



Multi-Payer Health Care Transformation

Evidence and Experience from Across the Country

Christopher F. Koller

President, Milbank Memorial Fund

New Jersey State Innovation Model (SIM) Delivery System Transformation Summit

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Milbank Memorial Fund

- 105 year old operating foundation
- National scope
- “Improving Population Health by connecting leaders and decision makers with the best evidence and experience”
- Three priorities
 - Be a source for evidence and experience in response to state requests
 - Build state health policy capacity
 - Increase impact of Milbank Quarterly



Why do we get poor health care value in US?

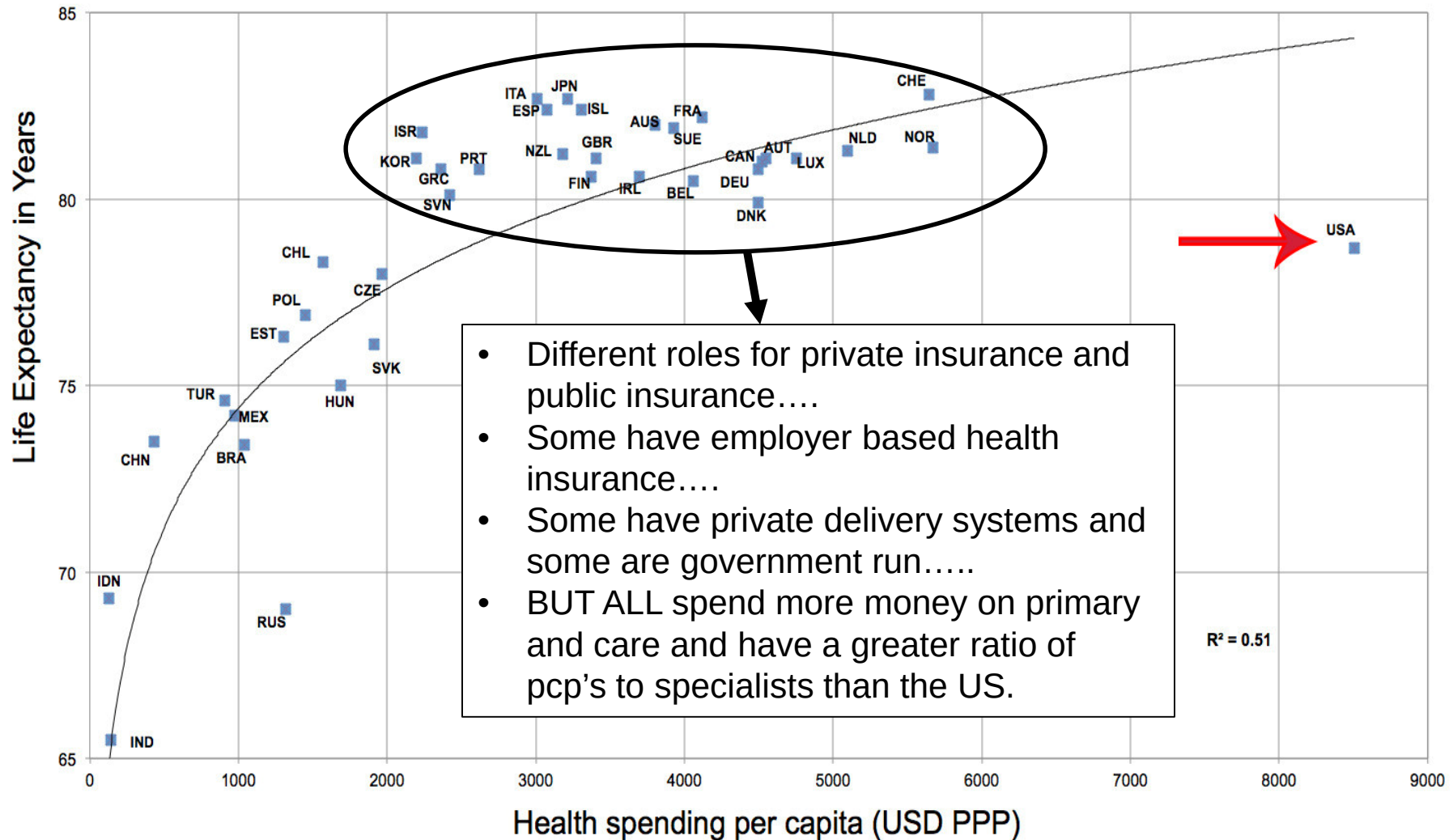


EXHIBIT 8

Relationship Between Provider Workforce And Quality: General Practitioners Per 10,000 And Quality Rank

