

Transcript of PAC Track 2 (Operationalizing CPC+ Data Distribution and Aligning Quality Measure Sets and Reporting), Meeting 2

January 30, 2017

[Music plays, slide appears at 01:12:10; presentation begins at 00:54:18]

[Charlie Fazio]

Well, hello, everybody. Uh, here, in the middle of the country, it's two minutes after noon. Um, my name is Charlie Fazio. I'm, eh, Chair of the PAC and I want to welcome you all to today's call. This is Session 2 of Track 2.

Um, you know, I've shared a bias with many of you, eh, before today. Um, and that bias is that I think one of the most important things we can do as an industry — whether as payers or providers — um, is change how we pay for care. And underneath of that is giving clinicians actionable information, reducing some of the background noise. I think those things rank right up there with [unintelligible] and are integral parts of it.

Um, so, I'm really excited about today's conversation, and the whole PAC team is...is really pleased that you're part of this conversation today. Eh, so, thanks for being here. Welcome, and with that I will turn it over to Michael Bailit].

[Michael Bailit]

Thank you, Charlie. Hi, everybody. So, eh, as Charlie said, this is Track 2, um, and Track 2 has two components. We are on the first part, which is Operationalizing, um, Data Distribution. Or, maybe otherwise stated, it's about Aligned Payer Data Support to Practices. Um, and so we, eh, we stepped into this the first time in Meeting Number 1 and we're going to continue exploring this topic today.

Uh, I'm going to, eh, do a little overview in principles work, then briefly summarize what we talked about in our first meeting, eh, and then we're going to focus today, really, on looking at, um, the range of options for aligning Payer Data Support, um — the shorthand term we're going to use today is Data Alignment — eh, and look at the range and then do some focused examinations of two approaches, one in Michigan and one in Arkansas, and I will be interviewing some esteemed guests to help us, eh, learn.

As always, you have the chat box function open to you. So, if you got questions, um, that you want to raise for me or for the people with whom I'm going to be speaking later, please enter them there. Or, if you have some information you want to share about what you are doing in your own region, you can enter it there too, um, and I'll make note of it and, eh, we'll pause and address what you'll like to share.

Eh, so, um, just a reminder, um, please comply with Federal law and don't share any information about, eh, financial arrangements during our conversation today. Um, our principles that we adopted previously called for us sharing information in a respectful, graceful manner, eh, so that we can, eh, share learning with one another. Um, please don't lobby CMS, and please do give us feedback, um, in the chat box at the end of the meeting and then after the meeting on what we can do to make these sessions helpful to you.

Um, as a reminder, we are focusing Track 2 on two of the 10 milestones in the CPC+ Payer Partner Collaboration Roadmap, Data Support and Quality Measurement. Eh, we're going to move to Quality Measurement later on, but, um, we're staying today with the topic of Data Support Practices.

During our first meeting, eh, we had some conversations about, um, how you all would like to support practices in your region in terms of their use of data and how you might do so in an aligned, cross-payer fashion. Um, overall, I would say the themes, eh, focused on what you want to provide and then how you want to provide it, including in a multi-payer context. All this with, um, a presumed, um, application then by the practices receiving the information. And I'm not going to read you all these bullets, but this captures, I think, everything that you shared at our first meeting.

Um, in addition, um, we talked about, eh, both, um, coordinating payer efforts, then separate reports to practices that might be aligned in content and format, as well as a more evolved strategy of actually aggregating data and then distributing, um, information reports using the aggregated data. Um, then, we talked a little bit about what's going on within the regions, and we certainly have a mix. Um, some of you are doing aggregations, some are aspiring to it, and some of you, um, you are not aspiring to it. First, if you can get to, um, alignment of, eh, reports in content and format, that would be a big step forward. And we heard, um, stories from, um, the states [unintelligible].

So, for today, I'm going to briefly review, eh, a continuum of sorts of data alignment approaches, and then we're going to, eh, have two conversations. Um, first, on an aggregated, eh, data strategy, um, and then on, um, a strategy that's focused more on aligning separate, eh, payer information distribution initiatives. Eh, and this is all in anticipation of us moving towards, in our next meeting, having you begin to share what some of your plans are, um, and have the opportunity to teach and learn from one another.

