Milbank Memorial Fund

Using evidence to improve population health.

Multipayer Primary Care:

A National Perspective

Lisa Dulsky Watkins, MD

Milbank Memorial Fund

Framework for Action Webinar Series | October 14, 2021

The Milbank Memorial Fund

The Milbank Memorial Fund is an endowed operating foundation that works to improve the health of populations by connecting leaders and decision makers with the best available evidence and experience. Founded in 1905, the Fund engages in nonpartisan analysis, collaboration, and communication on significant issues in health policy. It does this work by:

- publishing high-quality, evidence-based reports, books, and *The Milbank Quarterly*, a peer-reviewed journal of population health and health policy;
- convening state health policy decision makers on issues they identify as important to population health;
- and building communities of health policymakers to enhance their effectiveness.

The Milbank Memorial Fund Multipayer Primary Care (MPC) Network

The **Milbank Memorial Fund** supports local multipayer primary care transformation by bringing together neutral regional conveners, interested payers and others (through the MPC Network) to share experience, information and best practices.

The mission of the Multipayer Primary Care (MPC) Network is to facilitate and support regionally based multipayer primary care transformation.

The Fund provides a forum for these activities in virtual, telephonic, and in-person settings.

Milbank Memorial Fund

MPC Network
Underlying Assumptions

- Reformed primary care is essential to a high-performing health care system that can improve the health of populations.*

- To achieve reformed primary care, you need to align actions across multiple payers.

- The work of transforming primary care must occur locally.

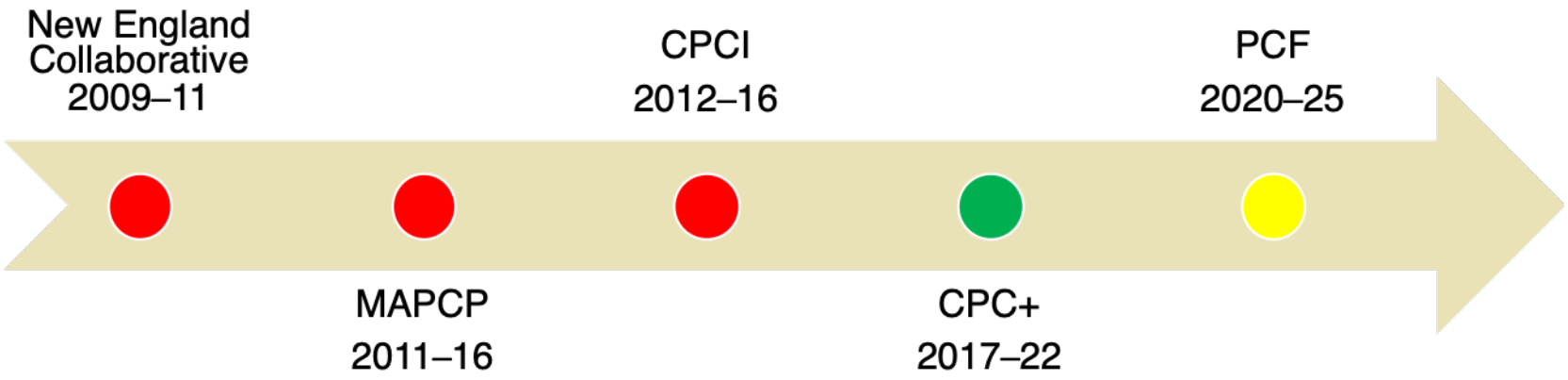
*Barbara Starfield, "The Centrality of Primary Care to Health Systems and Health," *Milbank Quarterly*, 2005.