Quality rank

1

26

51

1

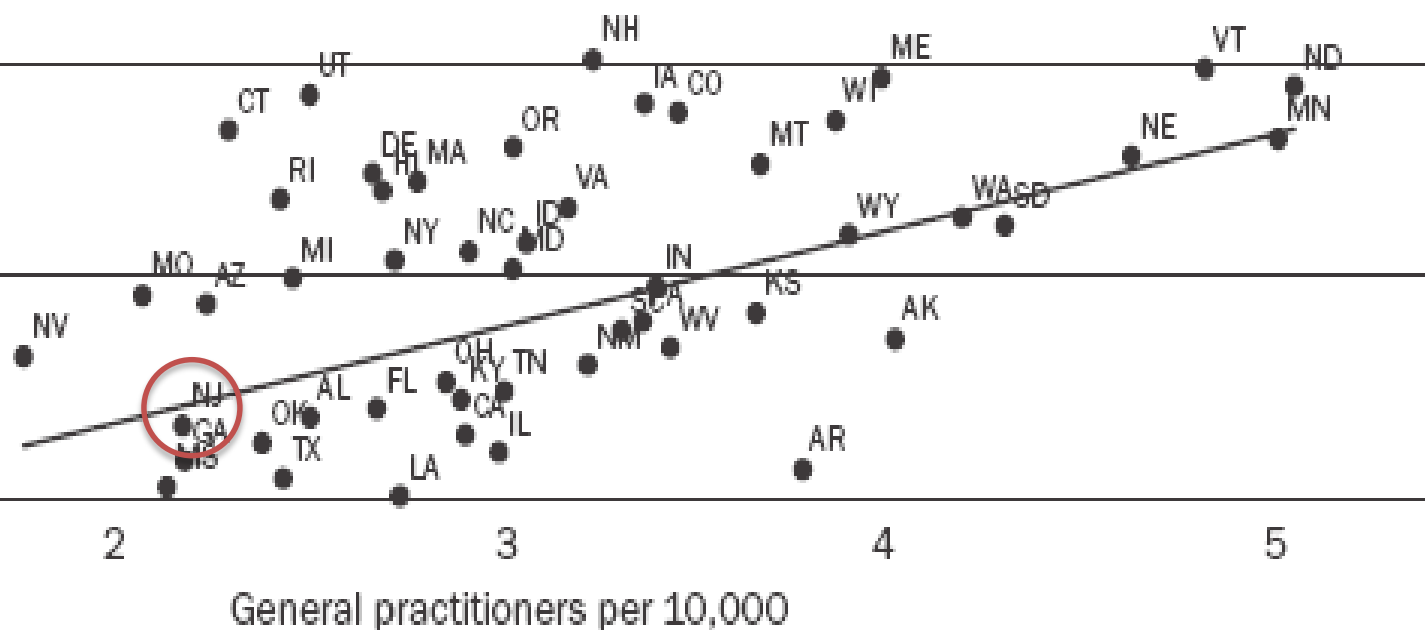
2

3

4

5

Same in US. More Primary Care gets you better quality.....



SOURCES: Medicare claims data; and Area Resource File, 2003.

NOTES: For quality ranking, smaller values equal higher quality. Total physicians held constant.

