

In-Person Kick-Off Meeting

Primary Care Payer Action Collaborative

October 26, 2016
8:30am-4:00pm

Highlights and Key Takeaways

Meeting Objectives

Objectives of the Primary Care Payer Action Collaborative (PAC) kick-off meeting:

- Build trust and understanding of the PAC’s role in accelerating progress toward shared goals;
- Begin developing shared goals for the PAC’s “national table” and plans for measuring success;
- Reach consensus on the learning and action topics most important to PAC participants;
- Conduct a “deep dive” into a substantive topic; and
- Articulate actionable next steps for PAC participants and the LAN consistent with participants’ top priorities and timelines.

Key Barriers to APM Implementation in Primary Care

Participants voiced challenges associated with APM implementation in primary care. Some of the key barriers discussed include:

- Engaging and showing APMs’ value to self-insured employers and their administrative services only (ASO) customers;
- Designing APMs that work with high-deductible plans, co-pays, and other cost-sharing benefit designs in a way that doesn’t discourage virtual medicine and other alternatives to face-to-face encounters; and
- Ensuring incentives flow to frontline clinicians.

The challenges created due to lack of aligned measures, data collection methods, and information portals must also be addressed.

The PAC: What It Is and What It Isn’t

The PAC’s emphasis is on taking action and facilitating shared problem solving to help participating payers make the case for APMs within their respective communities, avoid “reinventing the wheel,” be more confident in their approaches, and accelerate the regional work underway. The PAC is not a forum for lobbying or otherwise requesting answers or technical support directly from CMS. The PAC is also not a source of financial support for CPC+ payer partners.

Value of the PAC

In discussion of shared goals and the value of this “national table,” participants discussed their perspectives regarding the value of the PAC and how to take advantage of this opportunity to further primary care transformation. Participants stressed the importance of using this forum to:

- Develop relationships and learn from the experiences of other participating payers to accelerate action;
- Collaboratively identify solutions and pressure-test ideas from CPC;
- Consider how to bring together payers and align solutions across products (e.g., commercial, exchange and Medicare); and
- Build on CPC+ to engage other payers and stakeholders to transform care in regions.

PAC Priority Areas

In framing the discussion on PAC priority areas, Dr. Fazio noted the importance of focusing on areas where payers already overlap, as this is where the PAC can be successful. Recognizing the importance of ongoing activity within and across regions that’s specific to CPC+, participants stressed the need for PAC priorities to transcend CPC+. Participants also considered targets—everyone or just the “A and B+ students”—and minimal requirements for success.

Participants shared their organization’s interests and recommended focus areas for the PAC, which were grouped into the following seven “buckets” for prioritization:

- **Aligning Quality Measures and Reporting:** PAC participants view payer alignment on quality measures and reporting as both a top priority and “low-hanging fruit.” Based on provider feedback, streamlined reporting of meaningful quality measures—what payers report and what providers report—would relieve some administrative burden and facilitate APM adoption. Alignment should address the content, format, timing, and frequency of quality reports.
- **APMs for Primary Care:** Operationalizing APMs for primary care is a pragmatic issue that is top of mind for many payers. As part of this discussion, participants stressed the importance of designing models that support the flow of incentive payments to frontline care teams. Participants also expressed an interest in figuring out how to implement CPC+ Track 2 payments risk-adjusted care management payments.
- **Care Delivery:** According to participants, a coordinated approach involving diverse stakeholders is critical to transforming care within a region. One area of particular interest is coordination of care management for high-risk patients. In addition to effectively identifying and tracking patients for high-risk care management, there needs to be accountability for the management of care for these patients.
- **Cross Cutting Topics:**
 - **Attribution:** Participants identified attribution as an important cross-cutting topic. If payers want to hold providers accountable for managing a population, they need to know and have a methodology to clearly identify who is in that population. Although attribution is one of biggest points of disconnect with providers, there’s also a learning opportunity. Participants also discussed assignment and how it differs from attribution. As defined by one participant, attribution reflects the actual active pattern of care, which doesn’t have to be consistent with assignment. Providers and patients must agree under attribution; otherwise, its auto-assignment.
- **Data Support for Practices:** Data is an important area of focus and prevents challenges for multi-payer collaboration. Many opportunities for the PAC and issues were discussed including:
 - Solutions to data collection (e.g., for eCQM) and data sharing barriers;
 - Data interoperability and data-sharing solutions that give payers needed insight into provider; performance without adding undue cost and/or burden to providers;

- Collection and reporting of meaningful quality measures without full electronic medical record (EMR) adoption; and
 - Efficient solutions for integrating payer and EMR data.
- **Patient/Member Engagement:** Participants discussed benefit design as an important part of the equation to engage patients. Some studies suggest copays may be harmful and are not the best strategy for holding patients accountable. The ideal is true shared decision-making with patients. The current payment structure creates constraints and prevents this type of engagement during traditional office visits. Alternative payment models and the flexibility offered under this payment structure may offer different ways to engage patients.
 - **Shared Vision of Regional Success:** A shared definition of well-functioning primary care is needed to support alignment and move toward a shared vision of success within regions. Part of the discussion going forward will focus on the factors driving higher quality, higher patient satisfaction, and lower costs. Questions regarding the roles and responsibilities of payers and providers in well-functioning primary care will also need to be addressed and communicated more broadly.

