# 2018 Milbank Multi-State Collaborative Annual Meeting
# Breakout Session Summaries

**Milestone 1/2: Shared Vision of Regional Success/Regional Action Plan**
**Instructors:** Erik Muther (PA) and Emilie Sites (OR)

Summary:

The session started with a fifteen minute overview of Oregon's market, payers, competitive landscape, and history of partnership/collaboration. The breakout leaders then discussed some of the success they had in bringing payers together and getting agreement on a vision and plan, specifically how to formally document shared vision and priority goals, build meeting agendas, and invite rotating "guests" (like TMF, CMS, Health Information Exchange) to payer meetings to make sure everyone is connected and excited to attend. The next 20 minutes were spent on group questions and brain-storming on how to measure alignment. The breakout ended with a conversation on behavioral health integration, ideas on how providers could use the PHQ9, and how payers might be able to incentivize practices to do more with behavioral/mental health.

Themes:

- Keeping payer meetings focused on specific tasks (e.g. data integration, regional learning sessions) helps makes meeting frequently manageable
- Medicaid can take the lead when given the opportunity – Results in multiple payers acting as "one" given the regulated nature of the Medicaid market
- The entry of larger payers represents an opportunity for collaboration but there is little previous experience to build on
- There are organizational challenges to making progress even when there is one payer
- Making a plan is one thing but sticking to it is the hard part
- Payers need to understand that transforming primary care is not going to put them at a competitive advantage or disadvantage so it needs to be done together
- Documenting and distributing the regional action plan holds payers accountable and shows providers what payers are working on
- Conveners are important not just for natural decision-making and facilitation but also for "holding payers accountable" and building in CPC+ program management
- There are challenges in getting all the right folks in the payer organizations to sign off or review decisions

Key Takeaways:

1. Regions with a small number of competitive payers have a hard time coming together and making progress on Milestones 1&2

2. Payer meetings should be collaborative meetings with a diverse set of stakeholders, a shared vision statement, agreed-upon priority goals, and an agenda focused on specific and achievable tasks.
3. Payer collaboration has been difficult to execute and measure, especially in areas with little previous experience.
4. Multiple regions' payers expressed interest in exploring incentives for practices to increase behavioral health integration.

**Milestone 4: Alternative Payment Model for Primary Care**
**Instructors:** Edith Coakley Stowe and Julie Schilz

Summary:

This session discussed the multi-payer process, progress on Track 2, and feedback on the development and eventual implementation of Track 3. When discussing Track 2, participants discussed the difficulty in implementation, specifically the amount of resources practices are spending without ROI. Participants voiced feedback on how they would like to see Track 3 implemented and concerns they have on their initial understanding of the framework.

Themes:

*Sessions 1 & 2:*

- Group discussed what the term "risk" means, and if Track 3 (as currently outlined) describes "risk" or something that should be termed "Performance Incentive Risk"
- Participants indicated that Primary Care may not accept the risk on performance
- One participant indicated that constant revisions and moves stop engagement
- Group raised concern about Track 3 "grading on a curve" approach to PBIP if Track 3 is designed for the "best" (most advanced) practices, and that this could regulate good practices to "loser" status
- Group stated that the range (-10% to +50%) of incentives for Track 3 are needlessly broad and will feel overwhelming to practices. The large swing could be because upfront payments would be lower and this is viewed as driving incentive for performance
- Group raised concern of greater downside risk coupled with decreased upfront funding will curb provider demand if Track 3 model is voluntary—"Look carefully at overhead realities"
- Indication that Track 3 up-front payments may be lower, with more opportunity in the Performance (reward) Payment. This concerned some participants that performance would be adversely impacted by lower, up-front payments that fund infrastructure
- One suggestion was to move a group to Track 2 if they were not performing in Track 3. This was not initially seen as a positive option as the goal was to have options for progression. Pragmatically would change the pools
- Voluntary program against A students. Discussed competitive comparison—in Track 3 if A students compared against other A students' lowest performers who need to pay back could actually be outperforming Track 2 providers.
- Even in existing Track 2, how to spend the FFS payment is a problem: concerned that would be more so in Track 3 with even less programmatic guidance
- Question raised on whether folks would move back to MIPS as an easier track. NextGen Portfolio is complex, or would organizations move to Track 3 under CPC+?
- Indicated that CMS may view financial incentives as critical

- Discussions around quarterly prospective cap payment and recommendation of monthly payments and quarterly adjustments. Concern that providers will have difficulty budgeting
- Participants from Oklahoma and Michigan discussed the Multi-Payer alliance is less strong under CPC+ than it was under CPC Classic, stating there is less infrastructure/funding for multi-payer activities

*Session 3:*

- Representatives indicated that providers are asking for this model
- Group voiced interest in a longer lock-in to stay in the model so it would not be volatile
- CMMI may be considering a limited test, that would be similar in timespan to their other 4-5 year programs
- Discussed Admission Criteria
    - NCQA recognition – This was met with mixed reactions, some markets use, some do not, providers are negative
    - Past Performance
    - Want for deeper review of change package elements
- Group asked details on how a 10% risk adjustment would work

Key Takeaways:

1. Payers are still trying to navigate Track 2 implementation; progress is slower than expected and many are not seeing the ROI
2. Payers want to be involved in the CMS/CMMI Track 3 discussions to share their opinions on incentives, benchmarks, and what qualifies as a risk in addition to sharing their experiences with Track 2.

