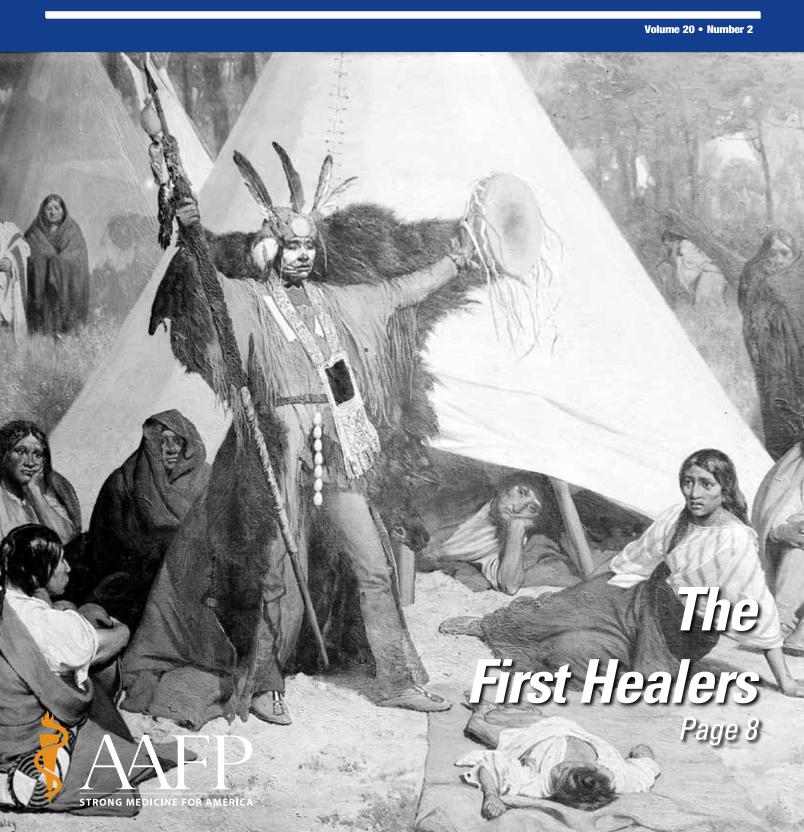
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## Arkansas Family Physician

The Arkansas Family Physician is the official magazine of the Arkansas Academy of Family Physicians

Managing Editor
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Dear Academy Member,

A report of the financial condition for year end 2015 of the AR AFP is provided as follows. Total assets are in the amount of \$727,542, a net income for the year of \$15,945. Of the income received, \$209,521. was membership dues: \$106,558. was annual scientific assembly registration, booth rentals and grants with the remainder of income being CME partnerships with Atlantic Health Partners, Core Content Review and CME



home study fees. Expense was in the amount of \$317,750, with the largest amount going to salaries and employee benefits; Annual Scientific Assembly, Office Rent and Equipment: travel of officers and directors to national meetings of the AAFP and the remainder was expenses less than \$6,000. in each line item for legislative, office insurance, supplies, postage, telephones, fax and internet and web site. The financial reports will be provided at the upcoming March board meeting. If you would like a copy, contact our office.

Plans are proceeding for the Academy's 69th Annual Scientific Assembly August 4-6 at Embassy Suites in Little Rock. A Pre Assembly program will be held the afternoon of Wednesday August 3. The program will be mailed in a couple of months and we do hope you will mark your calendars to attend! The Embassy offers free parking onsite, all rooms are suites and we hope you will enjoy a new site for another great CME event and opportunity to interact with you colleagues.

As we close the books on 2015, we still are assisting members in reporting CME for re-election for the period ending 12/31/15. If you are one of the 30 members who have received a letter that you are due hours for re-election purposes, please call us to see if we may assist you. These hours must be reported in March to retain membership. Our dues collections are running behind with 244 members in arrears on payment of membership dues. Please feel free to call us or the AAFP if you have questions.

The slate of officers and directors for the coming year will be presented in the next AFP Journal and the Annual Scientific Assembly Program and registration information will be included as well!

We urge you to become involved in the AR AFP. Give us a call at 501-223-2272 or email us at arafp@sbcglobal.net and let us know your interest.

Sincerely,

Carla Coleman

**Executive Vice President** 

On the cover: "The Medicine Man" licensed under Creative Commons Attribution 4.0 International License and free to share to but "not in any way that suggests an endorsement or use of this article". See Page 8 and 9 written by Dr. Sam Taggart of Benton, a retired Family Physician who has provided two previous articles for this publication.

## AHRQ Health Literacy Modules Available for Continuing Education (CE) and Maintenance of Certification (MOC) Credit.

Physicians and nurses can earn CE credits while learning about the challenges in caring for patients with low health literacy as well as strategies to improve overall patient communication and care. OptumHealth Education is issuing continuing education credit for taking the AHRQ-developed Health Literacy Knowledge Self-Assessment. No fees are charged for the two CE activities:

- 1 An Updated Overview of Health Literacy (https://www.optumhealtheducation.com/health-literacy-activity1), and
- 2 Improving Health Literacy by Improving Communication Skills (https://www.optumhealtheducation.com/wellness/health-literacy-activity2).

Contact moreinfo@optumhealtheducation.com with questions. Pediatricians and family physicians can earn credit for re-certification (MOC Part 2) as well as CE by taking the Health Literacy Knowledge Self-Assessment through the American Board of Pediatrics and the American Academy of Family Physicians, respectively.

To learn about AHRQ's tools to address health literacy, visit Health Literacy Topics at: http://www.ahrq.gov/health-care-information/topics/topic-health-literacy.html

To find out about other free AHRQ continuing education opportunities, go to: http://www.ahrq.gov/professionals/education/continuing-ed/index.html

#### PRINCIPAL INVESTIGATORS NEEDED

A Multispecialty Clinical Drug Research Group seeks Physicians working in Central Arkansas who are interested in acting as Principal Investigator or Sub-Investigator in clinical drug trials.

Qualifications include Current Medical License to practice in the State of Arkansas: Board Certification and available to see patients at Research Center in Little Rock. Additional information can be obtained by contacting Anita at 501 725 5834 or Sherry at 501 224-6727

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### Zoster Rates Among Arkansas Family Physicians

By: Julia Lyon M4, and Jack Lyon MD

Previous studies have postulated a decreased incidence of shingles in people exposed to children with varicella through their work.<sup>1,2</sup> These papers imply that those in the health care field, with higher rates of exposure to those with varicella, would be less likely to develop shingles than their non-healthcare peers.

In an effort to determine whether Arkansas family physicians were protected from shingles by their exposure to children with varicella, we conducted a survey of Arkansas family physicians and Arkansas lawyers at their respective educational meetings this summer.

The lawyers were intended to provide a control group reasonably matched for age, race, sex, and education level. We asked survey participants to provide their age and whether they had ever had shingles.

In total, we surveyed 87 family physicians and 61 lawyers in Arkansas. A cross-sectional study for the American Board of Family Medicine recently reported the prevalence of shingles at 12.8%.<sup>3</sup> Among our survey participants the prevalence of shingles was 16.09% (+/- 7.38, CI 95%) in the physician group and 8.20% (+/-6.84, CI 95%) in the lawyer group. The rates in the two groups are not different (p=0.15).

Our study was limited by several factors. We had a small sample size. Also, in order to keep the survey brief, we made assumptions about the characteristics of both groups when using the lawyer group as a control. The average age of the physicians polled was 55, but the average

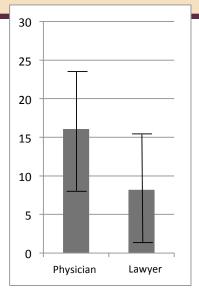


Figure 1: Prevalence of Shingles among Our Survey Participants

age in the lawyer group was only 48. It is known that herpes zoster incidence increases with age.<sup>4</sup>

Although our survey was limited, we found no protective effect for the physicians. We conclude that it is unlikely that the prevalence of shingles among Arkansas family physicians is less than the prevalence among Arkansas lawyers.

We feel that Arkansas family physicians should not assume that they are protected from shingles by exposure to the virus at their work; they should receive the herpes zoster vaccine as recommended.