Source: Baicker & Chandra, Health Affairs, April 7, 2004



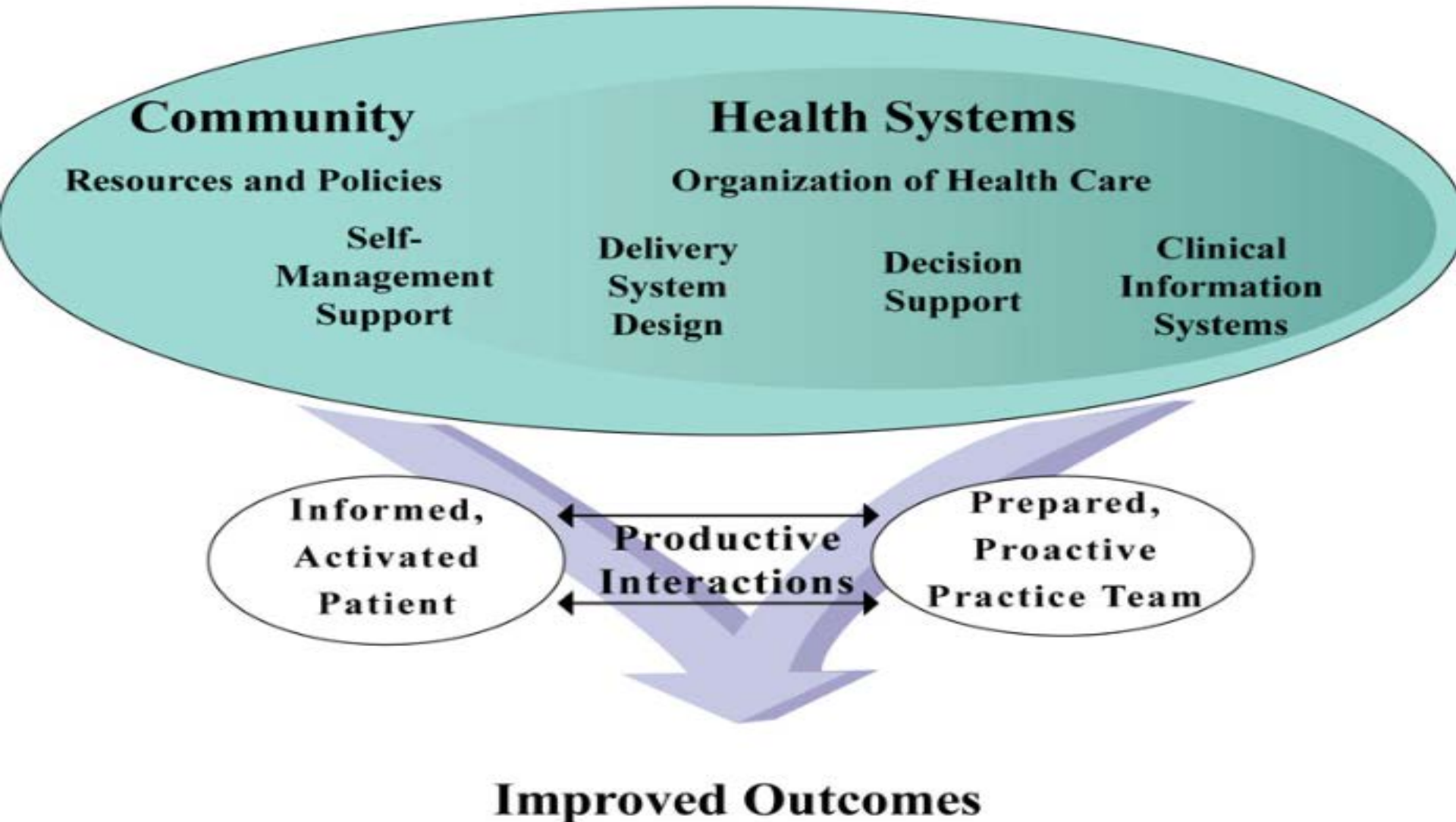
Relationship Between Provider Workforce And Medicare Spending: General Practitioners Per 10,000 And Spending Per Beneficiary In 2000

...and Lower Costs



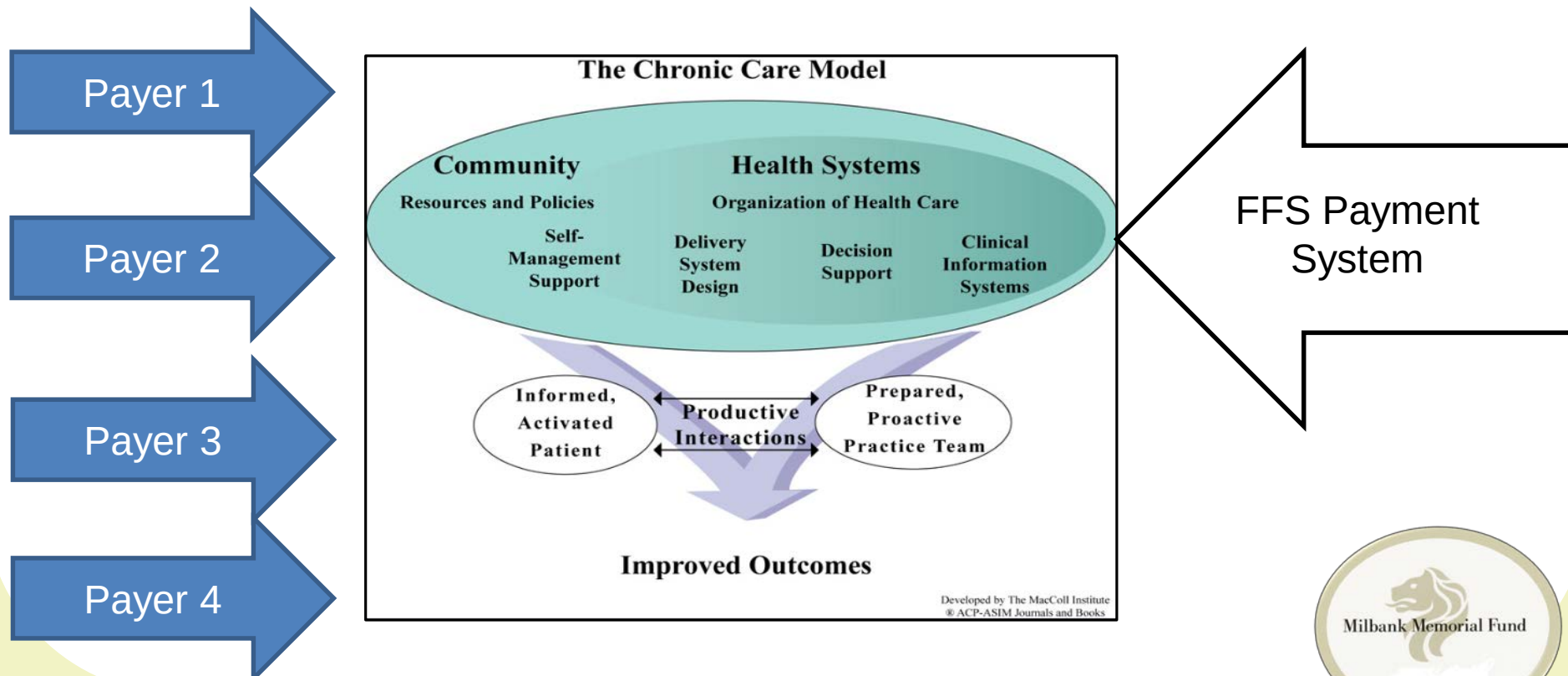
What does High Quality Primary Care Look Like?