So, um, in terms of the, um, continuum concept that I referenced, um, I think the schematic provides a helpful way of thinking about data alignment approaches. Um, the first, um, step that many regions take is to try to align the content in a format of separate reports from individual insurers to providers. And so, that can mean that, um, simply stated, everybody's sending information or reports out in Excel files to make it easier for practices to both do analysis and to activate information. Um, you know, a step above that is to say, "Well, and the reports are going to be sent in Excel with a common layout." And then, beyond that, um, the

reports are actually going to have common data elements. So, um, all in Excel, all the same layout, and all with, eh, the same data elements. That's a little bit of a mini continuum of how to create alignment without actually aggregating data. And then, of course, the step beyond that, below, is aggregating data, which could be aggregating claims data or aggregating clinical data, or both, um, which is, you know, probably the most, um, evolved strategy.

Um, but, um, the construction of the data is separate from the distribution of the data, and the right side of the slide really depicts some of the options for providing data to practices. So, um, sending separate but aligned reports is certainly a first step. Um, those reports can be sent out, um, individually by the payers or they can be made accessible by a common portal, because practices frequently complain, especially marked [unintelligible] about having to go to several portals to get different reports. Um, a further evolved strategy is sending a single report to practices, um, and then another strategy is, um, making data available in raw form via a web portal so that more sophisticated and larger organizations can do their own analysis; um, or providing web-based tools so that practices can go do their own analysis, eh, from an aggregated database. So, um, these are both, um, content construction and distribution strategies and they, um, they can be mixed and matched. But I think this, um, describes at least a range of options for, eh, data alignment, particularly in a multi-payer, regional strategy, um, which is of course envisioned by CPC+.

Any, eh, any thoughts and reactions to the slides? Does this resonate for you?

Okay. I'm not hearing anything or seeing anything in the chat box.

So, um, I think I'm going to, um, move on and note that during our last meeting, I think we identified some, um, data alignment strategies that fall into both an aggregation, um, category and, eh, a report alignment category. So, data aggregation: I think we identified a handful of states that, um, in some manner are doing this, and they are certainly not doing it the same way. We're going to hear, eh, in some detail from Michigan today. But what Michigan's done is quite different, for example, than what Vermont has done, and this slide just gives you a... and I won't even describe it as a fundamental schedule [unintelligible], but I'm going to let you know where there are some state or regional efforts that are aimed at data aggregation.

Um, and, um, there are of course, um, other, um, states that have not aggregated yet... I can hear somebody talking, so if you would mute yourself. I'd appreciate it. Thank you. I think we'd all appreciate it.

Um, and then, of course, oops [referring to skipped over slide] I didn't mean to go there yet, but I will go there in a minute. But there also are data alignments, and I'm going to share a couple of states that are doing the alignment later. Um, so, a couple of, eh, notes, um, that came into the chat box. Um, Charlotte Chris asked about frequency of reports. So, um, later on, um, actually momentarily, I'm going to talk to, um, a couple of people from Michigan and then we're going to talk to, um, Arkansas Blue Cross, and why, eh, don't I ask those speakers in

advance that when you share some information to let the group know how frequently you are distributing information, eh, to practices under your own initiatives.

Okay. So, um, our first guests are Diane Marriott and Ellen Bunting. Um, they are going to, um, share with us information about Michigan's, um, aggregated data strategy, which, I have to say, I think is a pretty cool one, um, and, eh, I look forward to having them share information with us. So, I'm going to ask them a few questions, um, and I'm going to invite all of you, um, to identify other questions you have. You can type them into the chat box, um, and, um, I will pull them up. Bill Golden's already shared a comment and that's something I'll ask of him later on.

But, um, Diana, I'm going to start by asking you how the Michigan Multi-Payer Primary Care Transformation Initiative — um, eh, which really has been a national leader in data aggregation of primary care practices — came together, eh, what led to the efforts starting, and, um, how many payers do you currently have participating.

**[Diane Marriott, Manager, Michigan Primary Care Transformation;
Lecturer, Department of Health Management and Policy, University of Michigan]**

Surely. We were catalyzed by the sister project to the CPC classic, the CMS' Multi-Payer Advance Primary Care Practice Demonstration, which launched on January 1st of 2012, um, and we were stayed without a pre-existing, multi-payer state database.

Um, as we, you know, planned for the MIPCT, the Michigan Primary Care Transformation, which was our brand name in Michigan for our participation in the MAPCT multi- payer demo, we knew that data, you know, as was referenced earlier, the whole concept of informing change through common data and through a common financial and clinical model, was very key. So, from the beginning, um, it... From the beginning, this idea of a multi- payer database for the project was an important one.

We began with four payer: Medicare, BCBSM — BlueCross and BlueShield of Michigan — BlueCare Network, and Medicaid. In 2013, we were grateful, in the middle of the year, to have grown a payer: Priority Health, in the west side of the state. In the breadth of that expansion, the... um, although it originally started as a three-year demonstration project, we advocated for and received a two-year extension from CMS and from our participating payer.