Milbank Memorial Fund

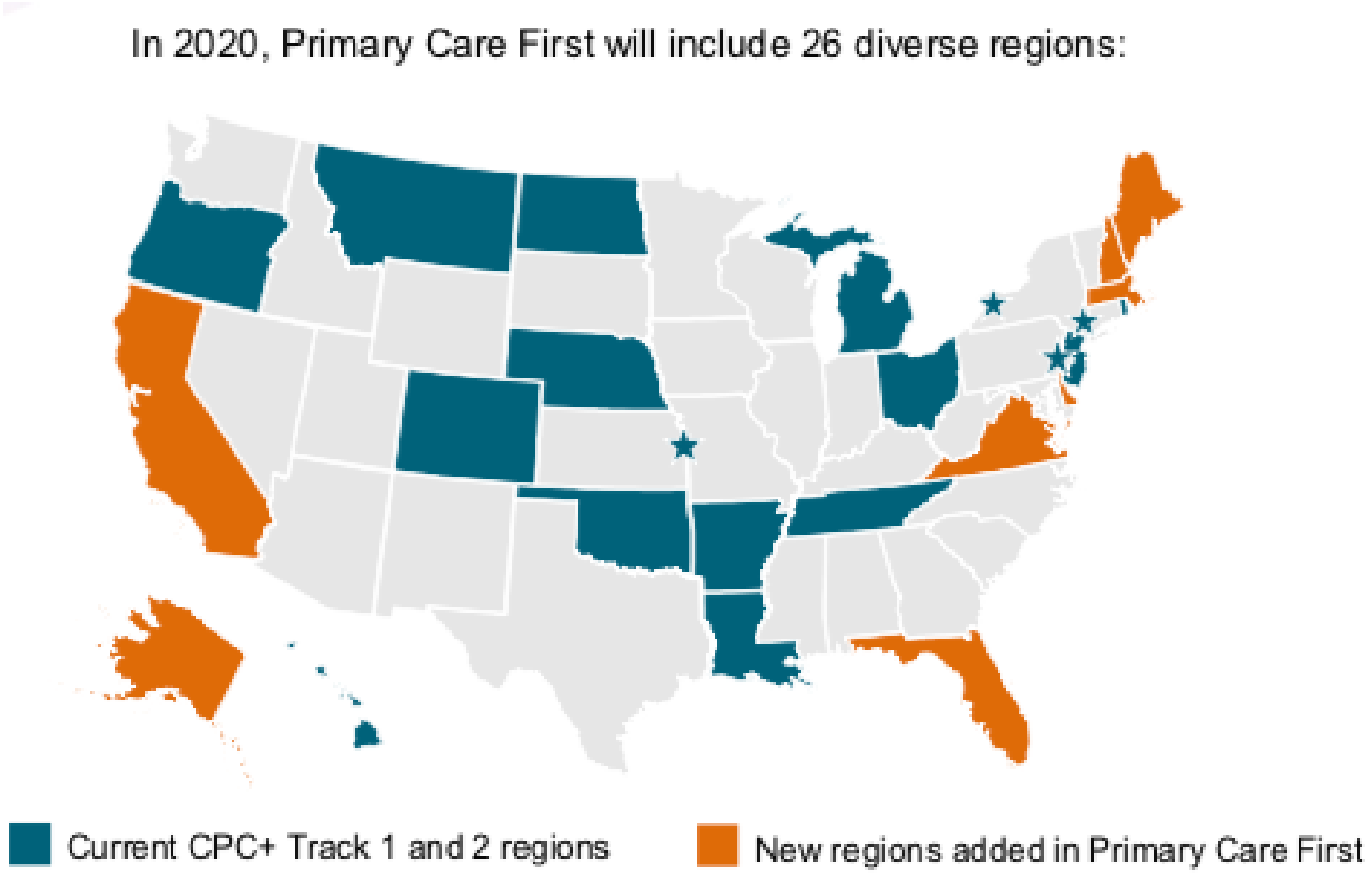
Medicare Innovation Center (CMMI) Multistate Programs

- Multipayer Advanced Primary Care Practice Demonstration (MAPCP)
- Comprehensive Primary Care Initiative (CPC)
- Comprehensive Primary Care Plus (CPC+)

