MEDICAL DIRECTOR MEETING – MINUTES
January 5, 2017

GROUP MEMBERS PRESENT: John Barravecchio, MD; Jatin Dave, MD; Louis DiLillo, MD; David Dohan; MD, Linda Doucette, Leonard Finn, MD; Harold Greenspan, MD; Thomas Jevon, MD; Dennis Markovitz, MD; Kanu Patel, MD; Anne Pinto, MD; Marc Pifko, MD; Michael Querner, MD; Sheila Rozumek, MD; Shah Pramodchandra, MD; Peter Sheckman, MD; Joseph Taylor, MD

WEBINAR: Emily Chin, MD; Andrew Fish; Robert Fraser, MD; Shawn Pawson, MD; Savitha Gowda, MD; Douglas Gronda, MD; Richard Daly, MD; Vinay Kumar, MD; Marguerite Roach; William Litterer, MD; Tushar Patel, MD

TOPIC	DISCUSSION/QUESTIONS	**QUESTIONS/ANSWERS/ACTION/ FOLLOW UP**	**WHO**
1. Review of December Meeting Jonathan Harding, MD	• 5 Star SEP provides opportunity for growth of group TMP membership from within your practice, or if you have growth capacity, for new patients in your practice • Pharmacy Presentations: • 2017 Formulary changes presented; see PP deck • Pharmacy Star Measures: Comprehensive Medication Review rate, Statin Use in Diabetes, Medication Adherence • i-Deal Therapy Program • Mail Order now has more financial benefit for members; member savings could help with adherence • Specialty Pharmacy: Using Caremark provides financial benefit to TMP and quality benefit for members – specialty care management	Work with your assigned Sales associate for ongoing enrollment promotion Informational; provide input into 2018 formulary by April 2017 If you have opted out of PCP endorsement of MTMP in letters to members please reconsider Encourage use of Mail Order for chronic meds (except inhalers, see below) Encourage your specialists to use Caremark as preferred Specialty	Group medical leader-ship

TOPIC	DISCUSSION/QUESTIONS	**QUESTIONS/ANSWERS/ACTION/ FOLLOW UP**	**WHO**
	• Role of Group/PO medical directors or designees in educating practitioners on Risk Adjustment • Reminder of previously presented Diagnosing and Documenting Opportunities: premorbid presentation of PVD COPD Diabetic complications • Dr. Harding pointed out the **financial hazard of NOT screening** for PVD in at-risk populations* - 10% underdiagnosed **PVD** x $200 pmpm revenue per dx ~ $20 pmpm in lost revenue across entire population - Equipment costs < $2000 and pays for itself with just ONE new diagnosis; can also be used to bill FFS payers - Tests can be performed by MAs or LPNs • Similar hazard in not screening for COPD • Several vendors can provide the service if you cannot make the case for capital acquisition to buy the equipment • Poll performed at January meeting, and 2/3 of live participants would participate in a purchasing collaborative to share volume discounts Additional opportunities presented at the December meeting: • Depression • Obesity • Malnutrition • Rheumatoid arthritis	Pharmacy for Tier 5 drugs Ensure someone else, if not you, has RA responsibility for your group, including practitioner education Ensure practices with TMP members have easy access to ABI machines, spirometers, nerve impedance measurement, retinal scans Investigate purchasing collaborative for these devices Review Dr. Huie's presentation slides Train, or arrange training for your practitioners re: how to make these diagnoses and how to document to support them	JH Group medical leader-ship