**Milestone 5: Care Delivery**
**Instructor:** Julie Schilz

Summary:

This session discussed engagement with Practice Transformation support in the regions represented at the meeting. Representatives shared tactics to engage the Practice Facilitators effectively to understand practice performance and establish a "mentor type of structure." It was expressed that mergers and acquisitions are changing the landscape of how the providers are organized. The session spent most of the time discussing the dynamic between Payers and Primary Care, with Payers indicating the goal to support Primary Care in staying independent. The session ran out of time to discuss sustainability for the payers who have transformation support staff. Those who have transformation staff within the payer organization found it to be a valuable resource.

Themes:

- Regions expressed the change package was thoughtful but in some cases the support provided did not maximize each of the change package elements
- Variety of responses related to trying to utilize the structure of CPC + Practice support to understand practice performance so that Payers would not feel compelled to add additional structures and requirements.
- Some in the group felt an underlying tone from CMMI/CPC + that since they were funding transformation support, recommendations or modifications from community partners were not welcome.
- A representative indicated the payers are collaborating well with CMMI contractor transformation staff, but that they also meet on their own with the groups on a quarterly basis.
- A representative indicated that they have a very good working relationship with the CMMI funded transformation support.
- A representative indicated wanting to align with the programs in the state so that providers have consistency, concerns about some of the changes recommended in case there is difficulty in revising a program quickly. This led to a discussion on the merits of tweaking to enhance a program versus stability in the construct. A tension was identified between Evaluation and Innovation, and updating program elements versus creating chaos by changing the program.
- Noted that groups have already implemented their collaborative care agreements so "offering flexibility" on the elements of the change package would not reduce burden. Many practices like the process of creating these.

Key Takeaways:

1. Mergers and acquisitions are changing the primary care landscape and how care is delivered
2. There is general consensus that the CMMI contracted Practice Transformation staff provide a valuable service

**Milestones 6/7: Data Support to Practices/Quality Measure Alignment**
**Instructors:** Craig Jones and David Kendrick (OK)

Summary:

Members from CMS opened the meeting with a set of announcements and asked for feedback in the following areas:

- CMS Leadership supportive of CPC+: Strong backing for the model and intend to continue
- Reduce provider burden: This is a big focus. To this end, CMS will:
    - Reduce frequency and number of questions on care delivery measures – Down from quarterly to twice per year, and with fewer questions.
    - Reduce eCQM measures reporting – down from 9 to 2. The two, based on payer surveys and across the board applicability analysis, are blood pressure and Hemoglobin A1C.
        - Some concerns this is too narrow, concerned that behavioral health is not represented.
- Accelerate move to value based reimbursement: Direct provider contracting RFI will likely morph into CPC+ Track 3. This track will have up-front payment, office based visit reimbursement, and back end bonus payment components. Form of this is unclear, but CMS is seeking feedback. Considering quarterly competitive analysis where top quartile gets upside of 50% and bottom quartile gets downside of 10%.
- Other key components and feedback:
    - Track 3 described as part of continuum to accelerate move to value based care. Need to be careful that Tracks 1 and 2 are still intact for model experiment and evaluation.
    - Emphasis on continuing office based visits. This is important and don't want everything to be virtual or for Physicians to not see patients and still collect fees.
    - Goal is to give big reward to top performers.
    - Reporting may be different. On the claims side for primary care, would just have simplified office visit claims. Hospital utilization still a big component, which is claims based, but there is a need to consider data and reporting implications.
    - Other Payers concerned that they won't have enough time to line up with Track 3 in 2019. They will likely have to amend their contracts later or come in a full year later.
    - CPC+ model generally lines up well with other payer models based on feedback.
    - Concern that bottom quartile practices which improve, but don't move all the way up to the top quartile will not get rewarded. Suggested an incentive for absolute improvement as well.
    - CMS is very interested in defining measures for a "good benchmark" and is currently doing a study on primary care

After the CMS discussion, the session focused on 4 major points: 1) Collision of programs (all payer, CPC+, SIM, etc.); 2) Payment model's unintended consequences; 3) Integrated practices; and 4) Support required.