We have 350 practices, about 1.2 million member lives, 37 physician organizations — which are kind of a special construct in Michigan, but, um, each of our practices is a member of a physician organization — 1,800 PCPs and, importantly, about 400 trained, care managers in those practices.

And again, we were a five-year demo from the beginning of 2012 to the end of 2016, but are grateful to have transitioned in coordination with our payer leadership into support of both the state PCMH SIM model and, of course, Michigan is also a CPC+ state. So, in terms of catalyzing, it was definitely the opportunity for Medicare to join Michigan back in 2012 with the MAPCP and, um, that was the initiation of the opportunity for the data aggregation approach, reporting

approach, a common care management training platform, and other support to advanced care. So, that's—

[Michael Bailit]

Diane, what— Sorry. I'm sorry for cutting you off. Can you share that data that you are aggregating right now and how many years it took for you to get to the point that you were aggregating?

[Diane Marriott]

Sure, and I'll partner with Ellen on this. Um, at the start of the... You know, we did some planning in 2011 for the launch on January 1st 2012, because there were a number of different attributes that were important to this. One was, um, for the practices to understand who the eligible members – who these 1.2 million lives – were and how that looked in their practices. So, um, you know, the... So, the... In short, the information that was aggregated included eligibility information. It included claims information. It also included – at a slightly later point – um, some information from the clinical record regarding, you know, some quality measurement, which I want to talk about. And we've also done some things in coordination with our health information network in Michigan, MiHIN, to enable, for practices with... um, that want to partner with us on it, ADT-alerting and those kinds of things.

So, we began in 2012, uh, and the member list was initiated early in 2012 through the Michigan Data Collaborative, so practices would know, on a multi-payer basis, which members were attributed to them. And it took about a year for the... uh, for us to receive the data, to really allow the MDC to get up and running with common reporting.

Ellen, do you want to talk more about, um, the timing from or—

[Michael Bailit]

Eh—

[Diane Marriott]

We defer to you, Michael.

[Michael Bailit]

Yeah, yeah. So, I'm interested... So when did the claims come and when did the clinical data come from? And you made reference to it coming from, I think, EHR, so a little bit more on that would helpful too. So, Ellen...

[Ellen Bunting, Manager, Michigan Data Collaborative, Michigan Medicine]

Yeah, sure. Um, I sent along a timeline that I think will help describe this. Brian was going to slip it into the slides here. And I think it'll help everyone understand, 'cause it's kind of complicated. But, uh, this does a good job of letting you understand when things started.

So, you're asking about when did we get data? Um, these... over on the left-hand line, in 2011, shows that we acquired Medicare and Medicaid data first. And, um, then, uh, the solid lines describe at what point where we actually displaying the data for physician organizations and practices to consume.

And so, it wasn't until 2012 that we had our first portal and dashboards out for people to look at the Medicare and Medicaid data. And then, as payer came on board and we, uh, were able to acquire their data, we were able to integrate it into the dashboards so that it could be a fully-integrated multi-payer set. So, um, I'm talking about, um, medical claims, pharmacy claims, and the eligibility data. And we then made a common set of quality measures that, um, kind of came on board a little bit in a staggered way too. And that's the green lines.

In the beginning, we had adult and pediatric quality measures and then we were able to, um, do comparisons by physician organizations of those quality measures. And then the final addition to the measure component of the dashboards was the electronic clinical quality measures. So, that's when we married EHR data that we got directly from the POs. So, the physician organizations for their participating practices would send us data from their EHRs, and then we aggregated it here and combined it with the claims data in order to create data that was supplemented by, um, electronic data.

And then you can see how the measures—

[Michael Bailit]

Sorry, Ellen, um, I just want to understand. So, the POs were sending you... Were they sending you measures or they were sending you raw EHR data?

[Ellen Bunting]

Raw EHR data that we processed and were able to pull out. They all used a common layout that, um, they were all familiar with because they were sending supplemental data in this fashion to one of our major payers, BlueCross/BlueShield of Michigan. So, they were familiar with this layout, which put us very far ahead of the game. And we could tell them, "Okay, so from this layout, we're going to be using these particular data elements in order to create the measures that, uh, were of interest." And so we worked pretty diligently with the physician organizations and the EHR vendors in order to get the extracts to us so that we could then combine it with the claims data to create either supplemented, heeded measures or else, measures that were a denominator from claims and an enumerator from the electronic medical record.

[Michael Bailit]

Great.

[Ellen Bunting]

And you can see at the top here—

[Michael Bailit]

Ellen, one question that just came in...