Multipayer Primary Care Programs Supported by Milbank

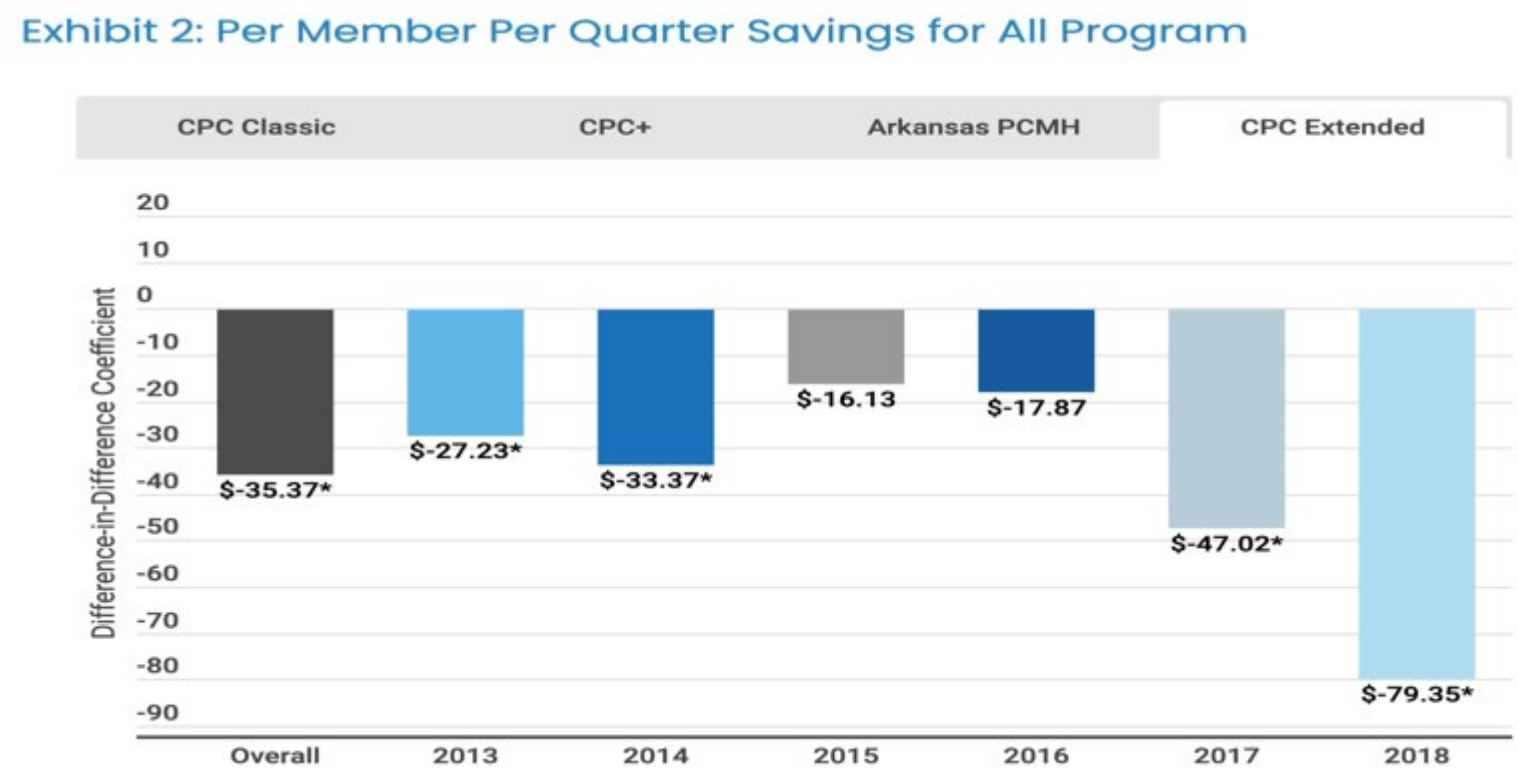


2021 CMMI Multistate Multipayer Primary Care Programs (CPC+ and Primary Care First)



Does Multipayer Primary Care Transformation Work?