TOPIC	DISCUSSION/QUESTIONS	**QUESTIONS/ANSWERS/ACTION/ FOLLOW UP**	**WHO**
Annual Review of New Codes for Inclusion in PCP Capitation List	• Most Provider Organizations are paid for primary care services through PCP capitation. • This allows better cash flow and incentives for care outside office visits (phone, e-mail, portal, telehealth) • In the interest of fairness among the PCPs in any group, a capitation agreement requires standardization of the scope of PCPs practice • TMP provides those standards in a PCP capitation list. The PCP Capitation list has been in existence since 1994. • Services not included in the PCP capitation list are reimbursed to the PCP providing them on FFS Medicare basis. • FFS payments come from the Provider Organization's Medical Services Fund. Thus the PO provides extra reimbursement for those PCPs who provide services beyond those expected of a PCP. PCP Capitation List Process • A designated person at TMP acquired the list of 408 codes added to the CPT manual during the calendar year 2016. • In some cases these codes crosswalk to previously existing codes. In those cases he designated whether the antecedent code had been on PCP capitation list. • A team reviewed all the new codes and eliminated those clearly not in PCP scope • We have the following list of remaining codes for which we want your input. Procedure codes that Tufts Health Plan Medicare Preferred would like the consensus of this group on adding to the PCP Capitation List New SNF rounding codes	Questions/comments • " In our group we didn't feel it was fair to people who don't round patients in a hospital or nursing homes to have it included in their caps, so we…reimburse docs for rounding patients in nursing homes and hospitals. Otherwise we would be paying others who are not doing it" • Complicated to figure out how people code. We just have a flat rate and code it the same way. More complicated to figure out all the extra codes • If I went to see a pt with acute congestive heart failure, does it risk adjust higher? Does it risk adjust if the pt is acute? A: HF risk adjusts but only need one diagnosis per year. • If the pt is seen by PCP , then the cost is lower • Need to get the Dr to think more about managing the pts, this is worth more than fee for service. People should learn how to use a capitated program • If I see a SNF pt who is in my call group, I do not get paid? A: No	

TOPIC	DISCUSSION/QUESTIONS	QUESTIONS/ANSWERS/ACTION/ FOLLOW UP	WHO

New Proc	Description
G9679	Onsite acute care treatment of a nursing facility resident with pneumonia. May only be billed once per day per beneficiary
G9680	Onsite acute care treatment of a nursing facility resident with CHF. May only be billed once per day per beneficiary
G9681	Onsite acute care treatment of a nursing facility resident with COPD or asthma. May only b billed once per day per beneficiary
G9682	Onsite acute care treatment of a nursing facility resident with a skin infection. May only be billed once per day per beneficiary
G9683	Onsite acute care treatment of a nursing facility resident with fluid or electrolyte disorder dehydration (similar pattern). May only be billed once per day per beneficiary
G9684	Onsite acute care treatment of a nursing facility resident for a UTI. May only be billed once per day per beneficiary
G9685	Evaluation and management of a beneficiary's acute change in condition in a nursing facili

- How does a Dr get paid if it's outside the cap?
  A: FFS at Medicare rates from MSF
- How do we know which groups are in the PCP cap? A: Check your contract or ask you Contract Manager
- Need to put into the cap or have a discussion about how we pay for nursing home and SNF visits.
- Groups with employed physicians had lower performance than groups that have physicians with incentives

There are existing SNF rounding codes currently in the PCP cap but that presumes that PCPs round their own patients in SNFs regularly. That was true years ago. Is it still a relevant policy for current practice?

No consensus on inclusion of new SNF rounding codes into PCP Cap. Some would like to pull all SNF rounding codes out. Some want them all in.

JH

Dr. Harding to bring back data on use of existing SNF rounding codes to make a more informed decision

MW

Other codes

There was a consensus to add these codes to the PCP capitation list

<table>
<tr><th>TOPIC</th><th>DISCUSSION/QUESTIONS</th><th>QUESTIONS/ANSWERS/ACTION/
FOLLOW UP</th><th>WHO</th></tr>
<tr><td></td><td>
<table>
<tr><th>New Proc</th><th>Description</th></tr>
<tr><td>80305</td><td>Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (eg, immunoassay); capable of being read by direct optical observation only (eg dipsticks, cups, cards, cartridges) includes sample validation when performed, per date of service</td></tr>
<tr><td>96160</td><td>Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument</td></tr>
<tr><td>96161</td><td>Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for th benefit of the patient, with scoring and documentation, per standardized instrument</td></tr>
<tr><td>G0505</td><td>Cognition and functional assessment using standardized instruments with development of recorded car plan for the patient with cognitive impairment, history obtained from patient and/or caregiver, in office other outpatient setting or home or domiciliary or rest home</td></tr>
<tr><td>G0506</td><td>Comprehensive assessment of and care planning for patients requiring chronic care management servic (list separately in addition to primary monthly care management service)</td></tr>
<tr><td colspan="2">The following procedure code was issued in 2015 and added to the PCP Capitation List that year. Should this procedure code stay on the PCP Capitation List?</td></tr>
<tr><td>99490</td><td>Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected</td></tr>
</table>
</td><td>Keep on PCP cap list</td><td></td></tr>
<tr><td>2018 Benefit Considerations

