

## Transcript of PAC Track 1 (Vision Statements), Meeting 2

January 20, 2017

[Alternating music and silence; Presentation begins at 00:10:38]

### **[Cathy Becker]**

Great. So thank you all and we look forward to a great meeting. And with that, I will turn it over to Michael to get started.

### **[Michael Bailit]**

Thanks, Cathy. Hi, everybody. Om, glad to be with you for our second of four meetings. Our agenda for today, om, begins with a little bit of context-setting, and then, om, I'm gonna have a couple of conversations, listed here as ah. The first is a live interview and then hearing from peers, om, in both cases, om, I'll be asking some questions, om, and then we'll invite om, you all to join in conversation, om, after we hear from, om, our featured guests today. But before we go there, om, I just want to remind you that you should not disclose any financial or otherwise competitively sensitive topics in our conversations today. Om, our principles for this collaborative, om, include asking you to actively engage and collaborate, maintain confidentiality, to always be respectful, om, to om, not lobby one another and certainly not CMS, and to please share feedback with us so we can know how we're doing. Om, the om, ah, PAC is uh, focused on om, the milestones that are part of the CPC+ paired partner collaboration roadmap. We are focused on milestone number one in this four session uh, uh, track one, and that's on shared vision of regional success. Uh, a shared vision of regional success, as you may recall from our first conversation, om, defines, uh, what, at a regional level is successful primary care transformation, uh, and om, states explicitly what you hope to accomplish at the end of each year. Om, it should be the consensus of all the payers in the region, uh and it should address the desired ends both in terms of cost and quality of care . . . are delivering as well as the work that you as payers are going to be doing with one another.

Uh, again, this is our second meeting. At our first one we talked about how do you define an effective vision and we talked about domains that might be included in a vision statement. Today we're gonna to focus on how might you evaluate success, because the vision statement should, uh, be measurable and be explicit in terms of what a success looks like as they noted at the end of each of the five years. Uh and we're gonna check in, om, with one region on their, uh, early process to develop a statement. Om, for our next conversation, February seventeenth, we're actually going to begin to talk about some of, om, . . . statements. More on that later.

So, uh, during our first conversation we did a little poll to see where each of you stands right now, uh, in terms of developing your regional vision statement, and you were at different places. Uh, we want to take a quick poll to see where you are right now. So if you wouldn't mind om, just clicking, for those of you who are online on the webinar, on the appropriate box so we can get a sense of where people are and what change may have happened since our first conversation. So I'll take a minute for you to vote. We've got five responses so far. Um, once there's some more, om, then, uh --. And I think altogether

we've got 32 people on the web right now, which of course includes some of the LAN staff. Om, but once I've heard some more responses then I'll close . . . around the room. OK, any more responses? For those of you online? Well, alright, so we've got om, om, eight responses. Om, four have completed the process, three are just developing the statement . . . are in the process of developing, uh and one ramping up to get ready for it. Okay. And, uh, there you can see the results.

Okay, so during our first conversation, um, we talked about the qualities of an effective vision statement, and I think we actually reached an agreement that um, there should be an overarching goal but with very specific improvement objectives. Om, there was concurrence among the group that a vision statement should include both process and outcome elements, om, recognizing that processes lead to the outcome. Om, there was a consensus that, om, the objectives should be measurable in an . . . to the extent that your activities are going to expand and improve over time, they should be scalable. Om, we also talked about domains, and I'm not gonna go through, om, each of these in detail, but om, there were a bunch of ideas that were generated in terms of practice transformation. The part of, uh, one key domain of success, but other domains included activities that payers can take, om, either, om, uh, in partnership with one another, om, and also in partnership with participating practices. So, one was achieving some alignment around measure definitions and even measures. Om, we also talked some about data infrastructure and what payers can do to facilitate, om, data provision to practices, om, payment, and then, om, outcomes, defined in terms of quality costs and patient experience. Uh, and again, we discussed domains of success being uh, also organizing principles for the construction of vision statement. Om, there are also, om, seemed to be, om, agreed toward the end of our conversation that might be helpful to start with your desired end and then work backwards to define, om, the processes to allow you to achieve that end. Om, and so om, I, I wanna build on that as we talk, uh, later today. That's seemed to be an idea that resonated with a number of you.