Arkansas (CPC, CPC+ and AR PCMH, commercial payer)



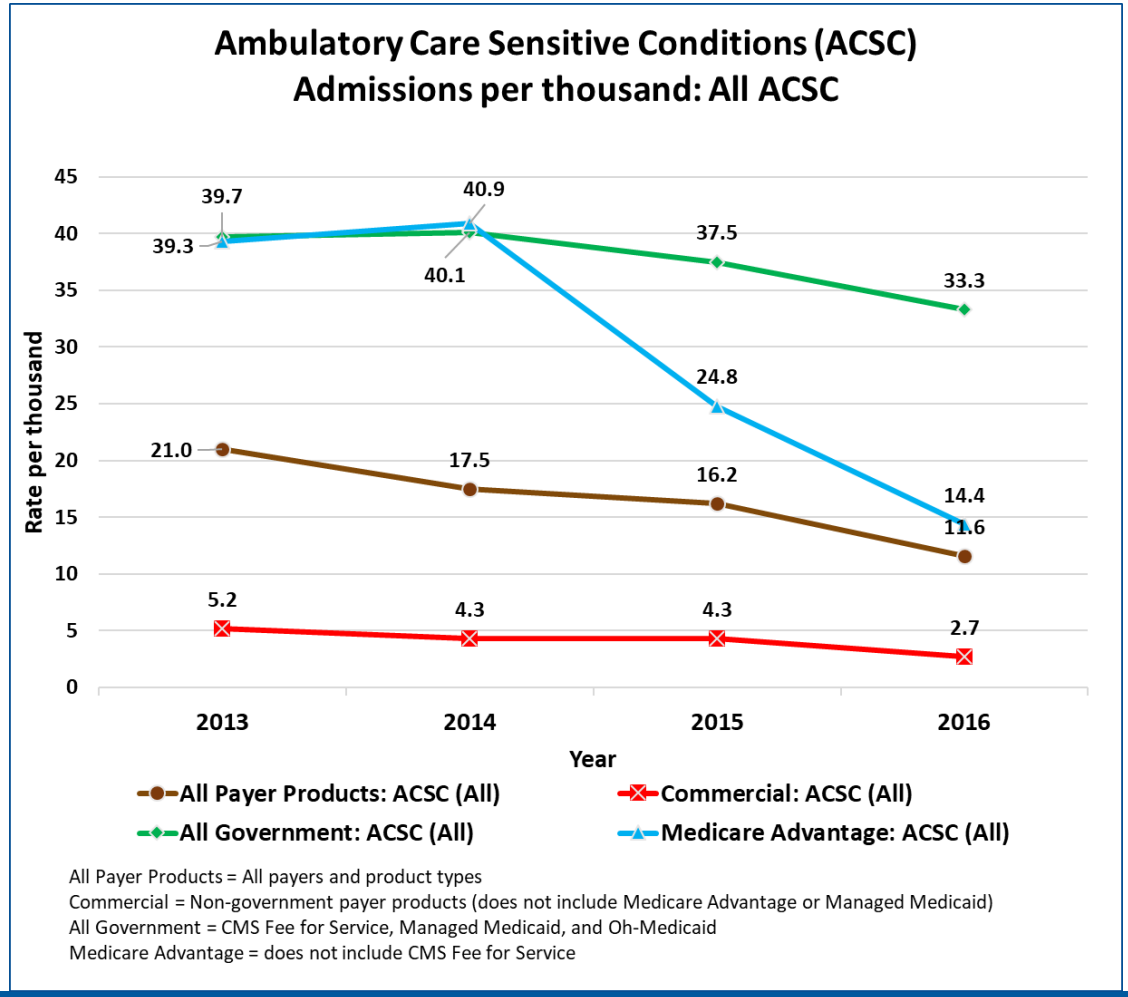
https://www.milbank.org/publications/value-based-primary-care-insights-from-a-commercial-insurer-in-arkansas/