Routine Travel Coverage</td><td>All THP products currently provide coverage for emergency and urgent care outside of the service area. We would like to assess adding a travel benefit to select plans.
• Consumer research indicates this to be a valuable benefit
• THP competitors currently offer this benefit
This travel benefit would:
• Provide coverage for all plan-covered services for members when they leave the service area temporarily (up to a max of 12 months). Plan rules would still apply when members are within the service area.
• Coverage would include non-emergency and urgent care services, such as office visits, labs, physical therapy, and preventive screenings, with in-network cost shares applied.
• Additional assessment to be done regarding how the benefit would be managed, such as requiring members to notify the plan when they will be out of the service area and how to define the geographic areas where the benefit will be offered.</td><td>• If a pt goes to FL for several months and needs INR check or has another dr for a routine check and we are saying no because it would come out of our funds instead of them going to the er there, which would be much more expensive, but not for us.
• Even regular Medicare would not cover pts who go outside the country as they don’t have any control of what’s being done
• The risk should still reside with THP and THP can reach out to</td><td>Caitlen Andrew</td></tr>
</table>

TOPIC	DISCUSSION/QUESTIONS	**QUESTIONS/ANSWERS/ACTION/ FOLLOW UP**	**WHO**
Adding Part B Drugs Cost Share	We would like to assess adding cost share to Part B drugs rendered at the doctor's office, facility, or pharmacy. Currently, all other Medicare Advantage insurance companies in Massachusetts offer plans that include this cost share. 1. What cost share limits would you be willing to see applied to the below Part B Drugs? 2. What other considerations should be addressed as this benefit is assessed?	PCPs and ask them if this is a reasonable thing for their pt to be doing. Otherwise pts see as many PCPs as they want • It would require more compensation, and there is not going to be extra money for this. • We don't allow our pts to get other PCPs out of state, as we don't know how they get managed • It is not possible to allow a pt to go to FL and authorize their chemotherapy there. What if complications happen there and pts get referred to someone else. • Come up with an idea to get a supplemental care for 3 months or so that the pt is going to be responsible for Consensus that the groups would object to adding this benefit if it was to be paid out of MSF. Fine if paid out of TRF Fine if self funded through a rider • THP should be looking closely for a program to manage centrally and control the most expensive biologics. Hep C	Caitlen Andrew

TOPIC	DISCUSSION/QUESTIONS	QUESTIONS/ANSWERS/ACTION/ FOLLOW UP	WHO
		drugs are such high cost that to attribute those drugs to RSO or to a group is not reasonable and had to be handled at a much larger group Consensus to add copay for part B drugs similar to competing plans to reduce the risk of adverse selection. Categories similar to competing plans	

Part B Drugs	Cost Share Limit (1-4)
Chemotherapy	
Drugs used with DME, such as infusion pumps or nebulizers	
Antigens	
Injectable Osteoporosis drugs	
Erythropoisis-stimulating agents (for ESRD or anemia related to other conditions	
Blood clotting factors to treat hemophilia	
Oral ESRD (if same drug available as injectable and is covered under Part B)	
Parenteral/enteral nutrition	
Intravenous Immune Globulin to treat primary diagnosis of immune deficiency disease	
Transplant drugs (immunosuppressive drugs) after Medicare-covered organ transplant	
Oral anti-nausea drugs as part of anti-cancer chemo regimen	