So for this meeting, om, we've already gotten a sense of where you are, are currently standing from the poll. Om, but we're gonna spend some time next understanding what are the means by which you might assess the impact of alignment, om, and uh, understand that both in terms of attesting multi-payer activity as well as understanding transformation at the practice level. Om, and uh, that's really gonna be a feature for the next um, uh, twenty or thirty minutes or so of our conversation.

So, om, we have two guests today. And, uh, I, uh, I want to thank uh, uh, Debbie and Alicia for their willingness to, uh, join us. Uh, again, om, the reason we're having them with us is that developing a vision statement that defines regional payer, uh, desired ends requires the means to measure and objectively assess the payment at both ends. So, om, my conversation with, uh, first Debbie and then Alicia, is intended to help you determine how you can define a vision statement that will, om, capture how you will assess whether your multi-payer effort has been successful at promoting transformation . . .

Um, so, um, the first uh – I'm gonna start with Debbie, and we're really fortunate to have Debbie because she, um, as a senior fellow at Mathematica, has been the project director and principal investigator for both CPC and CPC+, so I don't think we could actually have anybody any better than Debbie today. Om, she, om, does not have the time to, om, stay with us long enough to answer questions that you might have in response to her comments, uh, but she's offered to respond in writing to any questions that you might share. So, if you want to, uh, type in . . . the chat box, we will compile

them subsequent to today's conversation and share them with Debbie and ask her to provide a response . . . .

So, om, the first question, om, that, uh --. Well, lemme just explain my . . . with Debbie. Om, CPC is not just about affecting changes in primary care practices. It's also about payers changing how payers relate to both primary care practice and making changes in coordination with other payers. So, uh, Debbie, welcome. My first question for you is, om, can you tell me in your CPC classic evaluation activity how you looked at the effects of coordinated payer action?

**[Debbie Peikes]**

Thanks, Michael. It's great to be with all of you. Om, in our evaluation of the original CPC, we examined the effect of multi-payer collaboration on CPC implementation in each of the regions, and how, om, the payers came together to enhance their support to practices for changing care delivery. Uh, we did not look, om, at the effect on patients per se of the, uh, multi-payer collaboration. So specifically, we studied CPC collaboration activities through regular observations of multi-payer or multi-stakeholder meetings and qualitative data collection through annual interviews with participating payers, practices, and a number of other stakeholders. Om, we looked at these data by region and across the initiative as a whole to describe the collaborative dynamics and outcomes and assess the factors influencing them. I also wanna make clear that I'm speaking today drawing from our experience evaluating CPC, but I'm not speaking on behalf of CMS.

Anyway, let me share some of our findings. So there are 54 payers participating in CPC+; CPC original had 39 payers at its start, and this ranged from three to ten payers across the regions. I think it's pretty relevant in terms of lessons learned. Om, one of the most notable outcomes of CPC's multi-payer collaboration was the development of unified performance feedback reports. These unified reports took one of two forms: either aggregating the payers' data together in one single combined report, om, which three of CPC's seven regions achieved, or simply reporting the same measures in payers' performance reports with two regions achieved. In fact, some stakeholders described data aggregation as a potential game changer. Om, most notably, practices and regions with a number of different payers, rather than just one or two dominant payers, found the unified feedback reports to be, uh, incredibly useful. And early in CPC before the unified reports were developed, practices often had to review a half dozen or more feedback reports, each reporting on different metrics. [clears throat] Om, also important to note that it took two and a half years for the first region to deliver an aggregated report to practices. So it takes time.

A second, om, focus was aligned quality measures, and each of the seven CPC regions successfully reached agreement on a common set of metrics. Uh, but it's worth noting that agreeing on aligned measures was challenging, given that participating payers served different enrolled populations. So, for example, aligned measure for CPC placed a heavy emphasis on metrics relevant primarily to the Medicare population, and some payers such as Medicaid managed care plans, would have preferred more metrics relevant to the populations they served, such as children. Om, in part because of these concerns, only about half of the payers ultimately used aligned measures to determine practices' eligibility for shared savings, uh, in CPC. So while CPC . . . important progress in aligning quality metrics across payers, I suspect CPC+ may try to include metrics relevant to a wider set of enrolled patient population.

