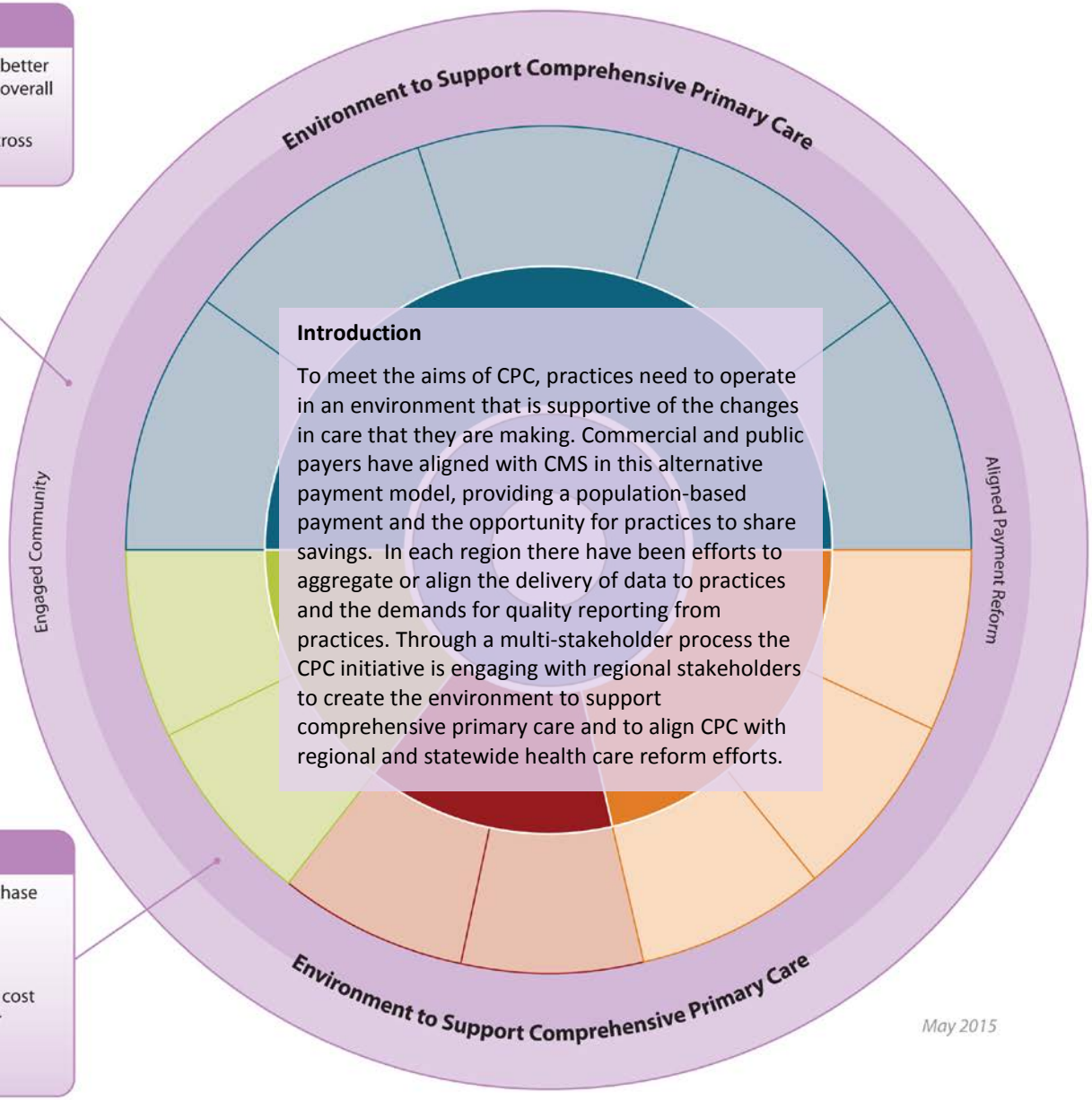
Primary Driver – 5.0 Environment to Support Comprehensive Primary Care

Change Concept 5.1

A. Engage stakeholders with an interest in better care, better health outcomes and lower overall cost of care in support of CPC practices.