The Chronic Care Model



Why Health Plan -Specific PCMH Programs Usually Fail

Many Payers...one patient panel

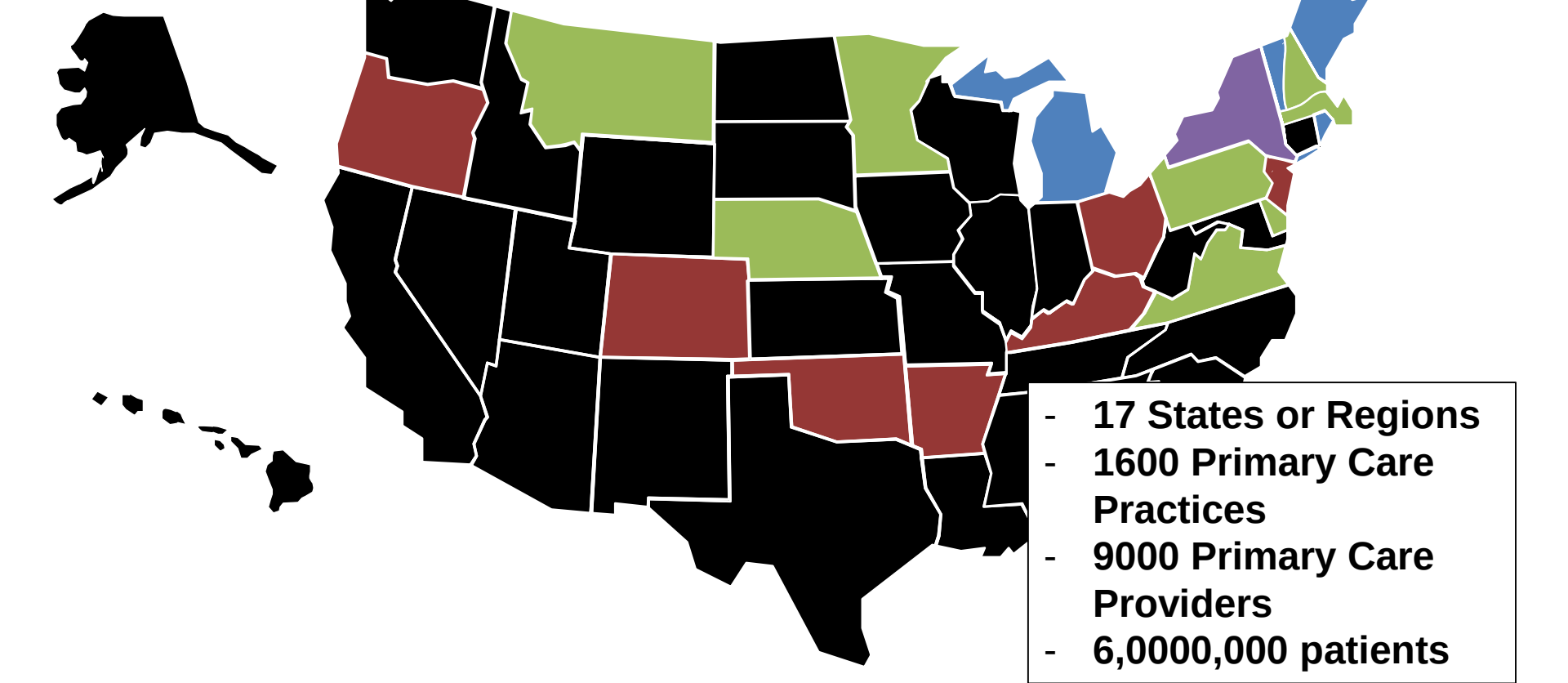


Essential Components of Multi Payer Primary Care Transformation

1. Multiple (public and private) payer participation
2. Strong roles for convening and project management, ideally from State government
4. Consistent standards for PCMH (or “Advanced Primary Care”) identification/recognition
5. Innovative payment reforms designed to support primary care with additional up-front money to practices
6. New staffing models for team-based primary care
7. Technical assistance to practice sites and collaborative learning
8. Common measurement of performance – at regular and frequent intervals, transparent and trustworthy