Turning to another area for payer collaboration, a number of patients and practices reported that their patients were confused by the presence of care managers at the practices and care managers from insurers and hospitals. Om, so this, uh, this might be – there might be room for developing an approach here to coordinate, then, with the practices’ care managers to, you know, best use your resources and not uh, overwhelm the patient.

And finally, CPC practices also struggled to arrange health information exchange with hospitals and ERs so they could learn when their patients were admitted and discharged and provide transitional care, om, and, you know, also deal with the frequent fliers. So I think there might be room in CPC+ for payers either in feeding this information directly to practices or brokering a common approach between hospitals and practices, so each practice in a region doesn’t have to figure this out for themselves.

So, just a recap, om, you know, the unified performance feedback reports, aligned quality measures, om, coordinating the care coordination, care managers and transitional care for patients, and, and doing some work to help, uh, bridge the information flows between hospitals and ERs and practices.

**[Michael Bailit]**

Ok, thanks, Debbie. So a, a number of these practices really, om, match up with the milestones in the collaborative roadmap, uh, but it’s interesting to hear how . . . played out. Om, I’m curious: did you learn of any common requests that practices made for care coordination that payers, om, weren’t able to achieve? And if so, were you able to identify the associated barriers?

**[Debbie Peikes]**

A good question. Om, the CPC practices were not necessarily making direct requests for payers to coordinate their efforts, so many payers did seek input from practices. More typical than requesting coordinated efforts, practices really pushed individual payers for timely performance feedback or questioned, om, what they perceived to be low care management fees from some payers. That said, the practices recognized and appreciated that payers were coming together to align incentives and encourage them to move, om, toward CPC’s goals. As one notable example of practices requesting care coordination, many practices liked the idea of unified performance feedback reports, which I mentioned earlier. Om, payers and most regions that aggregated data or aligned data feedback sought input from practices on the structure and content of what to include in the report. So, in Arkansas, for example, payers started providing practices aligned patient level data files, in addition to the practice level, of course after practices indicated that those files would be useful. But not all regions were able to make progress in this area, so, it’s a --, om, we can learn something from the barriers there. Uh, specific barriers, I would say, to successful progress on data aggregation included the time and prep work, taking considerably longer than payers had originally anticipated; om, anxiety among some payers that they might bear a disproportionate share of the costs; concerns around sharing proprietary payment data with a vendor; uh, for a time there was uncertainty about Medicare’s participation in data aggregation; and finally concerns about whether payers would realize a profit or return on investment, om, during the period of the initiative because it was time-limited.

So in considering what factors help spur collaborative success in regions that achieved it, we found two, uh, factors seem to be pretty important. The first, om -- . In CPC, each region had a facilitator that can lead payers and other stakeholders, and we saw that strong leadership from this facilitator played a very

important role. Ah, so it might be worth payers pitching in to fund a region-level facilitator in CPC+. Om, second – payers who have previously collaborated in the region tended to have more productive collaboration based on those relationships. Now, I’m telling you something [laughs] you can’t control, but we did see that, uh, regions lacking a strong facilitator and prior calla- at least, collaboration experience generally saw less engagement among payers and were not as successful in making progress on collaborative outcomes.

Now, other factors can also help strengthen collaboration. For example, most CPC regions had a payer champion, and by that, I mean a leader from one of the payers that sort of emerged organically as the group came together, someone just really stepped into the leadership, uh, really pushed the other payers along, and these payer champions played an important role keeping individual payer organizations and regions engaged in CPC, because everyone, all of you are facing, uh, competing organizational priorities. Om, the payer champion usually was not pushing an approach or strategy used by his or her specific organization, but rather just encouraging others to remain engaged and continue making progress. Om, it’s also worth noting and you all are probably aware of this, that, you know, the national payers, many of them, had to align with their organization’s corporate-wide strategy, so they may not have been as, uh, flexible to pursue approaches similar to the other payers in the region.

**[Michael Bailit]**

Thanks, Debbie. I’ve got one last question, and this is the natural clincher, of course, I’m gonna ask. Based on your assessment of payer impact on CPC practice transformation efforts, om, what recommendations would you make to, om, the payers participating on this call involved in CPC+ with the construction of the CPC+ regional insurer vision statement?