[Ellen Bunting]

Sure.

[Michael Bailit]

...from one of our participants—

[Ellen Bunting]

Uh-huh.

[Michael Bailit]

Right? [Reading the questions aloud]: I see that you got data from the ED coming to your system. Did you have arrangements with all the hospitals in Michigan?

[Ellen Bunting]

We were calculating ED measures from the claims data. So, we were able to figure out, um, you know, an ED event table – we called it – and then that’s how we calculated the ED admissions, or the ED rates, from the claims from the participating payer. Same with the, um—

[Diane Marriott]

...Initiative, right, we have for ADT-alerting, which is a partnership with some... with another organization. If there’s time or interest, we can talk about that later.

[Michael Bailit]

Okay, um...

[Diane Marriott]

But none of this—

[Michael Bailit]

No cost data is being distributed?

[Ellen Bunting]

Nope. We did not receive cost... We received cost data from Medicare, but we did not use it. We used it to make sure that where we were going with our standard costs was, uh, directionally appropriate, but we didn't report the actual Medicare cost data even though we received it. What we did instead was we created common standard costs across all of the payers and then we were able to calculate a per-member, per-month, um, measurement and, um, through standard costs. And those were available from the beginning.

[Michael Bailit]

Okay. Um, I'm wondering... Um, did you have any concerns and did you just take it... And did you take any steps to ensure comparability of data, particularly the EHR data that was coming in to you?

[Ellen Bunting]

Um, comparability...? Do you mean like...?

[Michael Bailit]

Well, you're relying on the practices, um, recording information in their EHRs consistently and accurately. So...

[Ellen Bunting]

We are.

[Michael Bailit]

So is there any... You are. Okay. And any issues with credibility on the parts of the practices when receiving your reports and saying, "Well, I don't trust the data"? Or, "I don't think data quality is good."

[Ellen Bunting]

Um, I would say that it wasn't necessarily, uh, "I don't think the data quality is good." They didn't... "The EMR data was not complete." So, we had 36 out of 37 POs sending us data, but they didn't send us data every month and they didn't send us data for their entire member list or every practice. So, some of the POs depended on the practices and, uh, to send them the information so they could send it on to us. Some of them had a centralized registry from which they drew the data. So, they were doing it in different ways that meant that the data wasn't complete for every single physician organization and practice. But what it was, was a very good way for them to determine how robust their, um, reporting systems were for this electronic clinical data. So, it really did help them move ahead to a point where now we're in the SIM world, um, where we're, uh, part of the state innovation model and the PCMH initiative is

requiring, uh, in order to be eligible to be able to send such a file... So, they're already, um, very far ahead in that domain because they've had practice, for the last five years, getting it to us.

[Michael Bailit]

Uh-hum. Okay. Bill Golden noted in the chat box that he sees a major speed bump in data aggregation being the lack of consistent, um, codes for benefit limits. Did you encounter either as a challenge?

[Ellen Bunting]

Um, well, we met to a common APCD layout and, um, we took a lot of, uh, help and, um, direction from NADO, which is, uh, National Association for...

[Diane Marriott]

...Health Data Organizations.

[Ellen Bunting]

Health Data Organizations, yes. So, they have a lot of resources there for organizations, which helped to build a multi-payer or all-payer claims database. So, we spent a lot of time way up front – and that's in the data acquisition area – of talking to the, um, different payers and making sure that we understood how their layout met to our layout. And then, once we did that initial work, we could really depend on what we had in our database as something we understood and we were able to report back to the, um, participating physician organizations and payers this new format that kind of helped them send us the information later. You know, it kind of evolved over time, so that we were always updating and getting better at understanding what each other's, uh, data dictionary was saying. Did that answer the question?

[Michael Bailit]

Bill... Yeah. Bill, do you want to ask a follow-up question? You can do so, you know, on the phone.

No? Okay.

Okay. So, um, you know, one of the things we want to focus on, 'cause this is really intended to be a, uh, a collaborative learning, uh, and action group... Uh, we're interested, um, then, Ellen, in the challenges that you faced along the way, um, that you both... you feel that you've been able to overcome and those that are still, um, continuing to stymie you. So, can you share the, you know, school-of-hard-knocks lessons that you've learned over time?

[Diane Marriott]

Ellen, how about if I start and then, um, I'm sure you'll have some great observations to add? Is that alright?

[Ellen Bunting]

That's fine. Thanks.