B. Support processes that integrate care across the Medical Neighborhood.



Introduction

To meet the aims of CPC, practices need to operate in an environment that is supportive of the changes in care that they are making. Commercial and public payers have aligned with CMS in this alternative payment model, providing a population-based payment and the opportunity for practices to share savings. In each region there have been efforts to aggregate or align the delivery of data to practices and the demands for quality reporting from practices. Through a multi-stakeholder process the CPC initiative is engaging with regional stakeholders to create the environment to support comprehensive primary care and to align CPC with regional and statewide health care reform efforts.

Change Concept 5.2

A. Use population-based payment to purchase comprehensive primary care services.

B. Provide actionable and timely cost and utilization data to practices.

C. Reward practice actions to reduce total cost of care through shared savings or other mechanism.

D. Align quality measures.

Primary Driver – 5.0 Environment to Support Comprehensive Primary Care

Secondary Driver	Change Concept	Change Tactics	Suggested Search Terms to Locate Applicable Resources
5.1 **Engaged Community**	A: Engage stakeholders with an interest in better care, better health outcomes, and lower overall cost of care in support of CPC practices.	• Engage consumers, employers, unions and other regional or local entities in support of CPC practices. • Engage policy-makers at the regional or state level in the work of CPC. • Ensure that other regional or state primary care improvement efforts are aware of and can align with CPC.	• Culture of improvement, payment, population health, revenue, shared savings
	B: Support processes that integrate care across the Medical Neighborhood.	• Engage hospitals, nursing facilities, pharmacies, other ambulatory providers and community-based services in efforts to improve coordination of care.	• Care coordination, medical neighborhood, population health
5.2 **Aligned Payment Reform**	A: Use population-based payment to purchase comprehensive primary care services.	• Prospectively align every member or beneficiary with a primary care provider, care team or practice. • Provide a per-member or beneficiary per-month supplement to fee for services for comprehensive primary care services. • Use a methodology shared with practices to risk adjust per member/beneficiary per month payment. • Align standards for Comprehensive Primary Care services.	• Culture of improvement, payment, population health, shared savings
	B: Provide actionable and timely cost and utilization data to practices.	• Provide at least quarterly reports of timely data, by provider and practice, of services received by beneficiaries from outside of the primary care practice. • Notify providers and practices of ER visits and admissions, as soon as possible. • Engage with practices to improve the usability and functionality of data reports.	• Analytic capability, high risk, medical neighborhood, population management
	C: Reward practice actions to reduce total cost of care through shared savings or other mechanism.	• Use shared savings or similar methodology to reward achievement of better care, better health outcomes and lower total cost of care. • Provide regular data that practices can use to guide practice changes to create shared savings. • Seek alignment between payment incentives and contract terms and the five Comprehensive Primary Care functions.	• Analytic capability, outcome measures, payment, revenue, shared savings
	D: Align quality measures.	• Seek alignment on all three types of CPC quality measures (quality of care, patient experience and cost of care) with CMS and other major payers in the market.	• Clinical quality measures, expense, patient experience, revenue, shared savings

Primary Driver – 5.0 Environment to Support Comprehensive Primary Care

Secondary Driver 5.1: Engaged Community

Change Concept
A: Engage stakeholders with an interest in better care, better health outcomes, and lower overall cost of care in support of CPC practices.