**[Debbie Peikes]**

A very good question, Michael. Om, first to state the obvious, uh, simply getting as many payers in your region involved as possible is really important. The greater the proportion of a practice’s lives that are covered, the more leverage is available for aligning incentives and changing care delivery. Uh, related to that, it’s important that payers don’t lose sight of self-insured lives. In some markets, self-insured lives, uh, made up a large proportion of the commercial age population, and in these regions if you didn’t have the self-insured lives in the initiative, it really, om, it really affected the level of funding available to practices to support practice transformation. So, uh, trying to get as many payers and as many of your lines of business, including self-insured, uh, in.

Second, I – I – obviously, identifying your goals, which might include unified performance feedback to practices; aligned ways to measure quality, and award performance, coordinated . . . , um, for regions that want to complement CMS’ learning supports; ways to promote information exchange between hospitals and ERs and the practices; and ways to coordinate care managers, as I, ah, mentioned before.

Third, uh, consider hiring a strong mutual facilitator at the regional level to support transformation efforts. Om, stakeholders in many CPC regions believe that having a multi-payer or multi-stakeholder facilitator was key to their success. So some of the things that those facilitators did included developing agendas, convening a . . . meeting, working with payers as needed on a one-on-one basis, and generally helping to get everyone on the same page and drive progress of the group. Om, particularly effective facilitators worked to gain purchase and trust; they fostered strong working relationships with and

among stakeholders; and they broke down broad initiative goals into concrete, achievable steps; om, and identified constructive creative steps to overcome barriers and make progress toward these goals. It sounds like some of the things that are happening in this call at the national level, but, you know, uh, at the regional level.

Om, fourth, having a realistic expectation of what you can achieve over a given time horizon is important. Om, so, you know, for example, in the case of the aggregated performance feedback, ah, there's a number of steps. Ah, participating payers must be willing to commit time and, and, and dollars; uh, select vendors; uh, work through contractual arrangements; and set up a governance structure; and it just takes a lot of time to work through those details, especially when each of you may have your own organizational constraints to, to balance. Om, given that the costs [coughs] of aggregation are typically split across payers proportional to the number of attributed lives they have in a region, waning commitment of one or more payers over time can have a big effect on whether a region can pull off aggregation, so, om, it's tricky.

So finally, our experience with the evaluation also suggests that payers should try to coordinate as much as possible with other regional initiatives. I say that, and at the same time, I do understand that CMS and some national payers may not be able to do this, om, again, due to some organizational constraints. So, uh, in some CPC regions, other primary care transformation efforts and HIE efforts, health information exchange efforts, were also underway, and often involved many of the same stakeholders. So, in cases where there was a lack of alignment in coordination among these concurrent initiatives, increased administrative burden, frustration, and confusion for practices, uh, which of course blows back to the payers. So, con- conversely to give some that initiatives can coordinate on and work toward their common goals is alignment provided a clearer and stronger signal to practices about what they should be working toward.

**[Michael Bailit]**

Great, Debbie. Thank you so much for giving us some of your time today. Om, I understand you can't be with us for the duration of today's conversation, but I want to remind everyone that if you've got questions about anything that Debbie shared, and I think that this is really some rich, helpful information, uh, to please put your questions into the chat box . . . so if anybody else has questions, uh, type them into the chat box. We will forward them to Debbie subsequent to, uh, today's conversation and provide you with her responses. So, Debbie, thank you again.

**[Debbie Peikes]**

Well, thanks for having me, and I really wish -- . I look forward to working with you all and wishing you . . time for everyone.

**[Michael Bailit]**

Thanks. Uh, all right, so uh, I'm gonna turn now to the PAC's very own Alicia Berkemeyer, uh, for questions that om, pivot away from assessing om, uh, what might be, uh, measurable, om, outcomes or ends that you might include in your vision statement for payer action to om, how might you assess uh, activity at the practice level. So, Alicia, welcome. Uh, my first question for you, om, has to do with, uh, measuring practice transformation. Om, it can be challenging to both payers and practices, om. Many

payers have opted for using external organization recognition systems with simplicity of administration, uh, but some others have reviewed care processes themselves at the practice level. Can you describe first what approach, om, you took and why.

