MEDICAL DIRECTOR MEETING – MINUTES

September 7, 2017

IDN GROUP MEMBERS PRESENT: Kim Ariyabuddhiphongs, John Barravecchio, Nancy Cibotti, Jatin Dave, Barbara Downey, Linda Doucette, Leonard Finn, Michelle Gochioco, Savitha Gowda, Harold Greenspan, Vinay Kumar, Dennis Markovitz, Denise Mayo, Michelle McGeachie, Kanu Patel, Marc Pifko, Roger Schutt, Pramodchandra Shah, Peter Sheckman, Joseph Taylor, Tina Waugh

Webinar: Bashir Bashiruddin, Ellyn Davis, Louis DiLillo, Robert Fraser, Douglas Gronda, William Medwid, Sara Nuciforo, Shawn Pawson

TOPIC	DISCUSSION/QUESTIONS	**QUESTIONS/ANSWERS/ACTION/ FOLLOW UP**	**WHO**
Review of August meeting	Best Practices in Managing Risk for Medicare Advantage population : Matt Chukwu and Tine Christensen Group Turnaround **Dr. Louis Di Lillo and Stacey Keogh** Silverlink Best Practices Panel Dr. Peter Sheckman and Brian Parillo Quality Profiles Dr. Jonathan Harding	Check these best practices against your own processes. Let us know ASAP if your group did not receive this report.	Group Medical Directors
Provider Dispute process	Group disputes would occur after someone in your group reviews the Paid Claims report [see next section] and identifies anomalies of claims that were paid that you believe should not have been paid, or are suspicious. Heather described the process and forms for both TMP and Commercial disputes, by the billing provider and by the group. Heather's dept. provides oversight; if you are not getting through using the channels presented, you can contact her. There should be a phone number to call to say: "This doesn't look right, please review. " Doctors don't have time to fill out long forms. Example: Called Provider Relations to report visits who were listed as "Referred," visiting a friend who billed as a psychologist; some claims were paid, some were not. Asked to	Use the process she outlined as your first attempt to resolve anomalies. Heather will share her email and phone number: 617.923.5807 heather_lawson@tufts-health.com Discuss with Claims dept. leadership	HL HL

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	fill out forms, doctors don't have time. If we fill out forms, please get back to us with a response What is the error rate for disputed claims?	 >1%	 HL
Paid Claims Reports	Dr. Harding asked, "Does each group have a process to review claims paid reports and deal with possibly inappropriately paid or charged claims?" A. Some do, some don't know. Comments re: usability of claims paid reports. • DRG description is not included. • Additional fields might facilitate room for the reporting of erroneous charges. Comment: What would help us to appeal would be correct coding: Different coded claims get paid at different amounts. Comment: Sometimes reviewer is not sure if this is wrong, but some claims look suspicious. Example: If a hernia billed as major abdominal surgery, it would be covered at $38,000 as compared to $3,000. Response: What we pay has nothing to do with what the hospital charges. Payment is based on the ICD10 and CPT codes submitted. When you are reviewing the claims paid report you won't know which codes were submitted and whether they are justified, unless you have access to the EMR or have personal knowledge of what occurred in the hospital. Group's focus for Paid claims report should be on referrals being sent out of group, use of inappropriate DME, services OOA that were emergency v. those that were referred. Gives leaders a feel for whether their PCPs are being good stewards of health care resources.	Please check to see who does this in your group. If no one, please assign this task. Heather will have conversation with Claims Team about the data elements, and about an electronic version of Claims Paid report instead of paper. Heather will work with Provider Relations to talk about updating the form and getting a voicemail line.	Group Medical Director HL/JH \ HL

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	If groups are reviewing DRGs as well on Claims paid reports, there will be some Duplication with DRG validation audits [below]. Jatin Dave suggestion: Small group of Medical directors review some cases from C claims paid report as small pilot to assess savings.		
DRG validation audits	Thousands of DRGs are reviewed reviewed by outside vendor: They review charts to determine if the codes submitted are justified by the documentation in the record. This is called DRG validation audits. There were questions re: the signals the vendor uses to select cases to review, how many are reviewed, what % of reviews result in a code retraction , what % are appealed what % are overturned on appeal. There were questions re: whether referrals from groups who detect suspicious DRGs on paid claims report, compared to what they know about what happened in the hospital, would supplement or merely duplicate Cotiviti's case finding process. What is the list of list of suspicious codes or DRGs? This group thought COPD exacerbation, pneumonia, congestive heart failure, urinary tract infection should be on the list.	Arrange a separate presentation about the DRG validation audit process at a future meeting. Ask Cotiviti if they could incorporate ad hoc referrals into their identification process.	JH DRG validation TMP contact