#### REFERENCES

- 1. Thomas, Sara L; Wheeler, Jeremy G; Hall, Andrew J. Contacts with herpes or with children and protection against herpes zoster in adults: a case-control study. *The Lancet* August 2002. 682-678
- 2. Salleras, M; et al. Contacts with children and young people and adult risk of suffering herpes zoster. *Vaccine*. 2011. Vol. 29, 7602-7605
- 3. Lee, Tae Joon; et al. Herpes Zoster Knowledge, Prevalence, and Vaccination Rate by Race. *Journal of the American Board of Family Medicine*. Jan-Feb 2013. Vol 26, 45-51
- 4. Yawn, B; et al. A Population-Based Study of the Incidence and Complication Rates of Herpes Zoster Before Zoster Vaccine Introduction. *Mayo Clinic Proceedings*. Nov 2007. Vol 82. 1341-9



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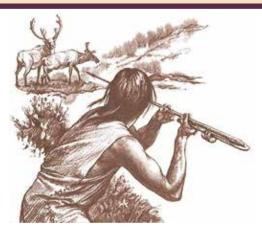
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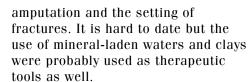


#### Throughout the Archaic Period **(8500BCE-600BCE)** there were small numbers of humans living in the Central Mississippi Valley, Ozark and Ouachita mountains. For most of this time these small bands of people were egalitarian with each man an encyclopedia of survival. By the Late Archaic period population numbers had begun to increase, sedentism and agriculture with trade were emerging. It is reasonable to speculate that the first people to identify themselves as full-time healers evolved in this same timeframe. It was during this time that stone effigies and tools used by healers around the world began to appear in the Mississippi and Ohio

## The First Healers

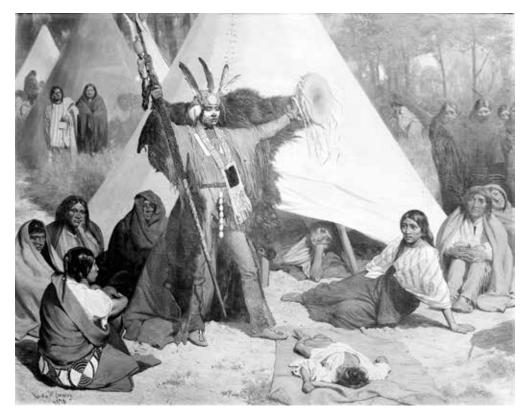
River valleys. Archeological artifacts such as a hollowed out human femur thought to have been used as a sucking or blowing pipe, stone smoking pipes, effigies of humans taking on the form of protective animals are all indications of efforts to intervene in health and disease.

With no written records it is difficult to be certain about timing but by the mid-17th century it is clear that the indigenous people of the people of the Central Mississippi Valley had developed a complex pharmacopeia and a number of surgical/orthopedic procedures that evolved over time. They had at their disposal a variety of biologic simples (herbs) and crude surgical techniques such as the opening of carbuncles, scarification of infected wounds, trepanation,

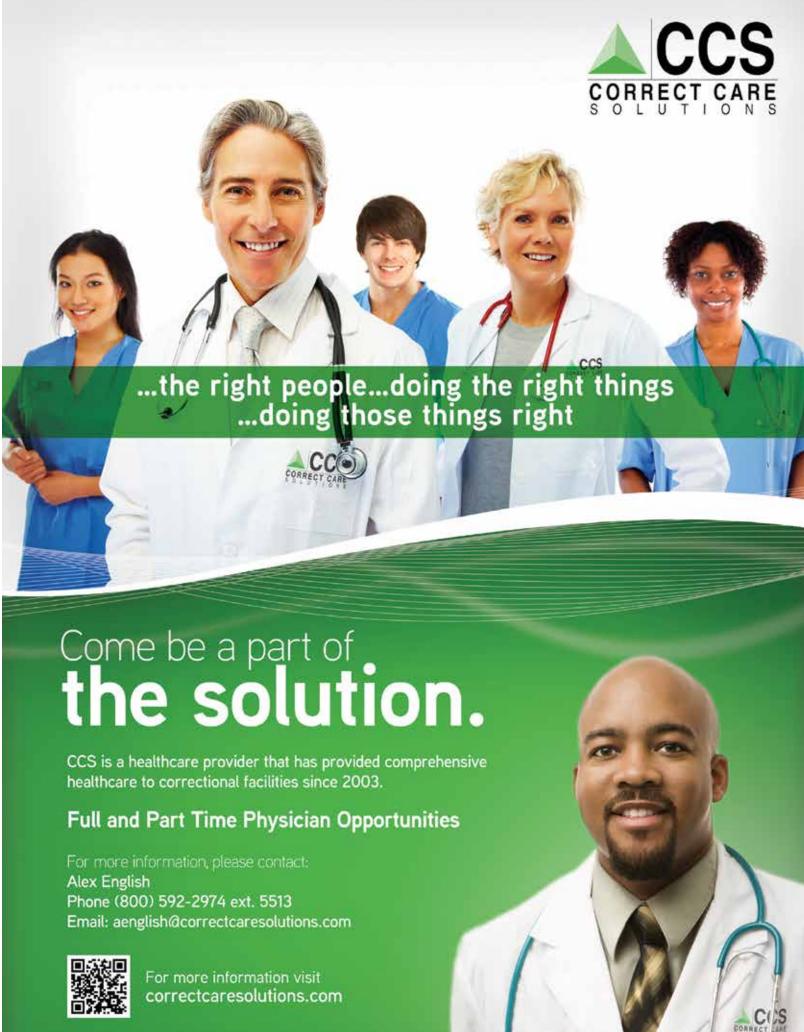


With the arrival of the Europeans in the 15th century a number of culturally prerogative terms were used to describe the work of these early healers such as shaman, witch doctors, jugglers, and savage medicine men suggesting that their approaches were dramatically different and inferior to that of their European cousins. A careful examination of the various approaches to the health of the individual or the community reveals that most of the systems of care had more in common than either admitted and they would eventually borrow heavily from each other.

Morris Arnold's book. Colonial Arkansas 1686-1804, contains an excellent discussion of French and Spanish health professionals in Arkansas during this era. In 1682 LaSalle had a surgeon during his sojourn in Arkansas. Among the small contingent of the Law Concession that actually made it to Arkansas in 1721 there was an apothecary and a surgeon. In 1748 a gentleman by the name of Lefevre served as the post surgeon at Arkansas Post: he was also described as a barber and tailor. In the early 1750's the French built a small fort at Arkansas Post and among the buildings was the description of a small hospital. Like most remote hospitals in this time these were small cabins with a cot designed to separate the sickest patients as they died. Early during the Spanish reign in Louisiana François Menard was listed



continued on page 10



#### continued from page 8

as the Post Surgeon; by 1770 he had resigned and spent the rest of his life as an active business man in the area. Interestingly, some of his descendants continue to live in Nady, Arkansas, an un-incorporated community, near the Menard-Hodges Indians Mounds and the former Arkansas Post.

With the Louisiana Purchase in 1803, and the beginning of the modern era, the one name that stands out is Dr. Peyton Pitman of Randolph County in Northeast Arkansas. Most of the new immigrants entering Arkansas did so along the Old Southwest Trail. In 1801 William Hix established ferry across the Current River and called it the "The Gateway to Arkansas." Sometime during the following ten years Dr. Peyton Pitman purchased the ferry and renamed it Pitman's Ferry. For forty years he was active in politics and the practice of medicine.