Change Tactic: *In addition to a strong payer group, engage consumers, employers, unions and other regional or local entities in support of CPC practices.*

Arkansas

- Multi-stakeholder meetings include payers, practice representatives, employers, patients and community health organization representatives and continue to expand.
- The focus of discussion in the past year has been on health literacy and data sharing.
- Lessons learned:
  - Provide early clear and consistent facilitation to focus members on concrete and attainable goals
  - Choose areas in which many or the most influential members could take action
  - Don't use workgroups or sub groups. Most topics are of interest to most members

Colorado

- Meetings began with 10 payers and now include physician leaders, participating practices, and later in the process, representatives from the State Department of Health Care Policy & Financing. There are plans to further expand participation to include patients, employers, hospitals and professional associations.
- The focus of efforts in the past year has been primarily on selecting a vendor to provide a data aggregation product, including development of technical requirements, making a determination on best value, contract award and program development.
- Lessons learned:
  - The importance of clear purpose, goals and agenda (and continually revisiting these)
  - Successful facilitation requires providing materials and interim communication to participants
  - Consistent, neutral facilitation creates a feeling of inclusion and common purpose
  - Group meetings should be transparent and allow generous discussion of post CPC payment options
  - Maximize stakeholders in messaging and other related activities (e.g., data aggregation)

Secondary Driver 5.1: Engaged Community, continued

New Jersey

- Multi-stakeholder meetings include payers, 16 participating practices, New Jersey state hospital association and consumer groups. Planning is underway to include the patient perspective and expand to add other provider types.
- The focus of efforts in the past year has been on including physicians, adding the patient perspective to the group, improving hospital data sharing, regional strategy for performing well in CPC and educating patients and hospitals on the benefits of CPC.
- Lessons learned:
  - All practices want to have knowledge of what the group is doing even if they are not participating.
  - Group can serve as leaders at the learning session and advocate for best practices that can improve regional performance.
  - Need to intentionally draw out smaller payers while allowing the major market player to be an inclusive regional leader and remain engaged.

New York

- Multi-stakeholder meetings includes payers, practices, consumer representatives and state financial and regulatory agencies tied to the CMMI State Innovation Model (SIM).
- The focus of efforts in the past year has been on the following:
  - Preparing for CMS to participate in regional all payer database (i.e., data aggregation)
  - Looking for opportunities to prompt larger organizations in the medical neighborhood to improve outflow of information to primary care about “their patients”
  - The effects of the non-overlap policy applying to CPC and the new Medicare Part B Chronic Care Management code
  - Advising the New York state department of health as they flesh out the SIM plans for Advanced Primary Care standards state-wide; engage CMS in strategies to align payment post CPC
  - Discussing drivers for lower utilization/costs with Regional Learning Faculty and encouraging all practice transparency for feedback report consolidation and collaboration
- Lessons learned:
  - Commercial payer signals to practices regarding their continued engagement and commitment to CPC-like non-visit/population payments are imperative in managing post-CPC anxiety.
  - Payers appreciate consistent and definitive leadership from CMS especially around data aggregation.
  - Consistent leadership by recognized regional leader ensures cohesion and consistent engagement by multi-stakeholder group members.

Secondary Driver 5.1: Engaged Community, continued

Ohio/Kentucky

- The Multi-stakeholder process builds on a multi-year effort in the region, with monthly meetings consisting primarily of CPC payers and providers, but which also include several purchasers and purchasing groups. This group engages with the employer community in CPC by coordinating ASO (Administrative Services Only) site visits. Multi-stakeholder process also involves non-CPC providers and systems (e.g., Mercy Health, which is a Medicare Shared Savings Program ACO).
- Focus has been on data aggregation and quarterly regional cost and utilization review.
- Lessons learned:
  - A vocal payer with opt-out inclusion of ASO clients can help to boost employer participation when combined with robust participation by employers and purchasers in the multi-stakeholder process.
  - Experienced and respected multi-stakeholder faculty is critical for identifying and inviting purchasers and consumer groups in the region.

Oklahoma

- Multi-stakeholder meetings include payers, practices and just recently included two major area employers, both of whom are very engaged and vocal: Mazzio's, a large multi-state restaurant franchise, and the Oklahoma Public Employees Health and Welfare Plan, which insures the majority of Oklahoma's municipal employees.
- The focus of the effort over the past year has been on data aggregation through the regional health exchange and continued use of the local payer contributed practice resources.
- Lessons learned:
  - While challenging to coordinate initially, the local "Field Services Team" comprised of the local commercial payer supplied practice transformation and care management specialists who work alongside CPC-provided faculty are considered by all members of the stakeholder group to be essential to the positive results seen early on in Tulsa.
  - The multi-stakeholder group provides a sense of identity and authority to CPC, which helped faculty gain 100 percent practice cooperation in disclosing their identities for the cost and utilization data sharing effort.