Milbank Memorial Fund Multi-State Collaborative 2015



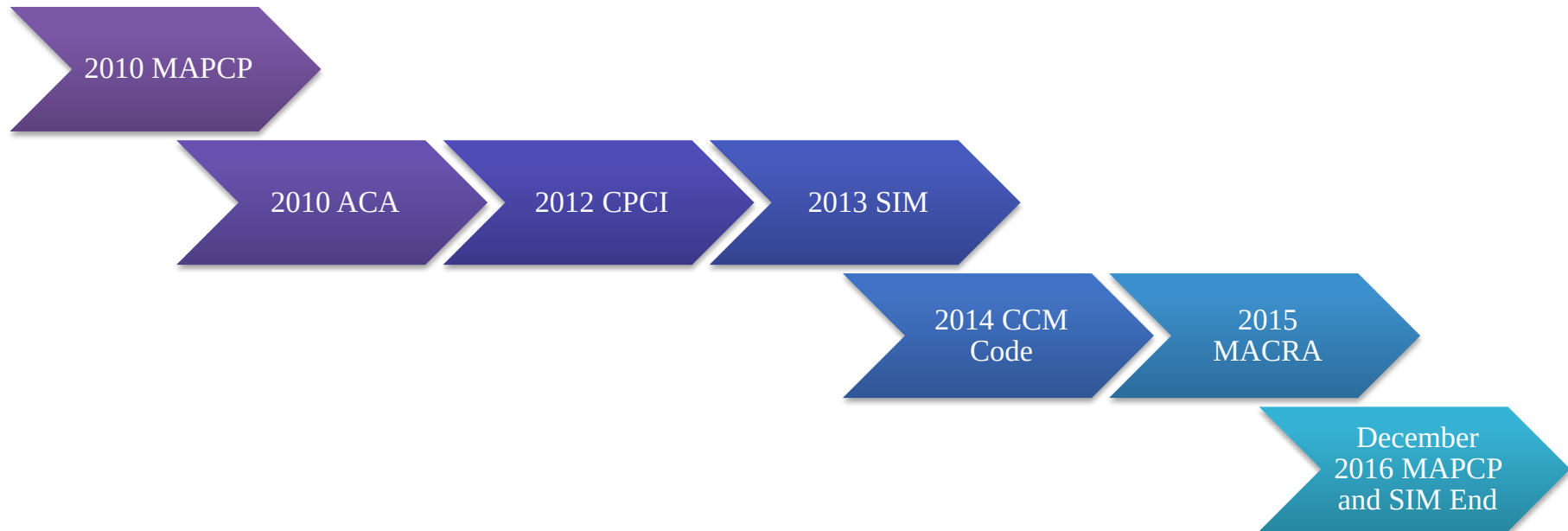
 MAPCP
  MAPCP and CPCI

 CPCI
  No CMMI Demonstration





As dominant payer – Medicare has been a key element of this work



SIM has also been a Catalyst

Primary Care Transformation - a critical element in SIM testing states:

Round One:

Vermont - ACO efforts

Oregon - Coordinated Care Organizations

Minnesota -Accountable Communities

Maine - ACO efforts

Arkansas - expanded PCMH using CPCI model

Round Two:

Connecticut – workforce development

Idaho – PCMH, increased connectivity

Michigan – accountable systems using PCMH

New York – regional PCMH development

Ohio – PCMH

Washington – practice transformation

Tennessee – adult and pediatric PCMH

Colorado – PCMH and Behavioral Health



What Constitutes “Transformed Primary Care”? – Here is how CPCI defines it

- Care Management and Care Coordination
 - Patients receiving personalized care management
 - Post-discharge and Emergency Department visit follow-up
- 24/7 Access
 - All practices offering enhanced access via patient portals, after-hours call lines, structured phone visits, text messaging, eVisits
- Shared Decision Making
 - Examples include advance care planning and smoking cessation
- Patient Experience
 - Patient Family Advisory Councils
 - Office survey
- Quality Improvement
 - Using data to guide improvements in care
 - Improving quality while reducing cost and inappropriate utilization



Results

- Well executed projects see reductions in cost increases and improved costs – usually by third year.
- Improvements are population wide, systematic and long lasting



Medicare Results - MAPCP

In its first year the “MAPCP Demonstration generated an estimated \$4.2 million in savings through the use of *advanced primary care* initiatives”, specifically that “that the rate of growth in Medicare FFS [fee-for-service] health care expenditures was reduced in Vermont and Michigan”.

