064</td>
<td>Diabetes: Low Density Lipoprotein (LDL) Management</td>
<td>23.93</td>
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</tbody>
</table>
### Table 4: Number and Percent of CPC Sites Reporting Valid Values, by Measure, 2015

<table>
<thead>
<tr>
<th>CMS Measure Number &amp; Version</th>
<th>NQF Measure Number</th>
<th>Measure Name</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>165v3</td>
<td>0018</td>
<td>Controlling High Blood Pressure</td>
<td>441</td>
<td>98.0</td>
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<tr>
<td>138v3</td>
<td>0028</td>
<td>Tobacco Use; Screening, and Cessation Intervention</td>
<td>408</td>
<td>90.7</td>
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<td>125v3</td>
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<td>Breast Cancer Screening</td>
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<td>91.6</td>
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<tr>
<td>130v3</td>
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<td>429</td>
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<td>0041</td>
<td>Preventive Care and Screening: Influenza Immunization</td>
<td>374</td>
<td>83.1</td>
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<tr>
<td>163v3</td>
<td>0064^b</td>
<td>Diabetes: Low Density Lipoprotein (LDL) Management</td>
<td>409</td>
<td>90.9</td>
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<tr>
<td>182v4</td>
<td>0075^b</td>
<td>Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (first performance rate)</td>
<td>362</td>
<td>80.4</td>
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<tr>
<td>144v3</td>
<td>0083</td>
<td>Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction</td>
<td>119</td>
<td>26.4</td>
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<tr>
<td>139v3</td>
<td>0101</td>
<td>Falls: Screening for Future Fall Risk</td>
<td>318</td>
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<tr>
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<td>0418</td>
<td>Screening for Clinical Depression and Follow-Up Plan</td>
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<td>68v4</td>
<td>0419</td>
<td>Documentation of Current Medications in the Medical Record</td>
<td>313</td>
<td>69.6</td>
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</tbody>
</table>

Abbreviations: CMS, Centers for Medicare & Medicaid Services; CPC, Comprehensive Primary Care
## PCMH Webinar: eCQM Survey

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<tbody>
<tr>
<td>182v4</td>
<td>0075</td>
<td>Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (perf. rate 1)</td>
<td>35.71 54.52 68.26</td>
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<tr>
<td>144v3</td>
<td>0083</td>
<td>Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)</td>
<td>78.26 90.83 100.00</td>
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<tr>
<td>139v3</td>
<td>0101</td>
<td>Falls: Screening for Future Fall Risk</td>
<td>1.18  28.57  71.79</td>
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<tr>
<td>2v4</td>
<td>0418</td>
<td>Screening for Clinical Depression and Follow-Up Plan</td>
<td>0.00  1.00  11.00</td>
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<tr>
<td>68v4</td>
<td>0419</td>
<td>Documentation of Current Medications in the Medical Record</td>
<td>72.96 90.88 97.00</td>
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</tbody>
</table>

**Abbreviations:** CMS, Centers for Medicare & Medicaid Services; NQF, National Quality Forum

*No longer endorsed by NQF
HCP – LAN Draft Report
EHR Contracts Untangled

SELECTING WISETLY, NEGOTIATING TERMS, AND
UNDERSTANDING THE FINE PRINT

Prepared under contract for:
The Office of the National Coordinator for Health Information Technology
Washington, D.C.

September 2016
2015 Medicaid Shared Savings Results
PCMH Webinar: 2017 Updates

• Activities
• Metrics
• Reports
• Validation
2017 PCMH Activities for Practice Support
PCMH Webinar: 2017 Updates – Activities for Practice Support

3 Month
Activity A:
Identify top 10% of high-priority patients (including BH clients)

6 Month
Activity B:
Provide 24/7 access to care

Activity C:
Document approach to expanding access to same-day appointments

Activity D:
Capacity to receive direct e-messaging from the patients: Describe method of e-messaging (New for 2017)

Activity E:
Enrollment in the Arkansas Prescription Monitoring Program (AR PMP): All PCPs must enroll in AR PMP. Report method(s) used to monitor controlled substance prescriptions using AR PMP. (New for 2017)
PCMH Webinar: 2017 Updates – Activities for Practice Support

12 Month

Activity F:
Childhood/Adult Practice Vaccination Strategy

Activity G:
Join SHARE or participate in a network that delivers hospital discharge information to practice within 48 hours

Activity H:
Incorporate e-prescribing into practice workflows
PCMH Webinar: 2017 Updates – Activities for Practice Support

12 Month

Activity I:

Care Plans for High-Priority Beneficiaries: Create Care Plans

Activity J:

Patient Literacy Assessment Tool: Choose any health literacy tool and administer the screening to at least 50 beneficiaries (enrolled in the PCMH program) or their caregivers (New for 2017)