**[Alicia Berkemeyer]**

Yes, I'd be happy to. Om, with the Arkansas model, we have, om, all along felt the importance of payer collaboration. Within our state we . . . 1600 practices and from a regional learning and faculty, we had two representatives. We actually started with one for a while for 69, so we as payers in the state came together and realized very quickly that we had to come up with solutions to support the practices because this was, for many of those practices, something very new and very difficult, om, for them to jump into. So we very quickly learned to work very closely with -- and our market was TNF om, it was TransforMed and then it turned TNF through the initiative. We tried to, as payers, bring to the table anyone that possibly could be working with a practice, or that could be in the practice, hear something from the practice, be contacted by the practice, to set up some communication process where we could collaborate and coordinate the practices and their success or possibly the practices that might need a little additional work. So that seems to be what has worked for us, and that measurement of success and really trying to put some focus on highlighting what practices in our state have done an exceptional job in particular areas of the milestones, and then trying to get those practices to work with us to share best practices with the others. So collaboration --

**[Michael Bailit]**

So, Alicia, when--. I'm sorry, I want to ask. So, did, did TransforMed or TNF essentially, om, make -- render a judgement for each practice in terms of whether, om, they had adequately transformed and then share that with the payers? How did that work?

**[Alicia Berkemeyer]**

Yes, that, that's typically om, based on the milestones and performance, TransforMed, and then TNF, that's, om, -- really would bring to the payers because -- each of us would bring -- . We have medical directors, we have network development reps, we have practice transformation coaches for all the payers. And so with those resources, if someone was gonna be in the area, we wanted to make sure we were all on the same page and understood who it was that was maybe needing some help and support, and that's kinda the -- . We let, om, TNF kinda lead that for us.

**[Michael Bailit]**

Ok, om, and, and it sounds like all the payers took the same approach, and I take it that was used as -- a good approach to take?

**[Alicia Berkemeyer]**

I think so. Om, you know, practices from the standpoint of the amount of work that has to be done, always request. . . more support and more help out there, but given the limited resources, I think it's worked very well.

**[Michael Bailit]**

And, and did, so did the practices feel that being assessed by TransforMed/TNF was, uh, burdensome, or I, I, I guess, that's probably, uh, a yes. But what kind of feedback did you get from using, uh, a third party agent to do this work for you? From the practices?

**[Alicia Berkemeyer]**

Well, I think the practices saw it as a collaboration, not so much a third party, because of TransforMed/TNF being contracted as a learning . . . CMS. They represented the Medicare population. And the rest of us as payers, either Medicaid or commercial payers, represented our business and understood. One of the things that we've heard from the practices is that they appreciate our coordination and our collaboration and our support working together. Om, I think Arkansas market is best known --. We, we have been guilty of maybe over-collaborating sometimes. But to this point, four years later, we still, every Monday are coming around the table and trying to align. It doesn't matter if it's practice support, if it is reporting back to the practices, trying to get our data fees back to the practices so they can drill down consistently with every payer down to the patient level. Om, our activity and quality metrics, trying to be very consistent, and then also sharing as much communication. Because at the end of the day, what we're trying to do is, is support the practices as best we can. And we know they've got a very difficult job in the transformation. And trying to come up with solutions on how can we make their big list easier. Om, one of the most recent things we're talking about right now is we're trying to work with CMS and the payers and even, uh, we're talking with Kansas City and Oklahoma too, can we create an audit process so it doesn't matter if the Medicare representatives and Medicaid representatives or Blue Cross or QualChoice goes out. If we go and audit the practice, how can we share that information so we don't have five people going into that practice for that same process. So, that's the alignment I think that the practices need and want from us, and we're working very hard just to see what kind of solutions and support we can help.

**[Michael Bailit]**

Now, you didn't go the, om, NCQA route, which a lot of payers do and require the practice to demonstrate that they are transformed, om, through NCQA recognition. Can you explain why you didn't take that approach? Om, and, om, and I guess can you just explain the rational for why you took the path you took and not that path.