<http://blog.cms.gov/2015/01/23/moving-forward-on-primary-care-transformation/>



Medicare Results - CPCI

CMS Innovation Center Director Patrick Conway states that “the CPC initiative, in its first year, decreased hospital admissions by 2% and emergency department visits by 3%, contributing to the reduction of expenditures nearly enough to offset care management fees paid by CMS.”

<http://blog.cms.gov/2015/01/23/moving-forward-on-primary-care-transformation/>

- The Mathematica report can be found in its entirety at <http://innovation.cms.gov/Files/reports/CPCI-EvalRpt1.pdf>

Year Two: due out in Q1 2016



Commercial Plans' Assessments

With 17 identified multi payer projects, many national and regional payers (private and public) now engaged

Outcomes of invitational June 2015 CPCI-participating payers' meeting:

- promising early results
- evident commitment to continue (with caveat that CMS stay involved)



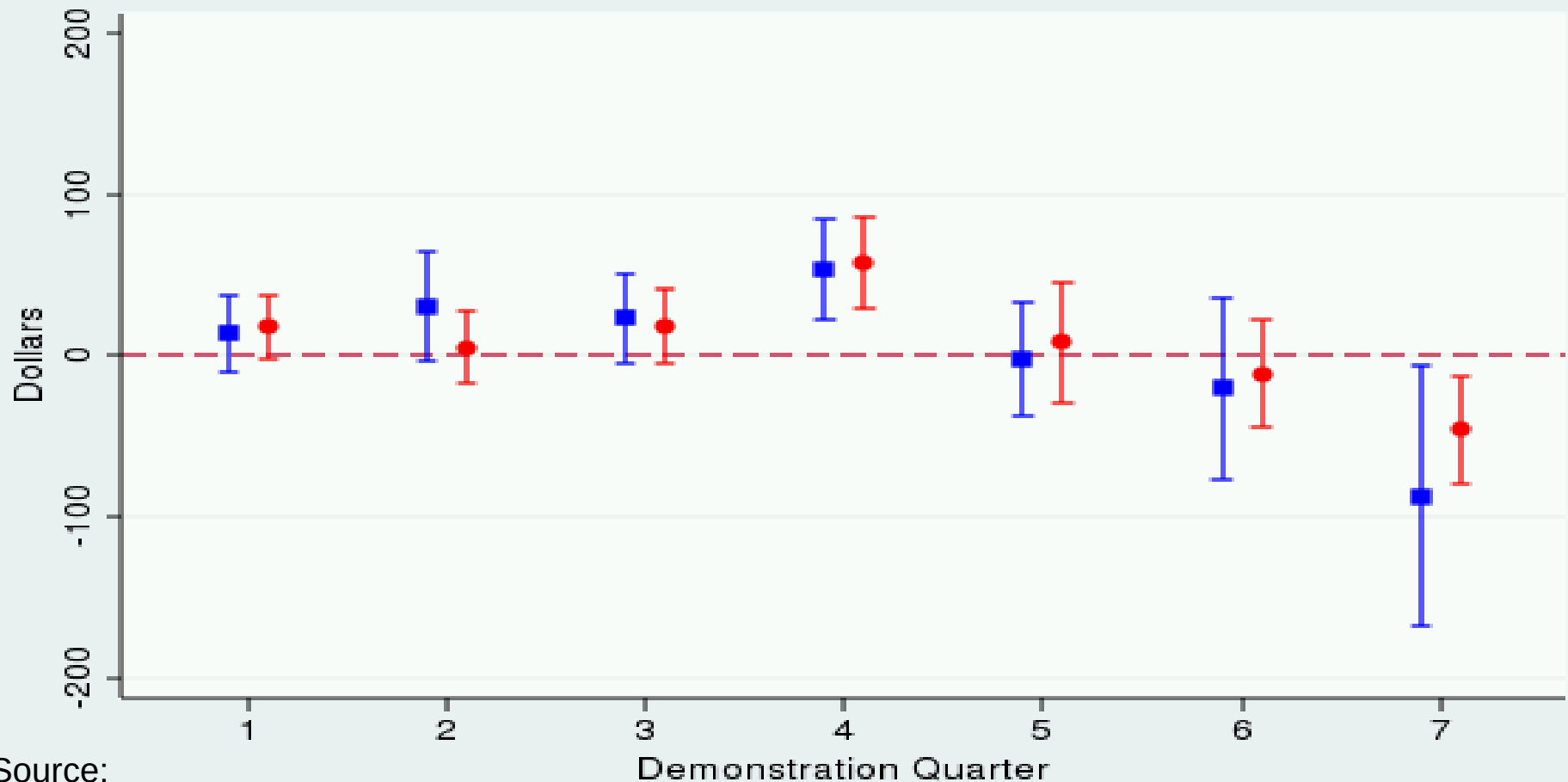
Example: Blue Cross & Blue Shield of RI

- PCMH practices vs non PCMH – for Medicare and Commercial patients, six year test period
 - 16 % lower admissions
 - 30% lower 30 day readmits
 - Improved diabetes care and colorectal screening
 - 5% lower total care costs
- Estimated 250% return on investment.