Activity K:

Ability to receive Patient Feedback: Indicate method used to receive patient feedback and describe how feedback is used to make improvement (New for 2017)
PCMH Webinar: 2017 Updates – Activities for Practice Support

12 Month

Activity L: Care Instructions for HPB: Create and share with the patient an after-visit summary of patient’s visit. Include updated/reconciled medication list, vital signs, summary of topics covered/considered, and follow-up instructions (New for 2017)

Activity M: Medication Management: Describe the practice’s EHR reconciliation process. Document updates to active medication list in EHR for HPB (New for 2017)

Activity N: 10-day follow-up after an acute inpatient hospital stay (New for 2017)
2017 Quality Metrics
PCMH Webinar: 2017 Quality Metrics

- **Metric 1 – PCP Visits**
  - Percentage of a practice’s high-priority beneficiaries who have been seen by any PCP within their PCMH at least twice in the past 12 months

- **Metric 2 – Infant Wellness**
  - Percentage of beneficiaries who turned 15 months old during the performance period who receive at least five wellness visits in their first 15 months (1-15 months)

- **Metric 3 – Child Wellness**
  - Percentage of beneficiaries 3-6 years of age who had one of more well-child visits during the measurement year
PCMH Webinar: 2017 Quality Metrics

- **Metric 4 – Adolescent Wellness**
  - Percentage of beneficiaries 12-20 years of age who had one or more well-care visits during the measurement year

- **Metric 5 – Asthma**
  - Percentage of beneficiaries 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed an asthma controller medication for at least 50 percent of their treatment period

- **Metric 6 – ADHD**
  - Percentage of beneficiaries 6-12 years of age with an ambulatory prescription dispensed for ADHD medication that was prescribed by their PCMH, who had a follow-up visit within 30 days by any practitioner with prescribing authority
PCMH Webinar: 2017 Quality Metrics

- **Metric 7 – URI**
  - Percentage of beneficiary events, ages 1 year and older, with a diagnosis of non-specified URI that had antibiotic treatment during the measurement period

- **Metric 8 – HbA1C**
  - Percentage of diabetes beneficiaries who complete annual HbA1C, between 18-75 years of age

- **Metric 9 – Diabetics on Statin**
  - Percentage of diabetic beneficiaries between 40-75 years of age who are on statin medication
PCMH Webinar: 2017 Quality Metrics

- **Metric 10 – Xanax**
  - Percentage of beneficiaries ages 18 and older who were prescribed chronic Alprazolam (Xanax) during the measurement period

- **Metric 11 – ODA**
  - Percentage of beneficiaries at least 18 years of age as of the beginning of the measurement period with diabetes mellitus who had at least two prescriptions for a single oral diabetes agent or at least two prescriptions for multiple agents within a diabetes drug class and who have a Proportion of Days Covered (PDC) of at least 0.8 for at least one diabetes drug class during the measurement period (12 consecutive months)

- **Metric 12 – Eye Exam**
  - Percentage of diabetic beneficiaries 18-75 years of age who had an eye exam (retinal) performed
• **Metric 13 – Medication Therapy**
  - Percentage of beneficiaries 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent (angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB) or diuretics) during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year

• **Metric 14 – Controlling BP**
  - Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period (All payer source)

• **Metric 15 – HbA1C Poor Control**
  - Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1C > 9.0% during the measurement period (All payer source)
Metric 16 – BMI

- Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of height, weight and body mass index (BMI) percentile documentation during the measurement period (All payer source)

Metric 17 – Tobacco Use

- Percentage of patients ages 18 and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as tobacco user during the measurement period (All payer source)

*Claims-based 2017 quality metric targets are set at a level no higher than the average performance of the shared savings entities in 2015*
2017 Quarterly Report Changes
(General Dynamic Health Solutions - GDHS)
PCMH Webinar: Quarterly Report Changes
Cost Analysis Page

- Full page to reflect total cost of care performance with new graphical representation
Activity Validation Update
(AFMC Quality Assurance)
AFMC PCMH Quality Assurance

### 2016 Care Plan Validation

<table>
<thead>
<tr>
<th>Deadline to attest is Dec. 31, 2016</th>
<th>Must attest to at least 80% of HPBs having a care plan and an update</th>
<th>Random selection for review</th>
</tr>
</thead>
</table>


AFMC PCMH Quality Assurance

QA Process during appeal process

- Complete attestation in AHIN portal
- Attestation review by QA
- Validation by QA
AFMC PCMH Quality Assurance

Returning to PCHM Program after suspension

Complete enrollment form

QA will review/revalidate activities or metrics that resulted in the suspension

Results will be reported to DMS
2017 Enrollment Update
Questions??