[Diane Marriott]

[Unintelligible]...When we, um, just in terms of the challenges we faced, I'd name a few. Initially, at the beginning, we were able to avert a bit of a challenge by incorporating, within our structure, um, a very, a small administrative fee that was paid in the PM, PM-basis by our participating payers, without whom none of this would be possible, um, and that admin fee... Our biggest line item on the admin fee was for the Michigan Data Collaborative, understandably. Um, but that allowed a resource and funding method for us to accomplish the important goal of data aggregation and a combined data aggregation strategy. And you know, we've just, uh, been, you know, in contact with and have observed that, um, in many states that can be a limiting reagent. So, figuring out just the technicality, the technical logistics of trying to streamline the process as much as possible and to share the cost equally was quite helpful to us, um—

[Michael Bailit]

So, who was your champion here? Was it Medicaid who first said "We're going to pay for it?" Was it BlueCross?

[Diane Marriott]

The whole, uh... I think our commercial payers have always been strong advocates of, um, of care transformation, particularly, in primary care in Michigan, but the whole opportunity to have Medicare coming to the table, we... In our proposal to Medicare, we incorporated a small administrative fee, which they granted in the, uh, in awarding Michigan as a part of our payment structure. So, that was immensely helpful, to bring the Medicare lives... to bring in as an opportunity the Medicare lives. Medicare, CMS, paid that admin fee, just as our other, um, participating payers did. So, it was, uh, that really became a catalyst for, uh, you know... BCPSM had a pre-existing program, which continues today, called the Physician Group Incentive Program, or PCHIP, so they certainly had a foothold in much of this work. That was tremendously helpful. Um, you know, Priority Health and BCN also had some commitments to Primary Care Transformation. So, it was, uh, it was a happy window of opportunity that, um, through a coordinated approach, we were able to season the state. And much the same for many of the states and regions who, you know, are on the call, that are, uh, that have experienced, um, CPC classic and that, um, those that are working on CPC+. So, it was the opportunity to provide the addition of Medicare lives that, uh, was a helpful catalyst.

[Michael Bailit]

That's a big carrot. Okay. So, other, um--

[Diane Marriott]

I'm sorry—

[Michael Bailit]

Um, other challenges and barriers that you have faced and overcome or have faced and not overcome?

[Diane Marriott]

Yeah, I'd mention two others. One is, um, you know, there's... Uh, we're so grateful for our participating payers, but there's a bit of a free rider effect when you've, um, in terms of, you know, trying to really create a common clinical and financial model for care transformation that is a common platform. Um, you know, there's, uh, there is a bit, um, and I'm sure mistaken resinate of a free rider problem in trying to, um, enlist the participation of all. I think that a third, uh, or additional, uh, is the whole chicken and the egg with evaluation. And specifically, quantitative evaluation with a control group. We, you know, we went through, uh... RTI was our evaluator and, you know, we're grateful that Michigan was the only state to have a positive ROI and MAPCP but, um, the whole chicken and the egg of, um, having to, you know, substantiate with published literature the, um, you know, how our program fared. The third is certainly the issues of sustainability. And um, you know, I'm sure all of the states together remember, you know, as we approach the end of the initial three-year demonstration... During that third year, everyone was hard at work for advocacy for an extension, which we were grateful to receive, um, and now with the evolution into the ongoing programs... But the challenges of sustainability, um, the challenges of trying to enlist all payers in and, uh, of the kind of balancing that change management and continued progress against the, um, you know, the important, uh, opportunity to have controlled, uh, you know, intervention group comparisons... So, I'd start with those and I'm sure Ellen has more.

[Ellen Bunting]

Yes, and eh, um, one of the things that I was going to note was a challenge – and I think we overcame it – was, um, this whole idea of what quality measures are people interested in. And, um, the MIPCT project had a number of committees that were multi-stakeholder committees, where people would come together and help make these high-level decisions that just, um, for us, as a data collaborative, gave us a good sense of, “Okay, we know what we're doing and we know who we're doing it for and we know when they want it.” And in such a sprawling project as this, you really need this kind of committee governance in order to help the data center understand its governance. And then, while I'm talking about governance, I might as well talk about the security environment. We're very lucky at the University of Michigan. We have very solid data centers, very solid firewalls. Um, we have a team of identity management people to help us with granting access and making sure that the right people are looking at the right

information, because we have, um, about 200 users who come into the portal and they look only at their data – whether they be from a physician organization or a practice – and they can download this data. So, we really are very interested in the data security and that is a challenge that, uh, we were able to overcome, thankfully, with the resources at the University of Michigan helping.

[Michael Bailit]

You know, Ellen, you talked about users but we haven't really, um, spent much time talking about, um, practice, um, applications of this information, because this is an enormous effort with significant costs and significant labor, all to provide practices with meaningful information. Can you share anything about, um, the extent to which you've evaluated, formally or informally, the extent to which practices have used the data and, uh, and achieved, uh, positive results as a result of it?

