

Delivery via Electronic Submission

Andrew Slavitt

Acting Administrator

Centers for Medicare and Medicaid Services

Department of Health and Human Services

Attention: CMS-1600-P, Mail Stop C4-26-05

7500 Security Boulevard

Baltimore, MD 21244-1850

Re: Comprehensive Primary Care Plus (CPC+)

May 13, 2016

Dear Administrator Slavitt,

On May 6, 2016, the Milbank Memorial Fund convened representatives from 21 payers in all seven current Comprehensive Primary Care (CPC) Initiative projects (a list of attending payers is attached as an addendum) to discuss their experiences with CPC and their thoughts about the proposed CPC+ project. I am writing to convey several important themes that emerged in the meeting and which participants believe merit your attention and focus.

Before discussing these themes, it is important to note several items:

* Each of the payers recognizes and supports the goals of multi payer primary care transformation. Each payer, however, is in the process of making its own determination about participation in CPC+, which they will communicate to you independently in the manner requested in the CMMI Request for Applications.
* No specific participation conditions were discussed at this meeting, nor were any terms of provider reimbursement.
* Although a draft of this letter was reviewed and commented upon by six of the payer representatives, responsibility for its accuracy rests with the Milbank Memorial Fund.

With these in mind, the payer meeting surfaced five overarching themes. Some are specific to CPC+ design and strategy and others are broader policy issues.

1. *Multi payer efforts in CPC+ must be supported at the market level with resources, expectations and with clear CMS engagement as a payer.*

In addition to payment innovations and practice transformation, the success of multi payer primary care transformation rests heavily on attaining alignment among all participating payers in a selected market on issues such as payent mechanisms, measurement selection, and data aggregation and reporting. This work, the responsibility of the Multi-Stakeholder Faculty in CPC Classic, is absolutely fundamental, precedes all other stakeholder efforts and must be adequately and fairly resourced and facilitated in ways acceptable to all payers. Participants in the May 6th meeting were greatly concerned that the CPC+ design may not allocate adequate resources to this effort. In addition, it should set clear expectations for the work of the payer collaborations, and ways for CMS to participate fully and consistently in its role as a payer at the regional/market level in these discussions.

1. *As the largest payer in the country, Medicare needs to articulate a clearer delivery system vision and take more responsibility for ensuring that its innovations complement rather than conflict with one another.*

The insistence that CMMI payment innovations such as ACOs, care bundles and primary care transformation efforts must be considered independent trials, forcing providers to choose one at the exclusion of others may make sense in terms of research sense. It does not reflect market realities and the desires of providers. In fact, primary care transformation should be at the very core of an ACO’s program. The MSSP and CPC Plus program reimbursement designs in particular appear to offer conflicting visions for the role of small and medium sized primary care practices in population health management. While there is not definitive evidence on the “best” practice model, CMMI payment innovations send powerful provider market messages, particularly when joined by commercial payers. Their implications need to be carefully considered and discussed before they are released.

1. *Self Insured companies are not participating in multi payer efforts in numbers commensurate with their market presence. CMS can catalyze their engagement.*

ERISA plans constitute sixty percent of commercial business. Payers and administrators report great difficulty in recruiting them to contribute to CPC and other shared contribution models. National self-insured business is particularly recalcitrant, and often appear to be willing to reap the benefits for their members but not to contribute to the costs and activities. As a result, payers will have difficulties implementing the Track 2 CPCP particularly with ASO clients. As country’s leading payer, is it in CMS’s interest to use its influence to convince national employers of the importance of their participation, and the positive returns the projects have seen. Participants are willing to join you in this effort.

1. *The provider selection process in CPC+ and the role of payers in that process are not clear.*

Payer partners should have an opportunity to participate in practice selection. CMMI staff should capitalize on the familiarity of payers with the practices in a given market as they select applicants through the least administratively complicated mechanism. These payer organizations would like to work with CMMI to develop, understand and support CPC+ policies relating to other aspects of provider participation – including allocating enrollment between Tracks 1 and 2 in markets, the circumstances of randomization and in what, if any, situation practices move from one track to another. Payers will also need flexibility to make independent, corporate decisions about which payment model is most appropriate for members served in practices designated by CMS for Medicare Track Two payment.

1. *There needs to be greater integration and coordination of payers in each market with the practice transformation efforts of Regional Learning Faculty (RLF) and a greater emphasis on total costs of care measurement in reporting and in practice milestones.*

Payers in CPC projects with greater access to the work of the RLF reported better ability to align their own provider network activities in reporting and contracting to support the RLF. CMMI can build these expectations into the scope of work of RLF. Particularly with the limited risk sharing activities in the CPC+ design, meeting participants strongly encourage CMS to make total costs of care awareness and management a critical part of RLF curriculum and project reporting activities. This focus is essential to the success of the CPC Plus project, as well as its perception in the minds of important stakeholders. Payers would also like to work more closely with CMS on the development of the milestones, their implementation and reporting guidance, and their audits or evaluation. This will go far in ensuring that the milestones and the work the PCP practices are doing are driving total cost of care reductions in addition to improving quality and patient and provider satisfaction.

In addition to the themes described here, operational and implementation items were identified at the meeting on May 6th. MMF will address these separately with CMMI staff. Individual payers may address specific concerns and questions in the RFA response process on their own.

Participants in the meeting enthusiastically share CMMI’s commitment to and energy for multi payer primary care transformation. They believe the prospects for the success of the CPC+ will be greatly enhanced with CMS’s steady attention to the five areas outlined here.

Thank you for your attention. On behalf of the meeting participants, we look forward to hearing the Administration’s thoughts and responses.

Sincerely,

Christopher F. Koller Lisa Dulsky Watkins, MD

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cc: Patrick Conway, MD, MSc

Deputy Administrator for Innovation & Quality, CMS Chief Medical Officer

ADDENDUM – CPC INITIATIVE PARTICIPATING PAYERS – MAY 6, 2016 – BALTIMORE, MD

Melody Anthony, Oklahoma Health Care Authority

Peter Aran, Blue Cross Blue Shield of Oklahoma

Tara Bergeron, Tuality (Oregon)

Alicia Berkemeyer, Blue Cross Blue Shield of Arkansas

Stephanie Bernardin, Cigna

Lori Cleary, UnitedHealthcare, OH

Karen Frederick Gallegos, Anthem

Patrick Gordon, Rocky Mountain Health Plan

Randal Huntley, Blue Cross Blue Shield of Arkansas

Kristine Jessen, UnitedHealthcare

Mary Bath Kaylor, Ohio Department of Medicaid

Robert La Penna, Empire Blue Cross Blue Shield of New York

Lubna Maruf, QualChoice of Arkansas

Jennifer Mueller, Colorado Choice Plans

Donna O’Shea, UnitedHealthcare

Bijal Patel, New York Anthem

Steven Peskin, Horizon Blue Cross Blue Shield of New Jersey

Joely Porter, Anthem

Dorien Rawlinson, Colorado Healthcare (United)

Julie Schilz, Anthem

Christa Shively, Providence Health and Services

Jack Sommers, Oklahoma CommunityCare

Mindy Stadtlander, CareOregon

Arica Watkins, Humana

Eileen Wood, Capital District Physicians’ Health Plan

Judy Zerzan, Colorado Department of Health Care Policy and Financing

Sara Zolinski, Ohio Department of Medicaid