

## Lab 3: Implementation: *Practice Engagement*

### Virtual Meeting 4 of 5

#### Primary Care Payer Action Collaborative

**October 10, 2017**  
2:00-3:30 pm (EST)

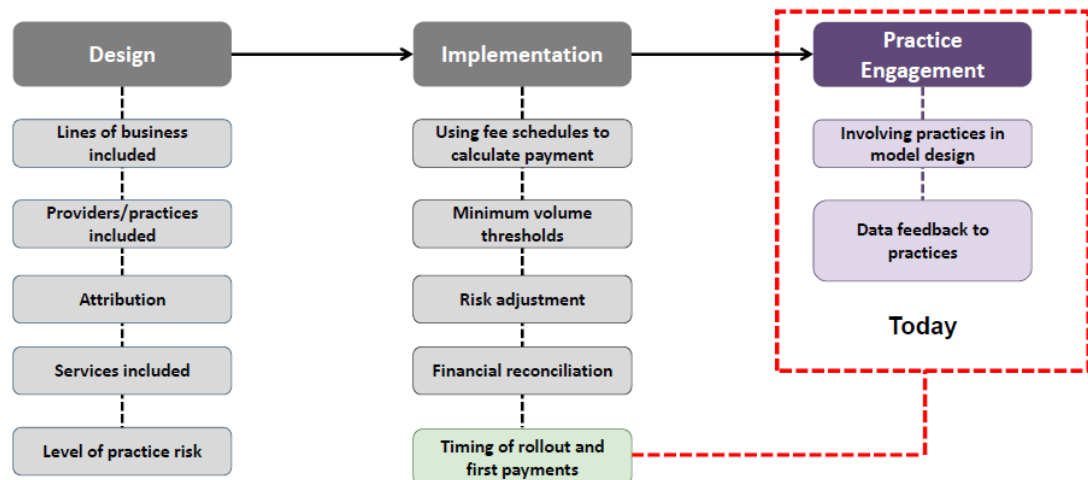
#### 1. Session Objectives

- Highlight best practices for practice engagement in developing and rolling out an alternative-to-FFS payment for primary care practices, including timing.
- Consider data flows between payer and practice.
- Identify problems and peer solutions at each step.

#### 2. Speaker Panel

- Christiane LaBonte, Payment, Policy, and Operations Analyst for CPC+ at CMMI
- Tom Foels MD, CMO, Independent Health, Buffalo New York
- Patrick Gordon, Associate Vice President, Rocky Mountain Health Plans, Western Colorado

#### 3. Alternative-to-FFS Work Flow



#### I. Involving practices in model design:

- What does practice engagement around the new model look like? How were practices involved in the design?**
  - CMS' (Medicare FFS) Track 2 "rollout" was part of the announcement of the model. CMS put out a [Payment Methodology paper](#), slides and an [on-demand webinar](#)

(YouTube video)<sup>1</sup> to explain the Track 2 payment model. “Visuals are really important as a way to explain the model.”

ii. Independent Health has had two rollouts – the original Medical Home model about 9 years ago and now a rollout to virtually all practices in the network ahead of 2018. “We now think the model is pretty tested.” To help guide the original rollout, Independent convened a group of physician advisors and plan members (beneficiaries). The model has evolved in several stages since that time, with a care management fee being added in 2008 and a “complete transformation” of the payment model to a predominantly population based payment in 2011. At that time, Independent communicated with practices in a way that focused on quality of care – *practices* started to say that they could improve quality of care with less of a focus on office visits. Independent hosts “town hall meetings” with practice staff, which has been a successful strategy. In general, practices asked them to “unveil what’s inside the black box” of the payment model and they really had to do that.

iii. Rocky had already rolled out a fee-for-service alternative model for Medicaid, which was “working pretty well.” Starting this year (2017), Rocky transitioned all CPC+ Track 2 practices into a similar model. “There has been tremendous interest in Track 2.” Rocky rolled out material and communicated with practices as a group, but “there was consternation and confusion.” Rocky realized over the course of the year that their team needed to be more hands-on and go practice by practice onsite; including sitting with practice teams and really getting into the detail and actuarial projections.

**b. How long does it take to roll out the payment model? How “baked” does the payment model need to be before socializing it?**

- i. Independent Health: “About a year.” First communications (mailings, ‘town hall’ meetings, emails, etc.) for a 2018 start went out in spring of 2017.
- ii. Rocky: Communication around the change has been intense throughout 2017. The payment model does need to be “baked” in the sense that it has to be actuarially “airtight.” It is essential that the plan be able to stand behind the financial work supporting the projected new payments to the practice.