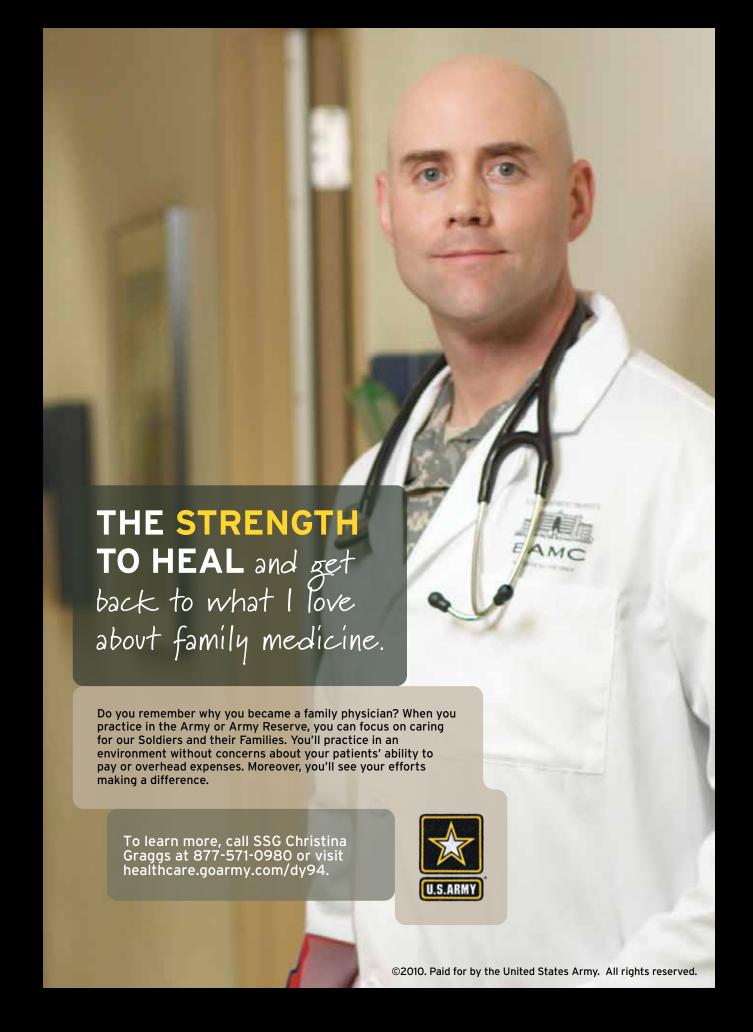
#### **Suggested Reading:**

Sabo, Geroge Indians of Arkansas: Archeology, History and Culture, Arkansas Archeological Survey Website, 2007 Morse, Dan A Human Femur Tube from Arkansas, Arkansas Archeologist Vol. 16.17.18:42-44

Arnold, Morris Colonial Arkansas 1686-1804 A Social and Cultural History, 1991, University of Arkansas Press

NorthwestHealth.com





### Guide to Submitting 2015 Physician Quality Reporting System Data

The Physician Quality Reporting System (PQRS) is applicable to all eligible professionals (i.e., physicians, practitioners and therapists) who bill Medicare Part B services. Hospitals and critical access hospitals performing billing method II must report PQRS data to avoid payment adjustment penalties. All eligible professionals who do not meet the criteria for satisfactory reporting or participating for 2015 PQRS will be subject to the 2017 negative payment adjustment with no exceptions.

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the 2015 PQRS data submission time frames:

- Electronic Health Record (EHR) Direct or Data Submission Vendor (Quality Reporting Document Architecture (QRDA) I or III) – Jan. 1, 2016 – Feb. 29, 2016
- Qualified clinical data registries (QCDRs) (QRDA III) Jan. 1, 2016 – Feb. 29, 2016
- Group practice reporting option Web Interface Jan. 18, 2016 March 11, 2016
- Qualified registries (Registry XML) Jan. 1, 2016 March 31, 2016 (Note, check the submission deadlines for specific registries.)
- QCDRs (QCDR XML) Jan. 1, 2016 March 31, 2016

Submission ends at 8 p.m. ET on the end date listed above for the specified time frames. An Enterprise Identity Management (EIDM) account with the "Submitter Role" is required for these PQRS data submission methods. Please see the EIDM System Toolkit for additional information: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/TheEIDMSystemToolkit.pdf

Eligible professionals who do not report quality measure data to meet the 2015 PQRS requirements will be subject to a negative PQRS payment adjustment on all Medicare Part B Physician Fee Schedule services rendered in 2017.

#### Quick start reporting

- Identify the Medicare Part B services and the providers linked to those services. An EHR or practice management system should be capable of compiling a list of Medicare Part B patients by provider.
- 2. **Identify a registry that will assist you with timely reporting.** If you are just getting started, a registry

is your best option to avoid the adjustment. There is a cost involved, and it is a manual process. Below are two registries different medical associations support:

- Covisint: http://www.covisint.com/healthcare-pgrs
- PQRS Wizard: https://pqrswizard.com/

Each registry has links on its website so that you can review individual measures and group measures. If you need additional information or specifics, you may look at CMS' PQRS 2015 submission page:

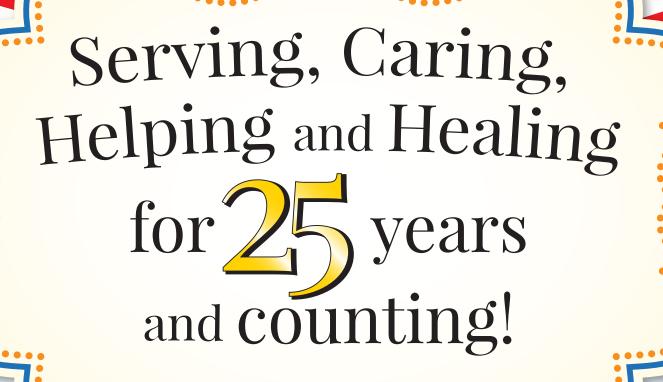
https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/pqrs/measurescodes.html

#### Determine the best approach for reporting

a. **Individual:** Eligible professionals may report individually. In order to earn the incentive, eligible professionals must report on nine measures that cross three National Quality Strategy Domains where 50 percent or more of the patients are in the Medicare Part B billing population. Measures with "0" percent performance rates are not counted. At least one cross-cutting measure must be reported for those individual providers with face-to-face encounters.

**To avoid the financial adjustment**, three measures for one National Quality Strategy Domain will suffice. However, eligible professionals who report between one and eight measures for fewer than three National Quality Domains will be subject to the Measure-Applicability Validation process: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/MAV\_CBT\_508.pdf

- b. **Group measures:** An incentive is possible if at least one registry measure group is comprised of 20 patients. The majority of the patients, which would equal 11, must be Medicare Part B fee-for-service patients. The group can be reported through 12 months (Jan. 1 Dec. 31, 2015) or for six consecutive months. Group measure encounter codes are largely office based, however there are a few codes which may work that are EHR based (Example: Diabetes Measures Group).
- **c. General PQRS Measures:** The table below lists some common PQRS measures that can be used universally by any provider. Please review emergency department services for additional reporting measures.





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Туре	Domain	PQRS #	Measure
Generic	Communication/Care Coordination	47	Advance Care Plan
	Community/Population Health	111	Pneumonia vaccine status in older adults
	Patient Safety	130	Documentation of Current Medications in the Medical Record
	Community/Population Health	131	Pain Assessment and Follow up

d. 2015 Specialty Measure Code Sets: The Measures Codes Web page contains information about PQRS quality measures, including detailed specifications and related release notes for the individual PQRS quality measures and measures groups for specialists. Download a zip file that contains a list of 2015 specialty measure sets: http://www.cms.gov/apps/ama/license.asp?file=/PQRS/Downloads/2015-Specialty-Measure-Sets.zip. (Zip file)

There are a number of measures applicable to all specialties. Visit the CMS Measures Codes Web page for more information: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html

#### Join the Value-Based Improvement and Outcomes Network

All providers are encouraged to join our network. To join, go to **www.tmfqin.org** and click the link in the upper right hand corner to create an account.

For additional help, call the Quality/Net Help Desk: 1-866-288-8912 (7 a.m. – 7 p.m. ET).