Oregon

- The multi-stakeholder group includes payers, practice representatives, the Oregon Health Authority and the Oregon Office for Health Policy and Research.
- The focus over the past year has been on alignment of quality measures and reporting requirements. The multi-stakeholder group also has focused on aligning the timing and delivery methods of reports from the Oregon payers.
- Lessons learned:
  - It is necessary to develop explicit agreements to encourage collaboration, such as to develop a decision-making protocol, to define "consensus" and to design a protocol for resolving disagreements.

Secondary Driver 5.1: Engaged Community, continued

- In a market where there are many overlapping initiatives that focus on patient-centered care delivery, it is important to set a clear focus for the multi-stakeholder group and to streamline work processes to maintain and encourage effort toward the goals of the group.

Change Tactic: *Engage policy-makers at the regional or state level in the work of CPC.*

Arkansas

- Department of Health officials participate in the multi-stakeholder group regularly and attend learning sessions. In addition, payers participate in an initiative called the Health Care Payment Improvement Initiative with the Arkansas Department of Human Services. CPC is directly connected to this initiative and efforts to move Arkansas toward a value-based payment system over time.

Colorado

- Initial conversations with representatives from the Governor's office have begun. Focus in on applying lessons learned from CPC to future SIM initiatives and other transformation efforts

New Jersey

- The multi-stakeholder meetings include consumer advocacy groups and a hospital association official working to develop statewide health care policy. The groups are interested in better educating patients and hospitals about CPC efforts and also improving the exchange of information so that health information is treated in a more patient centered manner.

New York

- The New York State agencies with oversight for implementing the state SIM, which draws heavily from CPC, attend and present regularly at the monthly multi-stakeholder meetings. Several group members are also active in the SIM steering committee charged with setting the Advanced Primary Care standards, which are the CPC-like standards the state of New York is formulating as requirements for non-visit/population payments by all payers to qualifying primary care practices in the state.

Secondary Driver 5.1: Engaged Community, continued

Ohio/Kentucky

- The Multi-stakeholder group includes representatives from the Ohio Governor's Office of Health Transformation, and is itself (the Health Collaborative) a regional convening body that focuses the region around health transformation.
- CPC heavily informed the design of Ohio's successful SIM test grant application, and the state works closely with the multi-stakeholder body in designing its approach.

Oklahoma

- The state Medicaid agency participates in the multi-stakeholder group meetings.
- My Health, which is the multi-stakeholder facilitator, is also playing a significant role in the Oklahoma SIM planning grant.

Oregon

- The Multi-stakeholder group includes the Oregon Health Authority and the Oregon Office for Health Policy and Research.

Change Tactic: *Ensure that other regional state or primary care improvement efforts are aware of and can align with CPC.*

Arkansas

- Private payer participation in the CPC effort allows for crosstalk with the SIM efforts and the Healthcare Payment Improvement Initiative in Arkansas. These payers are involved in most of the efforts taking place in the state – such as the Medicaid medical home initiative.

Colorado

- Representatives from the Governor's Office and their State Innovations Model (SIM) Manager participate in Colorado CPC Payer meetings and CPC practice models of integrated behavioral health informed the original SIM proposal. There are also separate SIM meetings which overlap significantly with the CPC payers. The SIM group also includes the regional CPC representative.

New Jersey

- One payer, Horizon, has a large primary care medical home program. That is the largest improvement effort taking place beyond CPC. NJ has a SIM design grant and all payers are involved in this.

Secondary Driver 5.1: Engaged Community, continued

New York

- The state SIM initiative is coordinating regularly with the New York CPC stakeholder members and working to actively align the state's Advanced Primary Care initiative (core of SIM) with CPC.