**c. What are practices’ frequently asked questions?**

- i. Independent Health: 1) Overall budget. Independent made it clear from the start that the new payment model was purposefully enhancing the budget for primary care payments. “If it had been a pure translation, there would have been distinct winners and losers, but we found that the practices that would really make less were those who were, at baseline, having a greater number of encounters per patient per year and/or coding higher than peers.” 2) What services are in vs. out of the population based payment? 3) Attribution: practices became more concerned about how to monitor which patients are on vs off the roster and how to check on that information. 4) Whether the practice still has to submit claims (answer: yes).
- ii. Rocky: Similar: attribution, risk adjustment and financial projections. On attribution: “we’ve done assignment for decades. It used to be: ‘this isn’t my patient’; now it’s

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<sup>1</sup> <https://www.youtube.com/watch?v=xPeyjE8couk&feature=youtu.be>

‘where are my patients?’” On overall budget, Rocky has similar thoughts to Independent Health: “our goal is to have a budget for primary care, and the new model only works if you look at the budget. If we saw encounter data fall off a cliff, we would know we’d have to make changes.”

- iii. CMS: For CMS, the most asked questions in Track 2 are regarding the restrictions on use of the Medicare CPCP (the FFS alternative payment) because the rules are different between the CPCP and Care Management Fee elements.

**d. Is there anything you wish you’d done differently?**

- i. Independent Health: “If we could go back, we probably would have done a little more socialization with the practices earlier.”
- ii. Rocky: “We would have taken our communication and doubled it”. Rocky has been rolling out the Track 2 model at the same time as significant Exchange product changes, which had a “double whammy” effect on practices. If able to turn back the clock, Rocky would have staggered those changes rather than impose them at the same time.

**Data flows between plan and practice under alternative-to-fee for service models**

**a. What information flows from the plan to the practice under the new model?**

- i. CMS sends a quarterly feedback report to all practices that includes proxies for beneficiary “leakage” as well as cost of care information. Practices receive a quarterly ‘Payment Brief.’ Payment information is available via the Practice Portal.
- ii. Independent Health produces practice facing reports that give comparative reports (side by side) showing last year’s earnings and current earnings. Practices get a sense of financial forecast under the new payment model as well as comparison with what they earned before.

**b. What information flows from the practice to the plan under the new model?**

- i. CMS: all CPC+ practices in both tracks submit quarterly Care Delivery Reports, which include information about how CPC+ funding is being applied to the care delivery model. Practices’ care delivery reports are available to participating payers in the region, providing they sign the MOU Amendment documents distributed during the summer of 2017.
- ii. Rocky: there isn’t any new reporting requirement on practices parallel to what CMS is requiring, but Rocky prioritizes sitting down with each practice on a monthly basis to communicate about what is going on at the practice (staff turnover, EHR operations, etc.) and practice and plan leadership priorities: “Human intelligence is a big part of this.”

**Supporting practices as they work on non-visit based forms of care**

**a. How is CMS’ Learning System supporting practices in transitioning to non-visit based forms of care?**

CMS supports a “learning system,” which includes multiple modalities (national webinars, local events, CPC+ Connect site). One of the national “action groups”

(voluntary groups involving both webinars and Connect activity) centers on non-visit based forms of care. There has been high practice interest in this type of learning.

- b. What can plans do regionally to support practices' transition to non-visit based forms of care?**
- i. Independent: "It's definitely a concern" that the model of care delivery really has to change at the same time as the payment model. "The most important changes are really around chronic care, which is so necessary in our communities." Independent has recently invested in an affiliate company that will provide practice-facing support via a field team that supports practices in population management, staff education, etc., as well as an all-payer IT solution.
  - ii. Rocky: Agree. The education really has to be a multi-payer process in the region. Another huge issue for the future, as more practices transition to population based payments, is how to measure productivity internally in the practice – since this is traditionally tied to fee for service "productivity." There is a lot more work to do!

**Parting words**

- i. Independent: "Put yourself in practices' shoes." Primary care is under extreme duress with accommodating heavy demands for clinical care, new administrative burdens, and now transition to a new payment system. We can't just say "here is a new payment model" and expect these practices to transition without our support.
- ii. Rocky: There are three basic ingredients to success: 1) Getting the payment model right; 2) Analytics; 3) Teaching practices how to improve.

**Session recording:** <https://protect-us.mimecast.com/s/enkRBdFeNppocr?domain=hcp-lan.org>

**Link to previous session:** <https://protect-us.mimecast.com/s/6RMqBvcgYAALiE?domain=hcp-lan.org>

**Link to following session:** <http://hcp-lan.org/workproducts/pac/PAC-Lab4.mp4>