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#### Human Papillomavirus (HPV) Vaccination Report: Arkansas

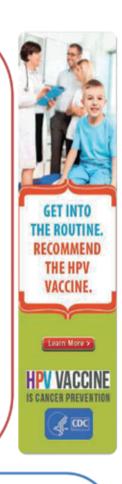
Working Together to Reach National Goals for HPV Vaccination

January 2016

#### 2016: The Year of Preventing Cancer Together!

The new year brings a new start and fresh opportunities to prioritize HPV vaccination. **Now** is the time to make changes and minimize missed opportunities! There are many effective ways to increase HPV vaccine coverage rates:

- Talk about HPV vaccination in terms of cancer prevention
- Avoid missed opportunities through strategies including recommending HPV vaccination the same way and on the same day as other vaccines
- Learn how to communicate successfully about HPV vaccination. Tips for answering
  questions parents may have can be found at: <a href="http://www.cdc.gov/hpv/hcp/answering-questions.html">http://www.cdc.gov/hpv/hcp/answering-questions.html</a>
- Use adolescent vaccination messaging for practice hold lines. Consider trying these five sample messages, available at: <a href="http://www.cdc.gov/vaccines/who/teens/for-hcp/adolescent-messaging.html">http://www.cdc.gov/vaccines/who/teens/for-hcp/adolescent-messaging.html</a>
- Identify HPV vaccination champions to help motivate and educate others
- Conduct or participate in AFIX (Assessment, Feedback, Incentives, and eXchange) visits.
   For more information on AFIX, visit CDC's website:
   http://www.cdc.gov/vaccines/programs/afix/index.html?s cid=cs 748
- Collaborate with partners to identify opportunities to work together to increase HPV vaccination
- Learn more about national initiatives, such as the National HPV Vaccination Roundtable.
   More information about Roundtable meetings is available at:
   <a href="http://www.cancer.org/healthy/informationforhealthcareprofessionals/nationalhpvvacci">http://www.cancer.org/healthy/informationforhealthcareprofessionals/nationalhpvvacci</a>
   nationroundtable/index





#### Resources and Materials

- CDC's learning module for gynecological cancer is available for CME: <a href="http://www.cdc.gov/cancer/knowledge/provider-education/index.htm">http://www.cdc.gov/cancer/knowledge/provider-education/index.htm</a>
- The FDA licensure of 9-valent HPV vaccine now includes males up to age 26. Learn more about this here: http://www.cdc.gov/hpv/downloads/9vhpv-fda.pdf
- Visit CDC's updated HPV Web Portal, www.cdc.gov/hpv, to find more resources such as:
  - o Immunization Safety Office Safety factsheets
  - Clinician factsheets
  - Materials for partners and programs
- For more information on cancer resources, visit: www.cdc.gov/cancer





## SHARE an Essential Component of Clinically Integrated Networks

**Emerging Health Information** Exchange (HIE) technology is opening up new avenues of securely exchanging private health data in Arkansas and across the country. Arkansas's HIE is SHARE, the State Health Alliance for Records Exchange, which is operated by the Office of Health Information Technology (OHIT). Since 2011, SHARE has become a fully functioning HIE and is capable of enabling realtime electronic exchange of health information between different types of health care providers. A Clinically Integrated Network (CIN) is a term that describes the integration of healthcare delivery sites and clinical information.

Clinical integration permits the coordination of care across a continuum of services to improve the value of the care provided and



includes preventive and outpatient care, post-acute care including skilled nursing, rehabilitation, long term care, behavioral health and home health services. Many healthcare



hospitals and clinicians in Arkansas are preparing for the reality of a risk sharing environment where hospitals and clinician's deliver higher quality and more efficient care in real-time in order to participate in cost savings. Hospitals in Arkansas are teaming up with SHARE to connect their referral sources including skilled nursing facilities, rehabilitation centers, long-term post-acute care facilities as well as behavioral health and home health agencies.\*

As hospitals navigate the challenges of risk sharing, the use of SHARE can help connect facilities in their CIN. Using SHARE allows all facilities, even if they are connected to different EMR systems to send secure messages, use the web-based portal known as the Virtual Health Record (VHR) or fully integrate with the HIE.

By identifying referral partners, hospitals and clinics connected with SHARE benefit from:

- Assistance in meeting their goals for the Meaningful Use Transition of Care metric;
- Reduced readmissions by providing proactive, patient centered post-discharge care;
- Connectivity with affiliated or non-owned referral practices.

CIN's provide the opportunity to



increase quality, reduce cost and position providers to be empowered to effectively manage utilization and the health of Arkansas populations in the future. SHARE demonstrates a value to the CIN by establishing mechanisms to hospitals and clinicians to monitor and control utilization of healthcare services that are designed to ensure quality of care. Establishing a network of providers throughout Arkansas enables enhanced coordination of care that provides a much needed platform to support care redesign and performance improvement initiatives.

**Coordination and Collaboration Use Case:** Rehabilitative Services for Persons with Mental Illness (RSPMI) and Inpatient Psychiatric Providers participated in a questionnaire developed by Beacon Health Options that gathered information on best practices and barriers to follow up care post hospitalization for adult psychiatric care. Based on the results of these questionnaires, Beacon developed a White Paper, titled *Perspectives* on Acute Hospitalization Aftercare: Questionnaire Responses from Arkansas' Behavioral Health Providers. The results of this study identified communication across levels of care as one barrier to follow up treatment.

Beacon Health Options has developed a partnership with the Arkansas Office of Health Information Technology (OHIT) to assist providers in using secured messaging through State Health Alliance for Records Exchange (SHARE; the State Health Information Exchange) that can improve communication regarding beneficiaries as they transition from one provider to another, discharge from inpatient care or for providers coordinating outpatient services.

Whether hospitals and clinicians need to focus on quality improvement, strengthened physician relationships, increased market share or improved risk sharing strategies, SHARE offers the technology and processes to enhance the hospital CIN. With 35 hospitals and over 400 provider

practices across the state currently using SHARE to make critical health information accessible when and where needed in a HIPAA-compliant environment, connection to SHARE will bring more value to your hospital than ever before.

#### **About SHARE**

The Arkansas State Health Alliance for Records Exchange (SHARE) has over 35 hospitals and 400 practices connected. SHARE is a secure, electronic system that allows health care providers, health services professionals and public health authorities in Arkansas to exchange accurate patient medical information in real-time. Organizations that participate in SHARE serve more than 1.6 million patients in Arkansas. For more information, visit www. SHAREArkansas.com.

\*Information and associated activities supported by funds provided by the Office of the National Coordinator for Health IT, Department of Health and Human Services, Grant Number 90IX0009/01-00.



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Now heading into the second year of implementation, Arkansas's PCMH model is one of the largest of its kind in the U.S. The state's PCMH model is designed to support primary care providers with new tools and resources in an effort to deliver high-quality primary care that is patient-centered and team-based, with an emphasis on care coordination and proactive preventive care. Goals of the PCMH program are to help patients stay healthy, increase the quality of care they receive, and reduce costs. PCMH transformation has been underway in Arkansas since October 2012, with 69 practices initially selected to participate in the Comprehensive Primary Care (CPC) initiative—a multi-payer PCMH program sponsored by the Center for Medicare and Medicaid Innovation (CMMI).<sup>1</sup> Building on successes and lessons learned from the CPC initiative. wave-two expansion of the state's Medicaid-led PCMH model began in January 2014. While the first wave of the state's program was predominately comprised of pediatric practices, subsequent enrollment periods and multi-payer participation have expanded the range of participation. With more providers delivering care under the PCMH model. Arkansas has made substantial progress towards the goal of having all of the state's citizens receiving comprehensive primary care under the PCMH model.

This year, for the first time, detailed information about system-wide cost and quality impacts of the PCMH model are available. After only one year of implementation, the state's model has demonstrated improvements in a range of quality indicators, while saving the state approximately \$34 million and generating approximately \$5 million in shared savings distributed to eligible providers. At the same time,

the Medicare-led CPC initiative has continued to support many of the state's primary care providers in delivering high-quality and efficient care. While this report focuses on the state's own multi-payer PCMH model, recent CPC program outcomes are available and have been detailed in separate reports.<sup>2</sup> Participating PCMH practices receive up-front payments that enable them to more proactively meet patient needs and practice transformation milestones, which include providing extended office hours and 24/7 access to medical assistance. In addition to financial support for care coordination and practice transformation in the form of per-member, per-month (PMPM) payments, PCMHs can receive upside gain-sharing based on either performance improvements or high performance compared to statewide averages. Quality metrics must be met under both options.

\*A detailed PCMH case study of Dr. Lonnie Robinson and Regional Family Medicine is included as appendix A in this report.