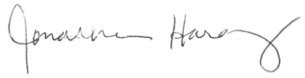
TOPIC	DISCUSSION/QUESTIONS	QUESTIONS/ANSWERS/ACTION/ FOLLOW UP	WHO
GOLD Guidelines for COPD Updated for 2017	**SUMMARY OF NEW RECOMMENDATIONS** ***Chapter 1*** The definition of COPD has been revised to include the impact of respiratory symptoms and the role of lung tissue and airway abnormalities in the development of COPD. The origin of COPD development is discussed relative to interactions of host factors and environmental exposures. ***Chapter 2*** The ABCD assessment tool has been refined to utilize respiratory symptoms and exacerbations alone to assign ABCD categories. The role of spirometry in overall management of COPD has been updated. ***Chapter 3*** Assessment and regular evaluation of inhaler technique has been added to attempt to improve therapeutic outcomes. Increased evidence for self-management, pulmonary rehabilitation, integrated care and palliative care is presented. Recommendations for noninvasive ventilation, oxygen therapy and lung volume reduction are provided based on new information. ***Chapter 4*** Examination of symptoms and future risk of exacerbations should provide the map for pharmacologic management of stable COPD. A shift towards more personalized approach to treatment is introduced, with strategies for escalation and de-escalation of pharmacotherapy. ***Chapter 5*** Detailed hospital discharge and follow up criteria are presented and include integrated team care. ***Chapter 6*** The strategies for the management of cardiovascular and other important comorbidities are presented in detail. The complex issues of multimorbidity and polypharmacy are outlined. **OVERALL KEY POINTS:** • *COPD should be considered in any patient who has dyspnea, chronic cough or sputum production, and/or a history of exposure to risk factors for the disease.* • *Spirometry is required to make the diagnosis; the presence of a post-bronchodilator $FEV_1/FVC < 0.70$ confirms the presence of persistent airflow limitation.* • *The goals of COPD assessment are to determine the severity of the disease, including the severity of airflow limitation, the impact of disease on the patient's health status, and the risk of future events (such as exacerbations, hospital admissions, or death), in order to guia therapy.* • *Concomitant chronic diseases occur frequently in COPD patients, including cardiovascular disease, skeletal muscle dysfunction, metabolic syndrome, osteoporosis, depression, anxiety, and lung cancer. These comorbidities should be actively sought and treated appropriately when present as they can influence mortality and hospitalizations independently.*		

TOPIC	DISCUSSION/QUESTIONS	QUESTIONS/ANSWERS/ACTION/ FOLLOW UP	WHO
	Standardized questionnaire validated to predict exacerbations  For each item below, place a mark (X) in the box that best describes you currently. Be sure to only select one response for each question. **Example:** I am very happy 0 (X) 2 3 4 5 I am very sad SCORE I never cough 0 1 2 3 4 5 I cough all the time I have no phlegm (mucus) in my chest at all 0 1 2 3 4 5 My chest is completely full of phlegm (mucus) My chest does not feel tight at all 0 1 2 3 4 5 My chest feels very tight When I walk up a hill or one flight of stairs I am not breathless 0 1 2 3 4 5 When I walk up a hill or one flight of stairs I am very breathless I am not limited doing any activities at home 0 1 2 3 4 5 I am very limited doing activities at home I am confident leaving my home despite my lung condition 0 1 2 3 4 5 I am not at all confident leaving my home because of my lung condition I sleep soundly 0 1 2 3 4 5 I don't sleep soundly because of my lung condition I have lots of energy 0 1 2 3 4 5 I have no energy at all TOTAL SCORE **Reference:** Jones et al. ERJ 2009; 34 (3); 648-54. How Should We Implement Selected Recommendations? • Inhaler technique needs to be assessed regularly. Should we recommend dispensing pharmacist observe technique with each inhaler renewal? Observe in PCP office?	• What do I do with my arthritic patients who have no ability to inhale? Are there any devices that I am not aware of?	

TOPIC	DISCUSSION/QUESTIONS	**QUESTIONS/ANSWERS/ACTION/ FOLLOW UP**	**WHO**
	• Pulmonary rehabilitation improves symptoms, quality of life, and physical and emotional participation in everyday activities. Is our pulmonary rehab network adequate? • Palliative approaches are effective in controlling symptoms in advanced COPD. Care Management v. PCP content for palliation and advance care planning for patients with advanced COPD • Osteoporosis, depression/anxiety, and obstructive sleep apnea are frequent, important comorbidities in COPD are often under-diagnosed, and are associated with poor health status and prognosis. We think all COPD patients should get a PHQ-2 and if positive PHQ-9 in CM content v. PCP content; also GAD	• Can pharmacists dispense sample inhalers so we can see what pts are doing with their inhalers at their appointments? • Put instructions on the Rx to have pharmacist show pts how to use inhalers. • How do we encourage all the pts who have inhalers to bring them to the office to have them checked? Schedule f/u session in February to present ways we might improve patient adherence with inhalers. We don't have sufficient OP pulmonary rehab network • Does anyone use GADs for anything? I hear it is a useful	JH

TOPIC	DISCUSSION/QUESTIONS	QUESTIONS/ANSWERS/ACTION/ FOLLOW UP	WHO
		clinical tool	

February 2 Agenda
Custom Care
Silverlink Survey Announcement
COPD Inhaler Management
2016 Evaluation



Jonathan Harding, MD, Senior Medical Director, Senior Products, Tufts Health Plan