Ohio/Kentucky

- The Ohio SIM proposal has a significant PCMH component that aligns with the CPC model.
- Other pilot demonstrations, such as the Integrated Care Delivery System and the Aligning Forces for Quality (ended in May 2015) project, align in part with the CPC model.
- Cincinnati ONC Regional Extension Center (REC) has been pivotal in assisting practices with HIT.

Oklahoma

- The state SIM planning grant is coordinating indirectly with CPC as the multi-stakeholder faculty is also actively engaged in the planning grant work.
- The region and state have a small number of payers, the dominant of which, Blue Cross Blue Shield, is the major CPC payer, seeing gains and actively taking the payment model statewide.

Oregon

- Efforts are underway in the state of Oregon to develop a state-wide primary care collaborative. This collaborative would include all major payers and other stakeholders in Oregon on a voluntary basis and would maximize the possibility for alignment of quality measures for payment incentives across the state. The CPC practices will be integrated into this initiative.

Change Concept
B: Support processes that integrate care across the Medical Neighborhood.

Participation in Multi-stakeholder activities varies between regions, and may include patient representatives, consumer groups, employers, policy makers and other health care provider types.

Change Tactic: *Engage hospitals, nursing facilities, pharmacies, other ambulatory providers and community-based services in efforts to improve coordination of care.*

Arkansas

- A variety of stakeholders – including pharmacies and community-based groups – have attended the multi-stakeholder group. The group's increasing focus on data sharing and health literacy is leading the group to involve more community based stakeholders and also hospital association officials.

Secondary Driver 5.1: Engaged Community, continued

Colorado

- Emphasis from CPC multi-stakeholder group to integrate in the future with health care entities that will facilitate a more integrated approach to care across the medical neighborhood. Strong emphasis on medication management and behavioral health integration.

New Jersey

- The state hospital association has been engaged in response to practices' need for better access to ER and discharge summary information.

New York

- The Leadership group is working with a larger medical council to identify pathways for real-time direct transmission of clinical summaries as patients transition across CPC practices, acute care facilities, home health agencies and skilled nursing facilities.
- There are two active regional health information exchanges, one affiliated with the multi-stakeholder facilitator and the other with the dominant payer, in the northern part of the region. Both are actively engaged with CPC in driving better connectivity with acute care and compacts with specialists.

Ohio/Kentucky

- The Area Agency on Aging is engaged with the CPC practices to develop better coordination with community-based services.
- Multi-stakeholder group includes non-CPC providers. Medical and community partners staff booths at in-person learning sessions.

Oklahoma

- The My Health regional health information exchange is the multi-stakeholder faculty and thus serves as the central point of coordination for CPC needs for information from other health care suppliers.

Oregon

- The leadership group and multi-stakeholder group are both working on alignment of measures and timing and delivery of payer reports. Both of these forums allow practice leaders and payers to examine their systems of coordination on a larger scale.

Primary Driver – 5.0 Environment to Support Comprehensive Primary Care

Secondary Driver 5.2: Aligned Payment Reform

Change Concept
A: Use population-based payment to purchase comprehensive primary care services.

All Regions

- All payers have aligned with CMS, providing non-visit-based payment and an opportunity to share in savings. Each payer uses their own methodology for patient attribution and risk adjustment and there is no coordination on payment between payers.

Change Concept
B: Provide actionable and timely cost and utilization data to practices.

All Regions

- Practices receive both aggregate practice-level feedback and patient-level data files from CMS every quarter. In May 2014, CMS began sharing with practice, payers and stakeholders quarterly region-level reports on descriptive trends and implementation findings, as well as practice-level data that can be used to identify practices with different outcomes. Outcomes are shown relative to all CPC practices.

Arkansas

- All Arkansas payers have started providing patient-level data to CPC practices. The format is not the same for these reports. The payers discussed how to access and use these reports at a learning session and will likely engage in more education of practices regarding these reports in the future. Some payers have been offering these reports for a longer period of time than others. Payers continue to provide quality, cost and utilization reports to practices on a quarterly basis. They are aligned around a set of core measures, not all measures. The core measures are calculated in the same way by payers so that practices can aggregate those measures.