#### Arkansas PCMH Progress Overview Enrollment

- 136 PCMHs are currently enrolledg in the state's Medicaidled, multi-payer PCMH program. Approximately twelve of these practices are also enrolled in the CPC initiative.
- Approximately 780 primary care providers are participating, representing 69 percent of all eligible providers.
- Approximately 331K Medicaid beneficiaries are covered, representing 82 percent of all eligible Medicaid beneficiaries.
- **58 practices** are currently enrolled in the Medicare-led CPC initiative.
- Multi-payer participation in either

the CPC initiative or the Arkansas PCMH program includes Medicaid, Medicare, AR BCBS, QC, United Healthcare, Centene/Ambetter, Humana, Arkansas State and Public School Employee Benefits Plan, Federal Employee Plan, Walmart, and Mercy Accountable Care Organization (Medicare shared savings program accountable care organization (ACO) in alignment with PCMH).

- As of 2015, QHPs operating on the Health Insurance Marketplace are required to participate in PCMH as mandated through the state's Health Care Independence Act, known as the Private Option.
- Preliminary 2016 enrollment totals for Medicaid indicate sustained momentum, with approximately 188 PCMHs enrolled, including 47 new PCMHs.

#### **Practice Achievements**

In 2014, the vast majority of practices met transformation milestones and either improved or maintained prior-year levels for approximately three-fourths of PCMH quality metrics. Quality metrics include: Increased pediatric wellness visits, Hemoglobin A1c testing for diabetics, breast cancer screenings, improved ADHD treatment management, and thyroid medication management.

#### **Cost Savings**

The state realized \$34.3 million in savings because of the PCMH program, of which \$12.1 million went towards care coordination payments to providers. The remaining \$22.2 million in net cost avoidance was shared between the state and 19 provider groups who met both quality and cost savings requirements. Shared savings checks were issued in October 2015.

with several clinics receiving over \$100,000.

In 2014, enrolled practices experienced a cost decrease of 1.2 percent, exceeding both the 2.6 percent benchmark trend increase and the 0.6 percent cost growth of non-enrolled practices.

Data provided by Arkansas DHS, pulled from PCMH Q4 reporting as of October, 2015. Includes practices that enrolled for 1/1/14, 7/1/14, and 1/1/15 start dates.

Practices are enrolled individually in the CPC initiative and current enrollment numbers are tracked by the Centers for Medicaid and Medicare Services: http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/Arkansas.html.

#### **Proposed Performance Target**

Performance target requirements for a proportion of hypertensive and diabetic individuals under clinical control are proposed to explicitly link population health needs and clinical performance expectations.

#### **Commercial Payer PCMH Support**

Beginning in 2015, AR BCBS, QC, and CAM offered financial support to practices enrolled in the state's PCMH program. United Healthcare will join in 2016. During the fall of 2015, AR BCBS and CAM held open enrollment for practices to sign up for PCMH program support. In addition to offering support to those PCMHs enrolled through Arkansas Medicaid, both AR BCBS and CAM have extended their support to include those practices that are certified as PCMHs by the National Committee for Ouality Assurance (NCOA). For 2016, QC and United Healthcare will offer support to those PCMHs enrolled via Arkansas Medicaid. Dual-specialized needs managed care plans are also required by regulation to participate in the state PCMH program. PCMH beneficiary attribution is still underway for the commercial carriers, but estimates for the number of attributed beneficiaries for each paver are:

 Arkansas Blue Cross Blue Shield: 157.000 attributed beneficiaries

- QualChoice: 4,300 attributed beneficiaries
- Centene / Ambetter: 44,000 eligible beneficiaries (attribution totals pending)
- United Healthcare: United is offering a qualified health plan (QHP) on the Health Insurance Exchange and will attribute members in 2016

In an effort to improve overall population health management and support the PCMH model, AR BCBS conducted a primary care provider attribution initiative for all beneficiaries in their fully-insured plans. In a process that spanned most of 2015. AR BCBS identified which beneficiaries had not selected a primary care provider. Those beneficiaries were subsequently assigned a primary care provider in their geographic proximity. These newly-attributed beneficiaries were then notified by AR BCBS of their assigned primary care provider. Beneficiaries are free to select a different primary care provider at any time. This process will allow AR BCBS to accurately track progress of population health management and quality metric outcomes across their enrolled PCMH practices.

#### **Provider Spotlight:**

Dr. Lonnie Robinson\*

"We formed a PCMH transformation team early in the process and everyone wanted to be on the team. Empowering our staff through the PCMH model has been very helpful. In the past our model was very physician-centric ... now we are all taking care of the patients as a team." Dr. Lonnie Robinson of Regional Family Medicine

Practice Accomplishments Include:

- 9% reduction in inpatient admissions
- 24/7 live voice access to care and improved patient communication
- Improved staff engagement and job satisfaction

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#### AAFP NRN Study Sheds Light on Asthma Treatment in Black Adults

■ No Difference Seen in Adding Anticholinergic vs. LABAs to Inhaled Corticosteroids

February 02, 2016 11:46 am Chris Crawford



Black adults in the United States have two times the mortality rate from asthma complications than do white patients, a difference that is at least partly due to genetics. So optimizing treatment of asthma in this population is critically important.

That's why the AAFP National Research Network collaborated with a number of organizations, including Brigham and Women's Hospital and the Harvard Clinical Research Institute in Boston and Olmsted Medical Center in Rochester, Minn., on a study published in *JAMA: the Journal of the American Medical Association(jama. jamanetwork.com)* that examined treatment options for black adults with asthma, as well as whether a particular genetic variation could be linked to treatment response.

Researchers found that among black adults with asthma who were treated with inhaled corticosteroids (ICS), adding a longacting beta agonist (LABA) didn't improve time to asthma exacerbation compared with adding tiotropium (Spiriva). In addition, allelic variation at the Arg16Gly locus of the beta2-adrenergic receptor (*ADRB2*) gene was not shown to be associated with response to treatment.

Previous research has suggested that Arg16Gly *ADRB2* allelic variation might be associated with higher rates of adverse outcomes when LABAs are used for asthma treatment, particularly in black patients.

Wilson Pace, M.D., a co-investigator on the project and principal investigator for the AAFP, told *AAFP News*, "We proved that this alternative medication works as well as beta agonists but not better. African Americans who took the trial drug versus the other did just as well."

The multisite, open-label, randomized clinical trial was conducted from March 2011 through July 2013 and included 1,070 black adults in the United States with moderate to severe asthma who were eligible for or already receiving step 3 or step 4 combination therapy as defined by National Heart, Lung and Blood Institute guidelines (www.nhlbi.nih.gov). Of that total, 532 patients were assigned to tiotropium and ICS therapy, and 538 patients were assigned to LABA and ICS therapy.

Specifically, patients received ICS treatment plus either daily tiotropium or twice daily LABAs. All patients were genotyped, completed monthly questionnaires and visited with researchers at baseline and again one, six, 12 and 18 months later.

Aside from being confined to a single racial group, study limitations included the fact that it was an open-label study that was not placebo-controlled. Patients' asthma status also was based on physician diagnosis with no required objective testing, as is common in community practice.

In addition, the population in this trial had a relatively high treatment discontinuation rate (31 percent to 35 percent) and a relatively poor adherence rate (60 percent) to medications. However, that adherence rate is comparable with published "real-world" asthma medication adherence rates of 30 percent to 60 percent.

Three deaths occurred during the trial, Pace noted, two of which were related to asthma events and one that was attributable to medication nonadherence.

"It was somewhat concerning that all of the deaths happened in the group using tiotropium and ICS treatment," he said.

Pace said no previous study of this size had examined how genetic variances among blacks affected their asthma rates. He added that this study was among information the FDA considered when the agency expanded the indications for tiotropium to include asthma treatment this past September. Previously, it was indicated only for treatment of chronic obstructive pulmonary disease.

#### Latest Published Evidence Finds Positive Outcomes Associated with Comprehensive Primary Care

■ As federal government redefines Medicare payments, health care experts discuss findings from new report on patient-centered medical home initiatives that control costs and improve quality

February 2, 2016 (WASHINGTON, DC)

Today at a briefing on Capitol Hill hosted by the bipartisan Congressional Primary Care Caucus, the Patient-Centered Primary Care Collaborative (PCPCC) unveiled its latest report highlighting new evidence that links the patient-centered medical home (PCMH) with lower costs and improved health care quality. "The Patient-Centered Medical Home's Impact on Cost and Quality: Annual Review of Evidence 2014-2015" highlights 30 primary care PCMH initiatives from around the country that measured cost and utilization of services. and includes an analysis of the findings. The report also describes the payment model for each initiative and the implications of Medicare payment reform. Does the patient-centered medical home work? The latest research demonstrates that the PCMH – or comprehensive primary care - can control costs and promote the right care," said Marci Nielsen, PhD, MPH, CEO of the PCPCC and lead author of the report. "The medical homes that have been around the longest showed the most improvement. And those that participated in multi-payer collaboratives – where payers and providers align payment models and performance measures – showed the most impressive costs and utilization outcomes. These are

important lessons as we implement federal payment reform: investments take time, sufficient resources, and collaboration to pay off."