Themes/comments:

*Session 1:*

- Value Case helps with provider relations and practice network, can help with reporting HEDIS measures, and is convenient for practices to see picture of patient population in one place
- Alignment on benchmarks is important
    - Want to see Medication Adherence as a possible place to align (Some Private Insurance is at 90% adherence where Medicaid is 40%)
    - Cancer screening would be an easy benchmark to align
    - Would be good to align on practice support across payers where it makes sense—like when delivering similar messages
    - It will be hard to align on patient attribution

*Session 2:*

- Value Case:
    - Increase quality of care and reduce costs
    - Promote total population (multi-payer) Practice Transformation
    - Have only one place to find information when programs overlap
    - Ability to report at practice level and roll up to organizational level
    - Value in shared learning and finding out who top performers are—in some regions, practices agree to "un-blind" practices on reports. For CPC Classic, this fostered interaction between practices.
    - Value in sharing costs across payers and practices
    - Value in practices paying in so they have "skin in the game"
    - Value in working with practices' payers that are usually not worked with (eg non-CPC+), this gives exposure to new practices and adds more value to practices that have a small percentage of their patient population
    - Larger sample sizes for measures, particularly for small practices
    - Payers can compare their members to market as a whole
    - Generally larger sample sizes and comparisons for practices
    - Can answer APCD question as voluntary and not have it mandated by state regulation
    - Can see churn and changeover in patients better
    - Reduce patient burden
    - Measures alignment part of value case and practice burden
- Discussion on challenges in decision making:
    - Push for consensus instead of any real enforcement power
    - Start with consensus in common areas like quality measures. Will grow to other areas like utilization and expenditure, particularly with addition of third payer (Medicare)
        - Limited to Medicare Advantage right now but may add other lines of business and payers. May invest in aggregator and expand into places like New Jersey

- Practice Use of Data Tools:
    - Timeliness of data—important to have within 6 months
    - Target practices not using data and find out why
    - Staff turnover is a big issue
    - Important to show practices how to make a habit of using data
    - Important to make practices pay ("skin in the game")
    - Practices tend to go where majority of patients are, in terms of tools
    - Helpful if practices can use tools across multiple models, for many reasons. Not just one use

*Session 3:*

- Value and Alignment
    - Integrating behavioral health
    - Provider satisfaction measures important across many programs
    - Depression screening is low for Medicare
    - Consistent approach to practice improvement
    - Value to payer collaboration and shared learning as well as better population health management
    - Good to have same look and feel for reports
    - Lack of HIE functionality can be a rate-limiting factor
    - Good to have an aligned core measure set across models—start large and shrink over time
    - Need for standard reporting to reduce burden in large markets
- Practice Use
    - Link reports to payment to increase practice usage
    - Benefits to closing gaps
    - Culture of collaboration helps in accepting alternative forms of reporting
    - Demand for data is increasing
    - Peer modeling and in-office coaching helps with practice uptake
    - Sense the CPC+ is under-resourced for coaching
    - Staff turnover is high within practices
    - Plans have a common method for grading practices

<u>Key Takeaways:</u>

1. Primary care faces difficulty in in controlling specialty costs, creating a more comprehensive strategy that encompasses different types of doctors and care, and reimbursing virtual visits.
2. Data is most effective when it is collected in a timely manner, groups are aligned on benchmarks, and practices are able to integrate the results into actions
3. Progress is highly variable

**Milestone 9: Multi-Stakeholder Engagement**
**Instructors:** Maurine Gilbert (VT) and Missy Davis (AR)
**Number of Participants:** 12, 14

Summary:

Participating states are in very different stages of multi-stakeholder engagement. While the stated goal is for identification of non-CPC+ payers, providers, associations, foundations, etc., some regions are still working to build solid collaboration between CPC+ payers. This session spent significant time discussing this critical step before discussing issues more broadly. The session closed with a discussion on regions where the CPC+ payers are convening large, multi-disciplinary stakeholder groups to work together to achieve a shared vision of success.

Themes:

- The places with the most active, inclusive multi-stakeholder engagement are often building on years (sometimes decades) of successful multi-organization, multi-sector teamwork in their community. Building trust, in people/organizations and believing that the time/effort/risks invested in working together will product meaningful results, takes time.
- When collaboration is newer, accomplishing small goals together helps demonstrate proof of efficacy and builds momentum for collaboration.
- Multi-stakeholder engagement efforts benefit from attention to detail, things as small as finding a comfortable, neutral space to meet or offering coffee or food, help create the conditions for collaboration. One region built time for informal conversation into a multi-stakeholder event, and found this helpful.
- Some participants are recognizing that multi-stakeholder groups with similar goals already exist in their regions. They are respecting their colleagues' time by participating in those groups, rather than building duplicative new multi-stakeholder groups. In all areas it makes sense to think critically about how to engage community resources to meet the unique goals of CPC+ while aligning with existing community efforts.

Key Takeaways:

1. Building multi-stakeholder engagement takes time and effort to build trust
2. One way to foster the relationship is to start with accomplishing small goals
3. Multi-stakeholder engagements do not always need to start from scratch, if similar groups are already meeting try to engage with those groups instead of duplicating existing efforts