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	What percentage does vendor reject?		
Managing IP BH What happens when someone discharged?	Policy that every BH have a visit within a week of discharge with BH and PCP Q. What is the success rate of office rate of BH visits (Tufts well over 80%) vs PCP visits? Do you check to ascertain qualityof patient and PCP interaction? Often there is a good relationship with the PCP, and the member has never seen the BH staff before. It ought to be mandatory to see familiar PCP within 7 days, more effective than making an appointment with a BH stranger. SK: We do chart audits with high-volume BH facilities, measuring documentation of trainsitions of care. Brief follow-up and intervention (in person or by phone) following BH discharge:Chances of engaging in outpatient care triple 42% reduction in readmissions 53% reduction in all-cause mortality 91% reduction in completed suicide SAMSHA estimates an ROI on facilitated BH care transitions of 2- 2.5:1. TMP BH dept. support these transitions in the following ways: • For fee-for-service inpatient BH facilities the TMP BH team reviews and assists with discharge planning and post-inpatient follow-up care while the member is still hospitalized • For behavioral health Designated Facilities, we give the DF latitude to manage their care but are available to help them with discharge resources and	BH dept. will help you find a BH specialist. Dedicated BH queue with after hours coverage with a live voice. Call 800.208.9565. Other issues: Call Steve Kozak directly at 781.956.1548. If these processes are not happening on your group's BH discharges contact Steve.	SK

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	long lengths of stay • Chart audits of high-volume BH facilities; includes validation of coordination of care with PCPs • For non-delegated PCP groups, the TMP case management team follows up with the member shortly after discharge to manage the transition • For delegated PCP groups, the TMP BH team provides discharge summaries directly to the designed group contact as soon as the discharge is confirmed (usually the day-of or the day-after); this allows the PCP group to manage the transition Once TMP has ensured that the PCP group knows about the discharge, what can the group do to ensure an effective transition? A. Post discharge outreach consisting of: • verification of safety plan and crisis plan • condition education and self-management plan • assessment of independent living situation and needs • activation of psychosocial resources and supports • identification of and addressing barriers to adherence • coaching and care-planning to enhance motivation around adherence • medication reconciliation and education • ensure PCP office visit is arranged and accessible • plan follow-up calls as indicated B. Ensure patient has spoken to new provider before first visit C. Send patient records over to provider before first visit D. Have a rapid referral protocol (appointment 24-48 hours post ER or discharge) E. After the initial follow-up contact, maintain a series of "caring contacts" (post cards, letters, email, text messages, phone calls, home visits) F. Offer BH services within the primary care setting G. Speak to the BH provider periodically H. Develop a form to use to send a written post-discharge summary to each patient after the first follow-up contact, listing out next steps, warning signs	Ensure these processes are in place with your group.	Group Medical Director

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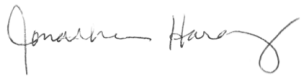
	to recognize, what to do in an emergency, and other elements of the care plan discussed Groups have noticed an uptick in BH costs. Steve reports that Unit cost has gone up 10 % and utilization up 10 %. Seen increase in substance abuse, now becoming a driver of costs. There is now access to treatment that wasn't previously covered. Increase in those with dementia who are difficult to move into next living arrangement		
AEP Awareness	Peter Lacomb presented strategies for groups that wish to grow their TMP membership. AEP [10/15-12/7] is the main opportunity to gain members. Think about notifying 64 year olds about TMP: Letter to avoid last-minute rush Reach out to those around that age in Commercial. Inpactful when coming from PCP office. <u>Staff education</u> Email from group leadership Invite TMP to practice meetings (PCP, office managers, etc.) Reminder to staff about 5-Star continuous enrollment opportunity <u>Patient education</u> Signage in office AEP announcement on website/social media Patient email Provider office marketing materials Medicare 101 sessions; mail invitations out to patient base.		
Future meetings	Reminder: The November meeting is at MMS and is on the SECOND Thursday, 11/9, rather than the usual first thursday		

October Agenda

Clinovations: EMR messages to improve risk adjustment, quality, and cost
October HEDIS profiles
Why are readmissions still so high?
Trend drivers



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