**[Alicia Berkemeyer]**

We actually, om. So, Arkansas Blue Cross and Blue Shield early on did a pilot back in 2009 and '10 and we really did that pilot based on NCQA recognition at that time, just to see how, you know, what the list was. And at that point based on the requirements, we did not see the alignment towards truly making transformation. Since then, the standards have changed, and Arkansas Blue Cross and Blue Shield did start, om, rewarding practices that were NCQA recognized with a higher care management fee, but it's not a requirement. And, om, you will see that change a little bit going forward, but I think the standards NCQA has, has come up with and the changes that they're making, we --, they do align more in practice transformation. Our concern was sometimes you can get a recognition, and you can check all the boxes, but not really change. And we really want to make sure we're making the changes, and they're sustainable changes and the practice to continue delivering true patient-centered medical home care.

**[Michael Bailit]**



Mm hmm. Ok, yeah. That makes sense. Ok, so let me move onto my next question and just remind all of you that if you've got any questions for Alicia or if there's anything you want to comment on, om, related to these topics, feel free to, uh, type it into the chat box, and, om, and I'll call on you momentarily. Om, so Alicia, my second question is – has to deal with, om, quality measurements. Om, it's uh, challenging to especially for important clinical outcomes, om, that you really can't pull a lot of claim data. Om, and traditionally, payers have not had access to clinical data to assess values like blood pressure or, om, blood sugar values, om, or non-billable, om, services like, uh, screenings for tobacco use. Om, can you talk about the approach that you took to assess quality impact given the, om, challenges of not having the, the access to non-claim based data?

**[Alicia Berkemeyer]**

That's really been a challenge in our market. Om, Arkansas has probably many more EMRs, home grown little EMRs out there, than maybe some of the other states. And so, unfortunately, what we really had to do with much of our quality during CPC was focus on claims data. We have, as a state, been really working with the practices trying to do some exploration and research and trying to see what we can do in receiving eCQMs and how we can set up connectivity with at least the most common EMRs. We have a patient-centered medical home portal and a care management portal that, om, we're looking at trying to share the data and receive that information. But, om, you know, we're working toward that progress; I, I sure wouldn't say that we've, you know, we're anywhere close to winning that battle. And that's one of the challenges, I think, is, is we do need that clinical and, that's when we did our pilot back in nine and ten, I guess I was foolish enough to think that oh it'd be, you know, we can get a vendor, and we can pull our, our claims data, and we can pull our, you know, the EMR data, and we can make actionable reports that everybody's gonna be better for. And one of the things we learned through that two years of struggle is that not only is it, om, difficult to get out of the different EMRs, sometimes within a particular practice, if you're not consistent on where you enter those fields, you know, it's kinda that old garbage in, garbage out. And so, we really felt like we had to step back and even start working practice by practice just to say, you know, I understand you ask every person if they smoke or not, but if it's not entered into the same field, then it can't be pulled out of the EMR, you know, and reported upon, then it didn't happen. So we feel like we've, we've really had to be boots on the ground working with the practices and the clinics and the different EMR, om, vendors to try to at least even get the data entered and aligned and processed so we can pull it out more clearly. But, we've done a lot of work and we've got a whole lot more work to do in that area.

**[Michael Bailit]**

So are you today using common claims-based measures across payers to assess practice, uh, quality?

**[Alicia Berkemeyer]**

Yes.

**[Michael Bailit]**

Ok. Ok. So for you, then, for your regional vision statement where you might include some quality objectives, you're going to include, om, at least in the, the initial terms, if not the later years of CPC+, om, performance improvement on claims-based quality measures. Is that fairly said?

**[Alicia Berkemeyer]**

Yeah, we're, we're really, om, it will be that but then we'll also be including that we want to move to getting the clinical data as well to support that. Our hope is that by, that by '18 we can start getting some of the MR data and the clinical data and the outcomes data along with the claims.

**[Michael Bailit]**

Ok, great. And I think, as many of you know, om, track two of the PAC is, om, focused on data aggregation and measure alignment, and that will be looking at some case examples of, uh, work, uh, aggregating data and aligning measures during our next call for track 2.

Ok, om, any questions that anyone has, uh, for Alicia regarding the work that she's described or any commenting you want to share regarding their own work? Peter, I see a comment for you, but I think it had to do with, om, Debbie's presentation.