Project Specific Results – Michigan MAPCP

Gradual decrease in Medicare per capita costs over two years



Source:
CMMI
Evaluation

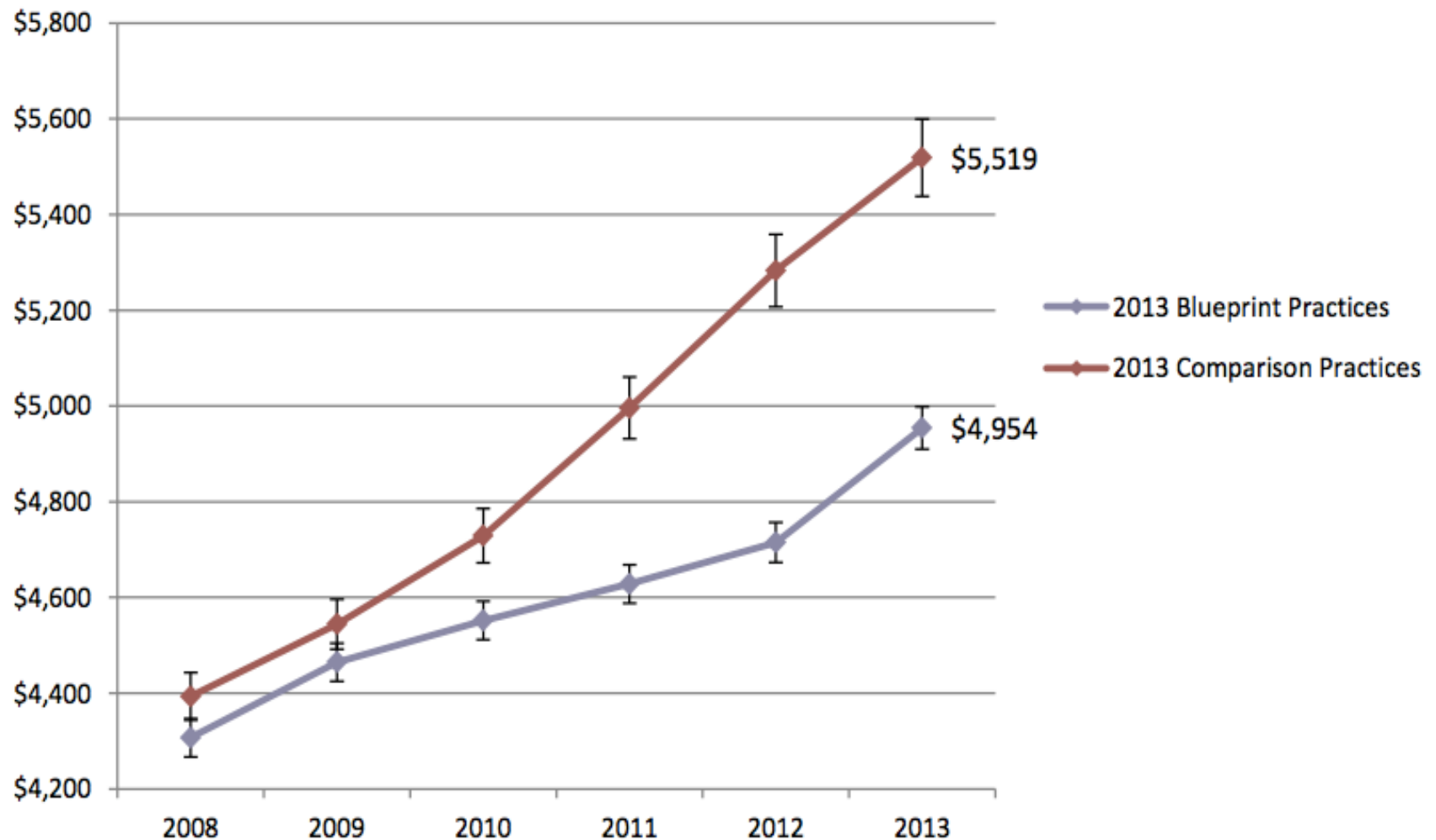
■ vs PCMH Comparison

● vs. Non-PCMH Comparison

Project Specific Results – Vermont MAPCP

Payment reform has contained costs over 5 years

Figure 4. Total expenditures per capita - commercially insured ages 18-64



Project Specific Results - OH/KY CPCI

Overall Medicare expenditures were lower among CPC-attributed patients after 2 years