[Ellen Bunting]

Um, sure. I'll talk, uh. I'll start here and then, Diane, I think I'll hand off to you because I think you might have something to add about the survey that was done.

Um, so, we know for a fact, because we can track it via, you know, who signs in and, um, what they go to, that monthly, uh, people are signing in and downloading member level reports as well as downloadable utilization reports that we, uh, provide. So, the member lists are very important because that's how they look at who is getting care management. And we provide some, um, value added elements about risk, risk adjustment, about how many, um, in-patient visits, uh, a member has had in the last six months, how many ED visits in the last six months... So, there's a lot of, um, information we glean from the data that we add to these lists, uh, so that practices know who their member panel is and a little about them so they can triage who needs care management. So, that was major focus of this entire project. Um, and secondly, we don't have the same kind of analytics that we can look at from the, um, dashboard point of view, and we do run into, "This data is not actionable because it's six months old." Um, but what we're really trying to message is that "We're giving you monthly reports. We know that you can use those. We're giving you utilization reports that are about the utilization your members have had in the last six months so you know who to target. So, why don't..." What the dashboards are trying to achieve is "What is happening over time? How is your quality measures improving over time? How is your data, um, provisioned, including over time? Are you able to give us the electronic, um, medical record data, um, as... in the frequencies that you wish?" So, we're really telling them the dashboards and the different, um, data that we provide to them to be looked at in terms of trends. And, hopefully, uh, if they're supposed to be going up, they're going up. If they're supposed to be going down, they go down. And then we... There was actually a survey that Diane might have, eh, some information on.

[Michael Bailit]

Right. Alright, I need to wrap us up. Um, I think we could probably stay for another hour with you, 'cause this is fascinating, but, um, we've only got a little over 20 minutes left and we have someone else with whom we have to speak. Um, so, um, I want to ask just one more question, because, um, and it's a brief one. Um, Charlie Christ asked earlier about the frequency of the reports. How often are you updating the reports that are available to the practices?

[Ellen Bunting]

So, in the previous, eh, slide you can see our releases, and we do releases, eh, approximately, quarterly. The releases are at the top. And so, we have two more releases in, um, 2017, and that'll be, um, the final half-year of 2016 and the full year of 2016, which we should wrap up in about August.

[Michael Bailit]

Okay, alright. I'm sorry. And one last question from Patrick Gordon. He asked, um, whether the payers run the attribution or whether you run the attribution or both.

[Ellen Bunting]

Both. We count on, um, the, eh, HMO products to give us an attribution monthly, and then from Medicare and Priority Health, we were running the attribution. Medicare only attributed to the, uh, practice. So, we needed to attribute up another level to the organizational, um, managing organizational level, which we called the Provider Organization or Physician Organization.

[Michael Bailit]

Alright. Alright, well, Ellen and Diane, I want to thank you so much for giving of your time today. Um, I think this has been, eh, a great learning experience for all of us. Um, and I can't say that I won't follow up with you, eh, to provide additional information to the group in the future. Um, but, um, again, thank you on behalf of all 54 of us participating right now.

[Diane Marriott]

We're grateful as well and always eager to learn from other states.

[Ellen Bunting]

Thank you for asking us.

[Michael Bailit]

Thank you. You're invited to stay on, if you'd like, till the end. We have, um, we have one more, eh, person with whom we're going to have a conversation today and, um, and this is to look at non-aggregated strategies because, um, Diane and Ellen, what you guys just described is probably what every region would like to do, but there are many regions for whom what you're

doing is a far reach right now. And so, um, an alternative strategy and, maybe for some, an interim strategy, um, is to try to, um, attain some of the other data alignment approaches that I shared in that continuum slide earlier. Um, and there are, um, at least, um, two slides... Two, I'm sorry, regions, um, states that are doing this. Um, Arkansas and Oregon, both participants in CPC+, being two of them. And we're going to learn a little bit today from Arkansas. So, Sarah Wang is with Arkansas BlueCross and BlueShield. And, um, I'm going to ask Sarah a few questions, which she's promised to answer. Uh and so, um, my first one is, you know, noting that data aggregation and dissemination, um, is a big accomplishment... Um, I know from personal experience working on multi-payer medical home initiatives in other states that just getting separate health plans to provide common information in a common format is a big challenge. So, um, Sarah, can you start by telling us when your data alignment efforts started, how many payers were participating, and why they came together?