Colorado

- Seven of 10 participating payers in Colorado have contracted with Rise Health to provide aggregated claims data to all Colorado CPC practices. The data aggregation tool will go live in May 2015. Practices and payers will use the web-based tool which allows authorized users to view and filter claims-based data across all seven participating payers. CMS is not currently participating in data aggregation but has started the approval process to participate.

Secondary Driver 5.2: Aligned Payment Reform, continued

New Jersey

- All payers are offering reports to practices. The reports are not aligned. The largest payer in the region (covering roughly 40 percent of the CPC population, with CMS covering another 40 percent) has implemented a PCMH data portal for practices, which contains utilization data at the patient level.

New York

- All payers are providing regular data reports to practices (these are not "aligned" as the payers had been providing an aggregated report through the Hudson Valley Medical Home program and are waiting on CMS to join the all payer database so they can re-start the provision of these reports).
- The region is considering aligned data reporting as a secondary strategy to data aggregation.
- One payer has implemented an online data portal for practices containing utilization data.

Ohio/Kentucky

- All payers are participating in aligned quarterly reporting as of fall 2014, providing reports to practices that report a similar set of utilization and quality metrics on a standardized timetable
- All payers are participating in data aggregation effort with first reports anticipated in November 2015. Payers will start submitting data June 8, 2015.
- Multiple payers have implemented a data portal for practices containing utilization data.

Oklahoma

- The regional HIE serves as data aggregator for all 62 Oklahoma CPC practices.
- The regional HIE is incorporating data from commercial payers and the feedback reports from CPC and data from hospitals and other providers into a web-based tool to make cost and utilization data available online in real time to participating practices.

Oregon

- All payers have provided utilization reports with aligned formats, based on the Medicare reports, to practices since the spring of 2014.

Secondary Driver 5.2: Aligned Payment Reform, continued

Change Concept
C: Reward practice actions to reduce total cost of care through shared savings or other mechanism.

All Regions

- All payers have aligned with CMS, providing non-visit-based payment and an opportunity to share in savings. Each payer uses their own methodology for patient attribution and risk adjustment and there is no coordination on payment between payers.

  Net savings will be calculated at the regional level and will be distributed by CMS in the third year of the program based on results from the second year. Distribution of any shared savings will be modified by CPC performance on quality and patient experience.

  Partnering payers each have their own specific methodology and do not coordinate.

Change Concept
D: Align quality measures.

Arkansas

- The payers have a core group of measures they report that are aligned so that practices can aggregate the measures if they desire to do so. Payers are also working to develop a regional feedback report similar to the CMS regional feedback report.

Colorado

- Colorado payers are aligned through the common data aggregation approach.

New Jersey

- Payers are not aligning quality measures but are actively sharing quality measure reports with providers and making changes to reports based on provider requests. For example, Horizon recently developed a unique report on the cost of specialists for patients being referred by CPC practices.

New York

- An initial assessment of the quality measures being used by the CMS and the four commercial health plans showed 34 unique measures across the five payers, with only one measure was consistent across all payers. Multi-stakeholder faculty led negotiations across payers to streamline measures, resulting in a reduction of the measures and a higher degree of alignment.

Secondary Driver 5.2: Aligned Payment Reform, continued

Ohio/Kentucky

- All payers are participating in aligned quarterly reporting as of the fourth quarter of 2014; payers generally agreed on a set of 21 CQMs at the beginning of CPC, although a few payers have divergent definitions for similar measures.
- Different payers are using different quality measures to determine eligibility for shared savings.

Oklahoma

- There are some very limited individual quality measures that each payer requires but are delivered by My Health, the regional health information hub.

Oregon

- This is a major focus of the Multi-stakeholder group, which is working to align measures and also to align timing and usefulness of payer reports for CPC practices. The group also is working to align and eliminate overlap of measures in various statewide initiatives to reduce the reporting burden on practices.