- More dramatic in highest risk-stratified group (the most ill and complicated patients)

Decreases were seen in ambulatory-sensitive admissions

Note – Official results beyond the first year of the CPCI are unavailable publicly. The first year report prepared by Mathematica Policy Research is available at <http://innovation.cms.gov/Files/reports/CPCI-EvalRpt1.pdf>



Colorado

- ER visits vs control group:
 - 7.9% reduction at the end of two years
 - Sustained at three years
- Primary Care visits
 - 1.5% reduction after three years vs controls
- Patients with two or more comorbidities:
 - similar patterns found, except that there was also a reduction in ambulatory care sensitive inpatient admissions (10.3 %; $p = 0.05$).

– Rosenthal et al. Journal of General Internal Medicine. Oct. 15



Don't Expect Immediate Results

Allow time to learn: PA Multi-Payer Part 1

In this early study of a multi payer project, participating practices that adopted new structural capabilities and received basic NCQA certification outcomes did not show reductions in their populations' utilization of hospital, emergency department, or ambulatory care services or total costs over 3 years.

Researchers: “findings suggest that medical home interventions may need further refinement.”

JAMA. 2014;311(8):815-825.
doi:10.1001/jama.2014.353



PA Multi-Payer Part 2

Round two - project components sharpened:

- Shared saving incentives

- Regular feedback to primary care practices from health plans on utilization of hospitals, EDs, and other medical services

- No financial incentive tied to early achievement of recognition

- All practices had an EHR at baseline and were more advanced PCMHs (per NCQA recognition scores)

Pilot practices had statistically significant better performance on the following:

- 4 process measures of diabetes and breast cancer screening

- 1.7% lower rates of all cause hospitalization

- 4.7% lower rates of all cause ED visits

- 3.2% lower rates of ambulatory sensitive ED visits

- 17.3% lower rates of ambulatory visits to specialists

JAMA Intern Med. doi:10.1001/jamainternmed.2015.2047



Success is Not Guaranteed.

Key Elements of Successful Projects:

1. Garner Meaningful Multi-payer Engagement	6. Support Practices with Technical Assistance and Collaboration
2. Good Project Leadership and Governance	7. Spark MD Enthusiasm in practices
3. Demand Federal Participation	8. Provide timely, accessible and usable data for improvement
4. Support with Meaningful Financing	9. Gather Together for collaborative learning
5. Clear, progressive PCMH standards with focus on high cost patients.	10. Require evaluation ...with realistic time tables



Who Convenes?: Role of State Governments – Important Catalysts for Multi-payer Work

Create Table, Vision- Strong Primary Care as Common Good, Address Antitrust



“Joiner”

- Build off dominant commercial market initiative
- set stage for other smaller payers
- EG: MI

“Inviter”

- Establish own program (usually Medicaid)
- Align with others.
- EG: ME, PA, AR, CO, OK

“Require-er”

- Call the issue
- Set direction
- Enforce with law or regulations
- EG: VT and RI

Acting State Agency – Medicaid, Governor’s Office, Health Department
Insurance Regulator

Precipitating Event: SIM Grant; Medicare Initiative (MAPCP, CPCI);
Medicaid.

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ACO's? Episodes? Capitation?

Advanced Primary Care is always the Foundation

State led Efforts:

- New York State, Oklahoma, Colorado and Michigan: Primary Care is Core of SIM Project
- Arkansas and Ohio: Multipayer Primary Care plus Episodes of Care
- Vermont and Oregon: Multipayer Primary Care as basis for Publicly Coordinated ACO's

Commercial Insurers:

- Anthem Insurance, Horizon Health Care (BCBSNJ) and Care First (BCBSMD): Advanced Primary Care is the way we do business.

Medicare

- High performing ACO's focus on primary care.



The Future for Multi-Payer Primary Care Transformation

1. Existing projects: continue to learn what works; improve measurement; solidify local oversight; incorporate social services
2. Commercial Payers:
 - Local leadership and momentum matters
 - Some national plans more engaged than others. Regional plans are easier to enroll.
 - Self Insured: Follow the leads of their administrators.

Medicare is Committed to Value of Multi -Payer Primary Care

Secretary has set a target for Value Based Payments – Starts with Primary Care

ACO results to date reinforce need for focus on primary as the core of any successful efforts.

The 2015 repeal of the Sustainable Growth Rate (SGR) and enactment of the Medicare Access and CHIP Reauthorization Act (MACRA) presents a unique set of opportunities:

- CPCI standards appears to be a potential framework for the future of primary care payment

With SIM and CPCI expiring in 2016, projects are negotiating terms for continued or expanded Medicare participation