[Sarah Wang]

Sure. Hi, there. Um, I think our first initiative, actually, was with our [unintelligible] of care back in mid-2012, and that was an initiative with, eh, local Medicaid, ourselves, and another local payer, QualChoice. But soon after that was when we found out that we had received... Um, we were participants in CPCI and so pretty soon after we had started, eh, we found out we had started with that program, that the conversations with all payers began as to how we were going to provide reporting, meaningful reporting to those providers. And since then, additional and with CPCI, anyways, we, eh, and as an additional payer with Humana, I think, the second year of the program.

[Michael Bailit]

Okay. And, um, I'm... I don't want to presume, but you chose a data alignment strategy without data aggregation. Um, was data aggregation—

[Sarah Wang]

Yes, sorry about that.

[Michael Bailit]

...something in your longer vision?

[Sarah Wang]

Um, I don't believe so. I think with, eh, the kind of the nature of, um, in Arkansas, really, the healthcare, eh, system in Arkansas itself, that... the... allowing the different payers to put their information independently, eh, making that available to the providers, and being able to respond to those questions when a provider has that, has been a meaningful approach. We do try to... we communicate regularly between payers and align our reporting as much as possible, but with the, eh... Separate reporting does allow us to do both costs and utilization quality metrics, which kind of... It gives the full picture for at least that population from that payer.

[Michael Bailit]

Uh-hum. Okay. So, can you explain where you are aligning with the other payers, um, both in terms of content and format, eh, and where you're doing things that are separate from those others.

[Sarah Wang]

Of course. It really depends on the different programs. So, like our cost of care program, it's really the exact same report layout. All the same data elements are actually on a common portal. Like, everything is the same. It's just from a separate payer. Eh, CPC, it is a very similar report. It has all the same metrics and, eh, data elements. And, I believe, in the same bodily layout as well. But some payers use that common portal while others do not. And so then our PC metrics program, it is similar to the episodes in that it's the same report layouts and file format.

[Michael Bailit]

Okay. And, um, and what kind of information are you sharing? You ran through before... so it's quality utilization... and what did I hear about costs? Did you mention cost data?

[Sarah Wang]

Yes, eh, for CPCI we have... we provide risk scores, inpatient, remission, ER, um, generics. Those kinds of things. Eh, then, for cost of care... initially, we were only showing the rolled up attributed member costs and then having it broken out by the different, by several different categories, but we received, eh, as a group, we all received feedback from payers, from providers, rather, that having something on a member level was more meaningful and actionable, eh, especially with the lag in claims data as it is. And I'm sure everyone's aware that giving something on a member level for what you do have was very helpful to help show what was occurring outside of that provider's clinic that they may have or may not have been aware of.

[Michael Bailit]

And so, are just you providing member level information or are the other payers doing that too?

[Sarah Wang]

I believe the other payers are providing that as well.

[Michael Bailit]

And is that an aligned strategy or is that something were people are just, um, doing it of their own accord?

[Sarah Wang]

Well, um, it was, eh, common feedback that we had all received. And so, I think the layouts might be a bit different on that aspect, but a similar effort made. We'd already—

[Michael Bailit]

...Um, and how do you—

[Sarah Wang]

I'm sorry.

[Michael Bailit]

I'm sorry. Go ahead. No, go ahead.

[Sarah Wang]

It was, eh, it's the kind of the drill down of the initial metrics that were agreed upon by all payers.

[Michael Bailit]

Uh-hum. And how do you, um, coordinate across payers? Do you have a standing workgroup to try to make sure that you're doing things in like fashion?

[Sarah Wang]

Uh-hum. I would say lots of communication. Eh, initially we kind of... since CPCI's come to an end and our episode model is, um, in... had been in production for a few years, we don't meet as regularly as we once did. But in the initial... the beginning phases, it was regular weekly, sometimes more, most often weekly meetings with the payer, with all the payers talking about what was meaningful to them as a metric, what could all the payers calculate, since we'd already made the decision to not go down the road of data aggregation. What was...what were all the measures that everyone could perform to provide...to make sure we had a similar process?

[Michael Bailit]

Okay. So, what are...what would you describe as the biggest challenges that you faced, um, in the past, um, as well as any that you may currently be facing? And, um, how did you, eh, how did you and the other payers overcome them?

[Sarah Wang]

I think some of the most challenging aspects were just trying to get everyone who needed to be at that table at the table at the same time. Eh, there's always been a lot of efforts made, eh, especially in our state along the lines of, eh, alternative payment models. And so, getting everyone there and working through and hashing out the details... 'cause, at a high level, it's... it doesn't as much effort to align and agree, but it's when you get down to more of the, eh, the analytical details of how that measure's going to be calculated that you start to, eh, that it starts to become more of a challenge and, eh, difficult conversation.