The fifth annual PCPCC report, published with support from the Milbank Memorial Fund, reviewed 17 peer-reviewed studies, 4 state government evaluations, 7 industry reports, and 3 independent evaluations of large federal PCMH initiatives, all published between October 2014 and November 2015. Panelists at the Capitol Hill briefing discussed the findings in light of the federal government's forthcoming definition and requirements for status as a

PCMH, which is in progress right now and will influence future enhanced Medicare payments. "The question is not whether we have to transform primary care, but how," said Christopher F. Koller, president of the Milbank Memorial Fund. "The evidence continues to build that a high performing. patient-centered medical home – especially when supported by multiple, committed and aligned payers – is the foundation for a better performing health care system. The findings in

this year's evidence report are particularly timely as Medicare's participation in the multi-payer projects is scheduled to conclude at the end of 2016."

"This year's PCPCC annual evidence report highlights several Blue Cross and Blue Shield (BCBS) companies that are working alongside health care providers to help patients get healthy faster and stay healthy longer," said Alissa Fox, senior vice president of the Office of Policy and Representation at the Blue Cross Blue Shield Association. "By investing in primary care and putting the patient at the center of their care, these innovative programs are improving health, decreasing hospital admissions and emergency room visits and reducing avoidable health care costs." The new report also highlights the critical need to assess the value of the PCMH from the perspective of patients, providers, and payers. While the goals or attributes for PCMH practices are often similar, the PCMH model is not "one size fits all." PCMH practices differ in terms of

their implementation, measurement, and performance, and the terms "medical home" and "PCMH" are not well understood by the public.

"Our findings should help solidify support for investing in primary care. It's the smart thing to do, but it isn't simple," said co-author Len Nichols, PhD, an economist and director of the Center for Health Policy and Research at George Mason University. "The push for value-based purchasing by the Centers for Medicare and Medicaid Services and Congressional passage of the Medicare Access and CHIP Reauthorization Act

#### SNAPSHOT OF THE EVIDENCE



(MACRA) are immensely important steps in the right direction to scale and spread the PCMH. But we also need to know which components of the PCMH matter most. Better defining the medical home – with clear measures to implement, recognize, and evaluate it – will help explain the value to patients, providers, and payers."

The report concludes with a call for comprehensive payment reform, alignment of payment and performance measurement, and a unified multi-stakeholder voice that speaks to the importance of alternative payment reforms to support the PCMH model. "For most Americans, primary care serves as the entry point and touchstone of the health care system, delivering and coordinating care for patients and families, with an emphasis on promoting population health and managing chronic illness," said PCPCC Board Chair Douglas Henley, MD, CEO of the Academy of Family Physicians (AAFP). "As such, primary care is well positioned to help repair and optimize our broken care delivery system.

With greater investment in and support for comprehensive patient-centered primary care through the PCMH, we can more systematically promote Triple Aim outcomes of better care, smarter spending, and healthier people. We can also make a much needed positive impact on improving the satisfaction and 'joy of practice' of primary care teams." All of the studies, programs, and reports included in this publication can be found online on the PCPCC's Primary Care Innovations and PCMH Map. The Map captures the extensive work and commitment of nearly 500 public and private initiatives nationwide that are

working to improve the U.S. health care system through enhanced primary care and the PCMH. Speakers at the briefing include: Rep. Joe Courtney (D-CT), co-chair of the Congressional Primary Care Caucus; Rep. David Rouzer (R-NC), co-chair of the Congressional Primary Care Caucus: Douglas Henley. MD, FAAFP, executive vice president and CEO. American Academy of Family Physicians; Marci Nielsen, PhD, MPH, chief executive officer. PCPCC; Alissa Fox, senior vice president, Office of Policy

and Representation, the Blue Cross Blue Shield Association; Christopher F. Koller, president, Milbank Memorial Fund; and Len Nichols, PhD, director of the Center for Health Policy Research and Ethics at George Mason University. The report was funded by the Milbank Memorial Fund, and the event was sponsored by the Blue Cross Blue Shield Association.

About the PCPCC Founded in 2006, the PCPCC is a not-for-profit membership organization dedicated to advancing an effective and efficient health care system built on a strong foundation of primary care and the patient-centered medical home (PCMH). The PCPCC achieves its mission through the work of its volunteer members, Stakeholder Centers, experts, and thought leaders focused on key issues of delivery reform, payment reform, patient engagement, and benefit design to drive health system transformation. For more information, or to become an executive member, visit www.pcpcc.org.

### Notice Regarding "Private Option" Claim Refund Requests and Remittance Offsets

## Claim Refund Requests and Remittance Offsets Arising from the Arkansas Department of Human Services Retroactive Termination of Private Option Health Insurance Coverage

Starting February 1, 2016 Arkansas Blue Cross Blue Shield Multi State Plan will be sending claim payment refund notices to providers for claims paid for health care services received by certain individuals insured through the Arkansas Health Care Independence Program (the Private Option). At the time Arkansas Blue made these claim payments the Arkansas Department of Human Services, DHS, the administrator of the Private Option, had certified coverage and paid the premium

amounts for these individuals. However, after the claims were paid by Arkansas Blue Cross, DHS terminated these individuals policies and set the effective date of those terminations to a date prior to the date the health care services were received. DHS also took back the premium payments that had been paid for the time periods that claims payments were made for health care services received by these individuals.

Providers receiving notices for claim payment refunds on or after

February 1 will have thirty days to remit the claim payments. If a provider does not remit payment, Arkansas Blue Cross and the Multi State Plan have already mailed some notices of refund requests for claim payments based on the DHSs retroactive termination of Private Option policies. With respect to the claims for which a notice was already sent to a provider, the first remittance advices containing offsets will be transmitted in mid February. If you should have any questions, please

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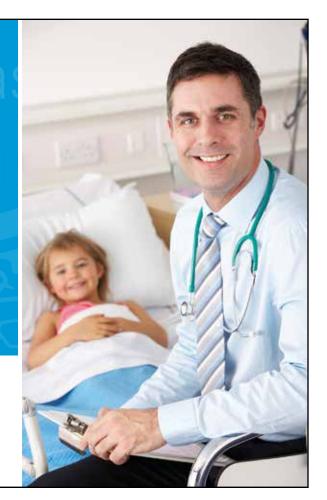
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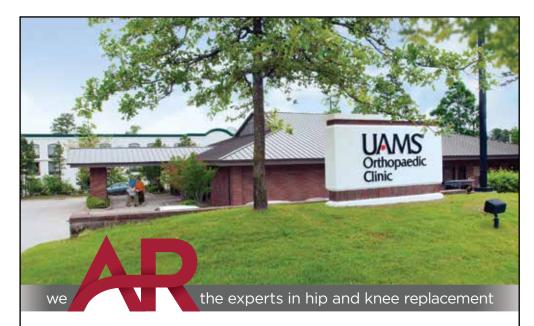


contact your Network Development Representative.

There is a possibility that when DHS retroactively terminated Arkansas Blue Cross or Multi State Plan coverage, DHS provided these individuals coverage with one of the other insurers providing coveage through the Private Option or coverage through Arkansas Medicaid. If so, the medical services for which Arkansas Blue Cross and the Multi State plan are requesting claim refunds may be covered by another insurer or traditional Medicaid. You are encouraged to contact your local DHS County Office to determine if other coverage exists.