[indistinct speaking]

Anybody else wanna share any thoughts? All right, well, Alicia I want to thank you for, uh, responding to my questions and sharing, om, the approach that you've taken to assessing practice transformation both in terms of performance and clinical quality, om, and uh, I'm sure the thoughts you shared and decisions you made will, uh, resonate with a lot of other people on the call.

**[Alicia Berkemeyer]**

Absolutely, thank you.

**[Michael Bailit]**

All right, so, yeah, so I'm gonna turn to om, our next conversation, om, and this is with Peter Bachini Vaccini and Jackie Ball who are with Aetna, om, in the Philadelphia region. Aetna is partnering with Independence Blue Cross, om, in a new region. They were not involved in CPC classic, and so, om, they've got to work together to create, om a new, uh, vision statement because there wasn't a previous one from which they could work. So, om, ah, we have asked Peter and Jackie if they can share what their process is because they're earlier along, uh, in the process, uh, and how they are working, om, uh, with uh, Independence Blue Cross, um, to develop a vision statement, what the process is and their timeline. So, Peter and Jackie. Om, can you, uh, can you just, uh, share, um, how I guess in this case it's just two payers so it was obvious who should participate in the process. Om, but can you share how you'll manage the process or how you are managing the process with, om, om, IBC because this is something new for both of you, om, to work cooperatively on something like this.

**[Peter Bachini]**

All right, thank you, uh, Michael, this is Peter. Om, and I, I just wanted to, to say that we're not going to speak for IBC on this. We're gonna, we're gonna speak for Aetna and, and sort of the process that we're going through, and om, to add a little further color to it, we, we do have yes, SEPA is a new region for CPC+, but we also have some experience and some knowledge from our current region, uh, which is om, in Ohio. So, we, we do have some lessons learned and some information that we have taken from there, but in all honesty, SEPA is just sort of a different animal, and, and, and was very very different, so we, we

looked at, om, CPC+ as just one of, you know, being a national payer, we have a number of value-based contracting, we call them VBC models in different areas, so in, om, agreeing to participate in the, the SEPA region, uh, we really did look at om, one of our models because we do use a PCMH model in different areas. Om, SEPA happened to be one of those areas where our collaboration model, uh that we have for value-based contracting was gonna fit, and, and om, and it was gonna, you know, dovetail nicely with, what we thought the goals and objectives for CPC+ were, uh, which is, you know, similar but different than, than CPC classic. So, om, we got together and, and, we don't have a convener, quite honestly, and it, and it was interesting, uh, what the previous speaker was saying, not Alicia, but the person from Mathematica, om, about, you know, how things moved a lot smoother in those areas with a, with a convener and we, quite honestly, you know, we're committed to this, and so we have been in discussions with, om, with IBC even without the convener in place, but realizing that we needed one, uh, I'm happy to say that we have, uh, preliminarily selected one for, for that region, so, uh, recognizing that it's important, especially when you're talking about data aggregation, that'll be very very important down the road. Um, we looked at that and have, uh, have come to agreement on who we're going to select moving forward, so that, that was probably the first major milestone even before talking about, uh, what we thought our, uh, value proposition was gonna be. I think, you know, based on previous meetings, uh, we all and when I say we all, all of the regions we're talking about the, the triple aim and the, the quadruple aim as sort of the basis for that and then sort of tweaking it regionally based on what we, what we felt we needed to do. So, uh, that's kind of where we're at today with our, our partner. Om, we have not had a meeting yet with the, uh, convener entity, uh, also included but we have had a good, I'd say half a dozen meetings almost, uh, between ourselves talking about these things and trying to agree upon it, and, and sorta CMS has attended these meetings as well, and sorta been the de facto convener, I will say, at least the, the moderator, uh, for these discussions.

**[Michael Bailit]**

Uh huh. So, om are there any challenge, obviously I think, except for you, for you to have a facilitator. Om, are there challenges that you anticipate, om, needing to work with another carrier to develop a vision statement, and if so, om, how do you think you'll manage it?