[Michael Bailit]

So, what made the difference in getting people to the table? So, how do you overcome that challenge?

[Sarah Wang]

Um, just keep working at it and, eh, I think it really comes down to, eh, executives, in...at the different payers had, eh...They were very interested in actively participating, not even...not just BlueCross, but Medicaid and the other payers. And so, having those executives actively at the table helps solidify the need and the importance of all the efforts being made.

[Michael Bailit]

Okay. So, you need a lot of will. And you have some challenges—

[Sarah Wang]

Yeah.

[Michael Bailit]

Heh. And any other challenges you want to highlight?

[Sarah Wang]

Um, I think that's really...the...I think the biggest challenge was when we were trying to figure out if we were going to take an alignment strategy or, um, an aggregation strategy, and how that was going to work. And we had initially gone down the, um, combined data but realized that we...I think, essentially, we came to an impasse as to showing, well, the cost, of course, but then showing the...your own cost information across the payers and what that was truly meaningful to a member even if we could've found a way to agree to do it. And so just working through all the options and then moving forward with what was a final decision was. It just...I wouldn't say so much as a challenge as it's time consuming. And then just working through those...the details of those individual reports once everything was decided.

[Michael Bailit]

So, what have the practices told you, if we had, eh, um, Little Rock Internal Medicine on the phone? What would they say about their experience with the aligned reports?

[Sarah Wang]

Well, that...I think, off the gate it'd be that, eh, the data's old. Um, like our colleagues mentioned earlier, that's always...I think we're talking a three-month lag, but we have grown and learnt along the way in the last five years as to identifying what is meaningful for a provider, and then that's like, um, and being responsive to feedback, I think is really what it comes down to. And so, you know, initially, it was pretty simple reporting and, as we go along, it's gotten...it's become more enhanced for additional support that we've been providing. And so, I anticipate that, with...when we start to roll out the CPC+ reporting that we'll, eh, we'll learn we'll learn from our mistakes along the way and, hopefully, the providers are seeing that we're taking the advice and suggestions and, um, just working together as best we can.

[Michael Bailit]

Okay. So, last question. Eh, so there's a region that's, eh, that has not yet aligned, um, existing reports, let alone aggregated data. Um, and they're just starting out. What would you recommend to them?

[Sarah Wang]

Communicate early and often is really the biggest thing I can say and, um, having...you have to have that champion, of having some buddy at the high levels who is willing to go to bat for the team on all the aspects across, you know, multiple payers. Once you have that, you really have that stepping stone to be able to, um, put yourself out there as to what...what can be done. And so, that's the biggest part that I would say.

[Michael Bailit]

Sarah, I want to thank you for taking the time to share your experience with us, um, because the...the Michigan aggregation approach is not something that's reachable for everyone, um, particularly in the short-term, so it's helpful to hear about an alternative approach that does bring value to practices, eh, and may be more achievable, um, in the shorter run. So, thank you, once again.

So, before we wrap up two things. Um, we're going to send you a summary of this meeting, including some of the ideas that have been generated during our conversation today, and we'll look for other ways that we can provide you with, um, resources that can be helpful.

For our next meeting, um, we are going to ask you in advance to share with us draft plans that you are developing at the regional level for data alignment via an aggregated strategy or a non-aggregated strategy, and this is both for aligning and for distributing.

Um, any feedback any of you want to provide to us on how today's meeting went?

Okay, I'm getting feedback from Jack, who says it's good to hear from Michigan and Arkansas. Thank you, Jack.

Um, if you have any feedback, or if there are people that you would like to hear from at our next meeting, eh, please email us. Um, you will receive, um, at the end of this call, via the webinar, um, a survey. Last time we had only one person respond. We'd like to, eh, increase that response rate. So, if you would please take a minute at the end of the webinar to the survey.

Um, for our next meeting, which is meeting number three, um, we're going to do, um, another, um, conversation and interview with, eh, a promising state or region, eh, with a different approach than what we heard today from Michigan and from BlueCross/BlueShield of Arkansas. Um, and in addition, um, we'd like to talk with at least, um, two of you about your plans that you are developing. Um, then, if we all think it makes sense, we're going to pivot in meetings four and five to start talking about aligning on measures, um, which is the...the latter part of this track two.

So, um, any questions or feedback, you can email any of us, um, and I think, um, this wraps up, um, our conversation for today. Again, you're going to get a survey pop up in your screen. So, please respond to it and, um, eh, I look forward to talking with all of you again in a few weeks.

Thank you everyone.