From Arkansas Blue Cross: We at Arkansas Blue Cross understand how disruptive coverage terminations and rescission of claim payments can be for the individuals whose policies are terminated for the providers who treated them and for the insurers that paid the claims in good faith. That is why in early 2015 Arkansas Blue Cross and other insurers who provided insurance through the Private Option insisted on a provision in the agreement with DHS governing the Private Option which DHS from retroactively terminating coverage unless such termination is required by law. (Under Federal regulations, the only instance where retroactive termination is justified occurs when the Medicaid program learns that a covered individual has died). Unfortunately, DHS has not honored this provision of the agreement. Last August, DHS admitted that it had invoked most of the Private Option retroactive terminations in error. DHS asked Arkansas Blue Cross and other carriers to refrain from processing claim refund requests based on DHSs assurance that it would work diligently to repay the premium owed to the insurers for all affected individuals. Based upon that assurance, Arkansas Blue Cross and the Multi State plan delayed the claim process and cooperated promptly

and fully with every DHS request for information and assistance in identifying the affected individuals and the months for which premiums were owed. Despite months of cooperation from Arkansas Blue Cross and the other insurers participating in the Private Option, DHS has failed to carry out its promise. Indeed to date, despite numerous inquiries from the insurers, DHS has failed to provide any information about its plans to resolve this retroactive termination issue.



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### Changing Behavior Can Improve Heart Disease

#### By David A. Nelsen, Jr., MD, MS

Adverse health behaviors such as a poor diet and inadequate physical activity have a tremendous effect on disease burden and the cost of health care (estimated > \$100 billion in 2000¹). Although evidence-based clinical guidelines are a mainstay for modern medical practice, guidelines for health behavior change are scarce. Additionally, interventions to change health behavior are perceived as difficult to implement and poorly reimbursed.

Behavioral health research typically involves "softer" social science methodologies that are not well understood by clinicians. From a clinical practice perspective, it is often easier to adjust medications than to institute systematic interventions promoting healthy diet and physical activity.

In 2010, the American Heart Association (AHA) issued a statement regarding the benefit of health behavior change to reduce cardiovascular disease risk. The statement was endorsed by the Preventive Cardiovascular Nurses Association and the Society of Behavioral Medicine.<sup>2</sup> In 2014, the United States Preventive Services Task Force published a "B" recommendation that clinicians offer intensive behavioral risk factor counseling services to overweight and obese individuals with cardiovascular risk.<sup>3</sup> A "B" recommendation means there is high certainty that the net benefit is moderate, or moderate certainty that the net benefit is moderate to substantial, and recommends that practices offer this service.

The AHA review encompasses 75 randomized, controlled trials designed to evaluate the impact of behavioral counseling for diet and physical activity lifestyle change. One-third of these trials focused on minority populations. The methods included mailed materials, telephone contacts and cognitive-behavioral programs. Participating clinicians included physicians, dieticians, nurses and other community resources.

The AHA group recommends specific strategies to promote healthy lifestyles relative to cardiovascular disease risk:

- Cognitive-behavioral strategies are essential.
   They focus on goal setting, follow-up and directed feedback, self-monitoring, motivational interviewing and multimodal strategies.
- Successful delivery strategies must be patientcentered and efficient. Strategies include individual and group-based, Internet and computer-based, and individualized print media.

 Strategies must also address cultural components and utilize community, church or workplaceoriented programs, including lay or peer health advisors who are sensitive to culture, language and literacy.

It is important to note that a brief clinical message (e.g., "you need to lose some weight") delivered by a physician is not generally effective unless coupled with a structured intervention.

#### Dietary approaches

An abundant body of evidence supports the use of dietary approaches to address hypertension and cardiovascular disease. An AHA scientific statement<sup>4</sup> has reviewed the evidence connecting dietary factors and hypertension. Weight loss, along with moderation of sodium and ethanol intake, has withstood the test of time as adjuvant therapy for hypertension.

Diet-related lifestyle modifications that are effective in the treatment of hypertension include:

- Weight loss a body mass index of <25 kg/m2 is ideal
- Reduced salt intake limit sodium intake to <65 mmol/day (1.5 grams of elemental sodium or 3.8 grams of sodium chloride)
- DASH diet (Dietary Approaches to Stop Hypertension) – consume a diet low in saturated fat and cholesterol, yet rich in fruits, vegetables and non-fat dairy products. Increase potassium intake to 120 mmol/day (4.7 grams potassium)
- Moderation of ethanol intake two drinks daily or less for men, one drink daily or less for women

The DASH diet has been successful in reducing hypertension. Black individuals are especially sensitive to the blood pressure lowering effects of reduced sodium intake and the DASH diet.

#### Physical activity

There is little doubt about the value of physical activity. Physical activity enhances longevity, mood and functional status. It reduces risks of osteoporosis, certain cancers, diabetes, stroke and heart disease. It boosts the immune system. Survey data reported on the Centers for Disease Control and Prevention's (CDC) website show a slight increase in reported

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physical activity among U.S. adults. While this is reassuring, it is in sharp contrast to skyrocketing obesity rates in children and adults. There continues to be a decline in physical activity with increasing age and in culturally disparate populations.

There is limited evidence that a behavioral risk counseling approach is effective to improve a patient's physical activity status.<sup>2</sup> The American College of Sports Medicine and the AHA have a practice guideline (2007) that specifically addresses physical activity.<sup>5</sup>

- (Healthy, non-pregnant) individuals ages 18 65 should engage in:
  - 30 minutes of moderate-intensity exercise (e.g., brisk walking) five days/ week OR
  - 20 minutes of vigorous activity (e.g., jogging) three days/week OR
  - An appropriate combination thereof
- All adults will benefit from musclestrengthening activities that maintain or increase muscular strength:
  - 8 10 exercises should be performed on two or more nonconsecutive days/ week

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#### **Hypertension and Cholesterol Guidelines**

The core tenants of hypertension management are: measure blood pressure accurately and frequently; treat hypertension to target; embrace lifestyle changes and tailor the approach to the patient.

Here's a condensed version of the updated hypertension guidelines<sup>1</sup>:

- Lifestyle interventions remain the cornerstone of hypertension therapy
- Treatment for patients > 60 years should be initiated at and maintained below 150/90
- The remainder of the population, including patients with diabetes and chronic kidney disease (CKD), should be treated at and maintained below 140/90
- Non-black patients should be treated with a thiazide diuretic, calcium channel blocker, ACE inhibitor or an ARB
- Black patients should be treated initially with a thiazide diuretic or a calcium channel blocker
- In patients > 18 years with CKD and hypertension, initial (or add-on) treatment should include an ACE or an ARB to preserve kidney function, regardless of diabetes status
- If BP goal is not achieved after one month, medication doses should be increased or additional agents added

The recommended target diagnostic and treatment values for calculated low-density lipoprotein (LDL-C) divide statin therapy into high, moderate and lower-intensity, based on the potency of the individual statin:

- High-intensity therapy, LDL-C lowering of  $\geq 50\%$ 
  - o Atorvastatin 80 mg.
  - o Rosuvastatin 40 mg.
- Moderate-intensity therapy LDL-C lowering of 30-50%
  - o Atorvastatin 10 mg.
  - o Rosuvastatin 10 mg.
  - o Simvastatin 20-40 mg.
  - o Pravastatin 40 mg.
  - o Lovastatin 40 mg.
  - o Fluvastatin 40 mg. BID
- Low-intensity therapy, LDL lowering <30%
  - o Pravastatin 10-20 mg.
  - o Lovastatin 20 mg.

NOTE: other FDA approved statins/doses exist but are not included due to absence from referenced clinical trials.

Practice implications include:

- Elimination of routine LDL re-assessments
- Avoidance of non-statin therapy in statin-tolerant patients (non-statin therapies are not recommended to prevent ASCVD due to lack of effect in clinical trials)
- Reduced utilization of other markers used in cholesterol management decisions, e.g., high-sensitivity CRP and calcium scores
- An updated 10-year ASCVD risk calculator replacing the Framingham model

Statin therapy is recommended for patients with:

- Clinical ASCVD
- Baseline LDL-C levels ≥ 190 mg/dL
- Diabetes, age 40-75, with LDL-C > 70
- Without ASCVD but with LDL-C > 70 with estimated 10-year ASCVD risk ≥ 7.5%

The guideline emphasizes lifestyle change including a heart-healthy diet, regular exercise, avoidance of tobacco and maintenance of a healthy weight. Lifestyle modification continues to be the basis of ASCVD risk reduction both prior to and coupled with the use of statins.