**[Peter Bachini]**

Om, not necessarily, uh coming up with a vision statement. I, I think, uh, as I said the, the quadruple triple aim that we've taken. Om, I think there will be a little, I'll call it, maybe friction is not the best word, but I'll call it that, is, there's different models. While in, om, SEPA we, we are going to be doing that. Aetna is committed to that for just the Medicare population. When we evaluated the different populations that we have in that region, Medicare was the best fit for it, so we don't have commercial or, or, Medicaid doing that. Om, that's, that's a difference and we're, we're certainly going to have a challenge there because I think commercial has a different perspective, certainly, on the types of quality measures and things like that that you're going to look at versus Medicare. I don't want to call it prescriptive, but it's pretty defined, Medicare. You know, the stars measures are the most important thing, so that's certainly what we would look to do, and I think IBC may have a different perspective given that they're commercial and, and, om other lines of business.

**[Michael Bailit]**

Mm hmm. Yeah, that makes sense. Ok, was there any other idea that you took away from my prior conversation with Debbie and Alicia that you think will, would be able to apply to your process?

**[Peter Bachini]**

Uh, oh, absolutely. Particularly the convener piece, and, and I think her discussion points on the aggregator, om, if I look back on how another region that we are in has done it, like Ohio, they are pretty, I'll call it pretty far down the continuum, maybe not as far as it sounded like Arkansas is, but certainly they're close to that because they do have a convener, uh, said convener who's been, uh, very, very collaborative and every payer in the state in Ohio needs to participate in this because the state is, is om, on board with CMS and they actually have their own uh, CPC, uh, they call it CPC+ as well, but it's based on the brand, so they have significant alignment with regards to quality measures and how they're reporting it and how they're collecting that information. They have a state-wide HIE that's in place. Again, those are things we're, we're hoping to maybe get in uh, in uh, Pennsylvania and, and we'll look toward that, but I think, particularly on the aggregators' position, that's gonna be a long, much longer process and different process because of the, the uh, challenges that I mentioned, or the differences that I mentioned.

**[Michael Bailit]**

Mm hmm. Ok. Uh, by the way, for those of you on the phone not familiar with the term SEPA, that's an acronym for Southeast Pennsylvania, S-E-P-A.

**[Peter Bachini]**

Thank you, Michael.

[Peter and Michael indistinctly talking simultaneously]

**[Michael Bailit]**

That's ok, part of my job is to be a translator. Om, thank you very much, Peter, for your willingness to describe where you guys are, om, in your process. Om, as I shared, om, earlier in the conversation, om, for our next meeting, 'cuz we've only got about five minutes left, om, what we would like to do is om, ask, om, om, uh, a few of you to share your vision statements. Based on the polling we did, some of you have completed the process and some of you are well along the way. So, om, we'd like to ask you to share your draft statements, om, with, uh, LAN team by February 10. Uh, Peter and Jackie and whoever may be on it from IBC, I'm giving you guys a pass given where you are right now in the process, but sounds like most people are, uh, much further along. So, om, uh, you'll get some follow up from Cathy and Lauren, but we'd like to spend time during our next conversation on February 17<sup>th</sup>, uh, reviewing, uh, what things look like and allow you to talk with one another about what you've drafted and ask questions, give one another feedback, uh, because no doubt you will vary in your approaches, and I think that might be a nice, uh, learning opportunity. So, om, we'll send you a summary of this conversation by February first. Om, as a reminder, if you've got any follow-up questions, uh, for Debbie on her presentation, uh, put them into the chat box or, or, email them subsequent to today's conversation. Om, we, om, again are asking you to share by February 10th, which is the week before our next conversation, your draft vision statements, om whether it's om, final or still in process. Om, and let

me ask, om, are there any other requests that any of you have for follow up or for future meeting content that you would like to make sure that we cover that would be helpful to you, for this track one?

Okay, any feedback on today's meeting? Om, did you like hearing from the people you heard from? Did we ask the right questions? Uh, is there something we can do to better meet your needs next time? [59:15] I would love at least one piece of feedback. From any of you. [coughs] All right, Jack said he enjoyed hearing from everyone. Thank you, Jack, and Patrick, uh, said the presentations were good and the problems were common ones to, om, ones that I assume he's experienced and probably many others of you as well. [coughs] So thank you, Jack and Patrick, for your feedback.

All right, so, om, as always feel free to follow-up, om, with us. Here's our contact information for the, uh, PAC team, and uh, we look forward to talking to you again on February 17<sup>th</sup>. Thanks, everybody.

**[unidentified person 3]**

Thank you.