Decisions:

Out of these buckets, participants voted to initially focus on:

- **Shared Vision of Regional Success:** Defining and assessing CPC+ success at regional level including but not limited to CPC+ milestones
- **APMs for Primary Care:** Operationalizing CPC+ Track 2 payments: Shared lessons learned, practical tools/templates
- **Quality Measure Alignment:** Aligning CPC+ measures, data, methodology, and reports for practices and aligning work beyond specified CPC+ measures (e.g., other measures on clinical outcomes, cost of care, patient engagement, etc.)

PAC Guiding Principles

PAC Participants agreed on the following “rules of the road” for the PAC:

- Committing to active engagement, collaboration, and information sharing;
- Maintaining confidentiality as part of the approach to learning and action;
- Agreeing to open, constructive, and respectful conversations;
- Refraining from lobbying CMS, an active partner as a fellow payer in this work; and
- Committing to sharing feedback with the LAN on what is or is not working in the facilitation and operations of the PAC, and supporting course-corrections where deemed necessary and appropriate.

Participants also touched on the importance of having a deliverable at the end of the PAC’s work that the group can agree to achieve, giving other participants grace and patience with mistakes and challenges along the way, and balancing face-to-face meetings with the realities of travel expenses and time constraints.

Deep Dive: Implementing CPC+ Track 2 Payments

A panel of three speakers—Julie Schilz with Anthem, Eileen Wood with Capital District Physicians’ Health Plan (CDPHP), and Patrick Gordon with Rock Mountain Health Plan (RMHP)—kicked off the working session on operationalizing CPC+ “Track 2” payments. An overarching theme of the discussion was the challenge of keeping “a foot in both worlds” by maintaining fee-for-service (FFS) infrastructure for some lines of business and transitioning to global/prospective

payments for other business segments and patient populations. The group also raised shared challenges, insights, and approaches in the following key areas:

- **Attribution:** The PAC identified patient attribution as one of the biggest areas of disconnect between payers and providers regarding Track 2 payments and APM implementation in general, and one of the most challenging to resolve. The speakers noted a universal approach to attribution is not likely on the horizon.
 - Just 24 percent of CDPHP members regularly see a primary care provider (PCP), making attribution even more challenging.
 - Provider consolidation adds to the complexity of attribution.
 - PCPs strive to have improved patient outcomes appropriately attributed to their care and express frustration when payment models can't fully account for "social determinants of health" beyond their control. "Give me something new to work with" is common feedback to CDPHP from PCPs regarding patient attribution and population-based measurement.

- **Global/Prospective Payments:** Both RMHP and CDPHP have observed that while global payments may create flexibility in care delivery, they don't provide freedom from coding.
 - Under its global payment model, RMHP incentivizes PCPs to continue to submit encounter claims for risk-adjustment and data-collection purposes. The plan generates provider reports from the data that support peer-to-peer comparisons and examine care under FFS versus global payments.
 - In its approach to global payments, CDPHP continues to use claims and coding data to implement performance- and quality-based incentives. PAC participants expressed interest in ways to account for care modalities that aren't captured well by current coding, such as telemedicine. CDPHP uses care-management codes in certain cases and reimburses PCPs for innovative care such as telemedicine through downstream quality-based payments and other methods that don't rely on coding.

The speakers emphasized the complexities of implementing prospective payments despite the desire to shift from retrospective performance-based payments.

- Anthem acknowledged it varies payment models based on business segment, and prospective payments aren't always feasible. For example, self-insured ASO clients have been more reluctant to adopt a prospective payment model.
- Accounting for member cost-share in prospective payments, particularly in high-deductible health plans (HDHPs), presents challenges. On a monthly basis, CDPHP "debits out" member cost-sharing amounts from the prospective payment. In the case of HDHPs, payers must also find ways to align provider and patient incentives so that patients don't delay care and ultimately drive costs up and quality indicators down.
- With appropriate actuarial and rate-setting methods, RMHP has implemented global and prospective payments across product lines, including HDHPs and PPOs. RMHP, CDPHP, and Anthem also use data collection and payment reconciliation ("claw-backs" when necessary) to help discourage providers from redirecting patients—to urgent care, for example—as a way of maximizing payments.

- **Physician Leadership and Engagement:** The PAC acknowledged a strong need for provider outreach and education on CPC+ and APMs in general. The speakers agreed physician leadership within practices is critical to successfully implementing CPC+ Track 2 payments and other APMs. Payers can cultivate physician leadership and engagement by reorganizing their relationships with practices and designing the right incentives.
 - Some plans have adopted a “sales model” approach to better respond to practice needs, including hiring former pharmaceutical representatives to continue their trusted relationships with a practice. Other plans “embed” nurse practitioners to help practices adjust to new systems and processes.
 - Payers are working to move PCPs from an “early adopter” stage to the critical mass necessary to accelerate APM adoption and produce meaningful transformation. Some payers are incentivizing more PCP participation by tying bonus payments to organizational performance.

Next Steps

Dr. Fazio emphasized the importance of beginning to think about “what’s next” in the near and long-term for the PAC. In the near-term, the LAN will focus on:

- Developing a calendar of virtual and in-person PAC events based on participant input;
- Circulating a contact list of meeting participants; and
- Developing a virtual repository for PAC participants to access resources and current versions of PAC documents (e.g., meeting notes, materials, etc.)

PAC participants were asked to review priority topics, goals, and outputs shared in a follow-up email and send feedback to Lauren Icard with any additional thoughts gleaned from their respective organizations.