<sup>1</sup>The hypertension guideline was convened as the Eighth Joint National Committee (JNC-8) by the National Heart, Lung and Blood Institute (NHLBI). The hyperlipidemia guideline was convened by the NHLBI as the Fourth Adult Treatment Panel (ATP-IV).



#### continued from page 26

- Resistance weight should allow 8 - 12 repetitions before producing muscular fatigue
- Modalities include weighttraining, calisthenics, stairs and resistance exercises

There are separate guidelines addressing patients with functional limitations, heart disease, etc. Physicians should prescribe a specific exercise program and consult other providers as appropriate to the patient's condition.

When reviewing a clinical guideline or a clinical reference, it is tempting to jump straight to the treatment section and spend our time managing medications. Health behavior change is difficult

for many patients. Firm physician advice should include referral to a structured program designed to optimize uptake and sustainability of a healthy lifestyle.

Behavioral risk counseling is a natural fit for the patient-centered, team-based approach of the patientcentered medical home (PCMH). Advanced elements of PCMH include measures to support selfcare and shared decision making. Cardiovascular health is essential to overall health, and health behavior change is an appropriate modality for primary care physicians. We should routinely screen patients for healthy diet and physical activity, and recommend specific measures to address these issues in appropriate patients.

Dr. Nelsen is an associate medical director, Arkansas Foundation for Medical Care.

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## CARTI Welcomes Dr. David Hays



The staff of CARTI is pleased to welcome David Hays, M.D. as our newest diagnostic radiologist. He specializes in Interventional Radiology and Oncology.

Dr. Hays comes to CARTI from Baptist Health Medical Center, where he served as Section Chief of the Interventional Radiology Department, as well as the Medical Director of the Noninvasive Vascular Lab. Dr. Hays was previously with Radiology

Consultants of Little Rock, P.A. and received his medical degree at the University of Arkansas for Medical Sciences. CARTI is thrilled to welcome him to our staff.

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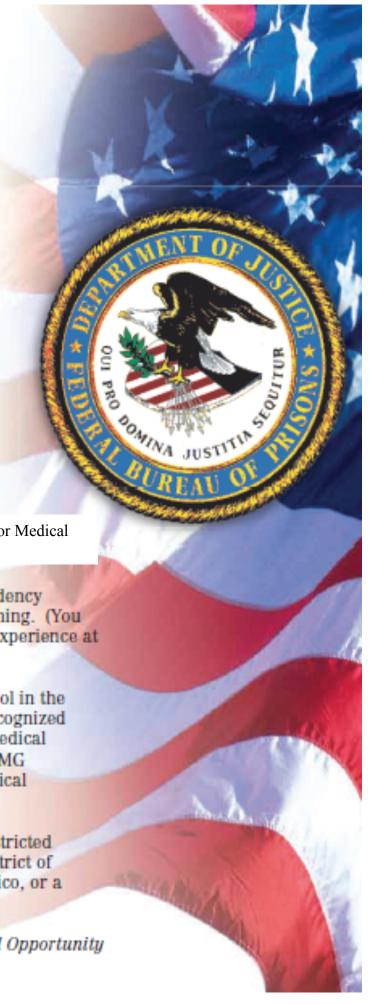
FCC Forrest City, AR currently has (2) vacancies for Medical Officer. Please note the following requirements:

TRAINING - for the GS-15, 5 years of residency training or equivalent experience and training. (You may still be qualified with less residency/experience at a lower GS.)

DEGREE - Doctor of Medicine from a school in the United States or Canada approved by a recognized accrediting body; if degree from foreign medical school, must have the certification by ECFMG (Educational Commission for Foreign Medical Graduates)

LICENSURE - a permanent, full and unrestricted license to practice medicine in a State, District of Columbia, the Commonwealth of Puerto Rico, or a territory of the United States.

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#### MU Hardship Exception Application Process, Round Two

■ AAFP Promises Followup Questions

January 26, 2016 02:13 pm Sheri Porter

As promised, CMS recently announced a new "streamlined" process(www.cms.gov) physicians, hospitals and critical-access hospitals can use to apply for a hardship exception that could exempt them from financial penalties for failing to meet meaningful use stage two requirements for 2015.

The announcement came on the heels of the December 2015 passage of the Patient Access and Medicare Protection Act that included a provision giving CMS the authority to expedite these applications by allowing the HHS secretary to consider hardship exceptions for "categories" of health care professionals.

Previously, applications were reviewed only on a case-by-case basis.

Importantly, the latest CMS announcement included a determination that the agency had the authority to allow groups of providers to request a hardship exception using a single application form.

#### Story Highlights

 CMS recently approved a simplified application process for physicians to apply for hardship exceptions related to meaningful use stage two requirements for 2015.

- As reported in December, new legislation gives CMS the authority to expedite applications by considering "categories" of health care professions. The just-announced process also allows groups of providers to apply using a single application form.
- The AAFP will continue to work with CMS to ensure that family physicians are insulated from unfair penalties.

The hardship categories are the same for individual and group application requests. For instance, circumstances of significant hardship include

- insufficient Internet access or insurmountable barriers to obtaining infrastructure such as lack of broadband technology,
- extreme and uncontrollable circumstances in the form of a natural disaster that destroyed an electronic health records (EHR) system,
- closure of a practice or hospital.
- severe financial distress such as bankruptcy or debt restructuring, and
- lack of control over the availability of certified EHR technology.

Although supportive of CMS' efforts overall, the AAFP continues to have some reservations about how the agency is tackling specific issues.

In an interview with *AAFP News*, Steve Waldren, M.D., director of the AAFP's Alliance for eHealth Innovation, questioned whether CMS had done enough to insulate physicians from unfair penalties.

"Certain things were not addressed in today's announcement from CMS, and so the process moving forward is still far from crystal clear," said Waldren.

For instance, although Waldren welcomed the introduction of a simplified application form, he said the AAFP needed assurance that the abbreviated process would not put family physicians at additional risk in the event of a meaningful use audit.

## Reconsideration Application Deadline Also Approaches

Some family physicians who received letters from Medicare stating they

were subject to the 2016 meaningful use penalty may want to contest that determination.

Such physicians have until Feb. 29 to submit a payment adjustment reconsideration application.(www.cms. gov) Follow CMS' instructions(www.cms. gov) on how to complete the form.

Electronic submission of the application is strongly recommended; in the event that is not possible, fax the application to (814) 464-0147.

"The AAFP intends to follow up with CMS on this hardship exemption issue and get all of our questions answered. As we learn more, we'll pass that information on to family physicians," said Waldren.

The AAFP strongly supported the legislation that gave CMS the nod to, in the short term, expedite the hardship application process via categorical authority. In a Dec. 21 statement, AAFP President Wanda Filer, M.D., M.B.A., called the bill's passage a "reprieve" for physicians who were not able to attest to meaningful use "through no fault of their own."

Deadlines for the submission remain the same as previously reported: Physicians have until March 15 to submit hardship exception applications; eligible hospitals and critical-access hospitals must submit by April 1.

Hardship applications (www.cms. gov) are available online. Follow CMS' instructions (www.cms.gov) for completing the forms.

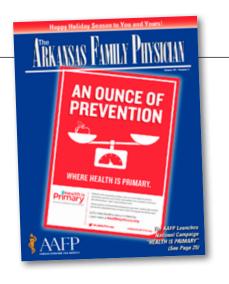
Remember, CMS' categorical authority expires April 1; after that date, CMS must revert back to considering case-by-case hardship exemptions until July 1.

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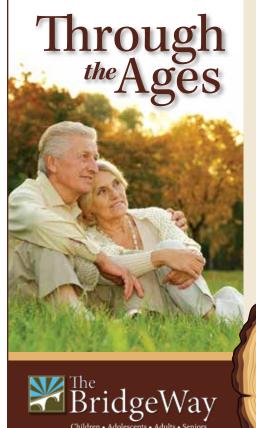
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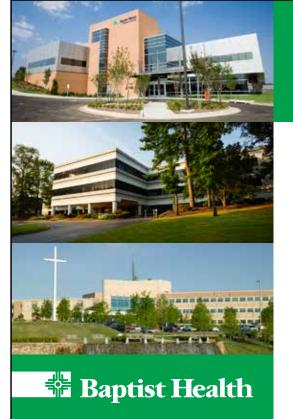
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