Milbank Memorial Fund

Oklahoma (CPC, Medicare Fee-for-Service beneficiaries)

	Oklahoma	All CPCI regions
Total Practices in 2016	60	439
%Practices Submitting Electronic Clinical Quality (eCQM) Reporting	98%	97%
%Practices Eligible for Shared Savings Based on Meeting Quality Requirements	98%	97%
Medicare Gross // Net Savings	5.7% // 4.0%	0.2% // -1.7%
Total Amount Earned by Region	$9,127,320	$10,180,003
Net Savings Per Beneficiary Per Month	$34.77	-$13.54

Ohio (CPC, commercial and public payers)



All Payer Products = All payers and product types
Commercial = Non-government payer products (does not include Medicare Advantage or Managed Medicaid)
All Government = CMS Fee for Service, Managed Medicaid, and Oh-Medicaid
Medicare Advantage = does not include CMS Fee for Service

Milbank Memorial Fund

Oregon (CPC+, commercial and public payers)

- In 2017, practices participating in both CPC classic and CPC+ performed better across all payer types than practices in the comparison group on 24 of 26 quality measures, including breast and cervical cancer screening and several chronic disease measures.

- Practices that participated in both programs showed positive trends in emergency department utilization and avoidable emergency department utilization across all payer types.

- Participating practices had lower per member per month adjusted claims-based costs among commercially insured members for numerous service types.

- The results indicate positive impacts of CPC program participation and lend continued support for CPC+ and other value-based payment programs in Oregon.

https://www.milbank.org/publications/the-impact-of-federal-value-based-primary-care-programs-on-participating-oregon-practices-a-snapshot/

Rhode Island (MAPCP and CPC+)

Care Transformation Initiative of Rhode Island (CTC-RI)

- 128 primary practices, including all FQHCs, serving 700,000 Rhode Islanders, of which 27 primary care practices are part of the integrated behavioral health initiative
- Investment from every health insurance plan in Rhode Island , including private and public plans
- CTC-RI practices demonstrate lower total cost of care by $217 million in 2016 when compared to non-patient-centered medical homes in Rhode Island, according to data from the state's All-Payer Claims Database.

Maryland Primary Care Program (single state multipayer effort)

- Investing in primary care practices to build a strong, statewide infrastructure to prevent and manage chronic disease
- Innovative hospital/provider partnerships
- Response to the Coronavirus pandemic – decreased impact in attributed population
- Federally Qualified Health Centers – application period open in 2020
- Multipayer program - CareFirst Blue Cross/Blue Shield joined as aligned payer in 2020 (> 1200 practices added)
- Dually-eligible for Medicaid and Medicare individuals' entry into MDPCP

https://www.milbank.org/publications/marylands-innovative-primary-care-program-building-a-foundation-for-health-and-well-being/

The National Academies of
SCIENCES · ENGINEERING · MEDICINE



Implementing High-Quality Primary Care:

Rebuilding the Foundation of Health Care

Nationalacademies.org/primarycare
primarycare@nas.edu

Plans for the Future

Nationally
Elizabeth Fowler, J.D., Ph.D., director of the Center for Medicare and Medicaid Innovation (CMMI), said the organization is undergoing a strategic evaluation to determine how its alternative payment models can have a transformative impact on the healthcare delivery system, including looking at models with a health equity lens.*

Locally
The work will continue to be done at the regional level. The state of Washington is an exemplar for the the rest of the nation.

*April 2021 - National Association of Accountable Care Organizations

Questions?



THE HEALTH COLLABORATIVE

Multi-payer Database

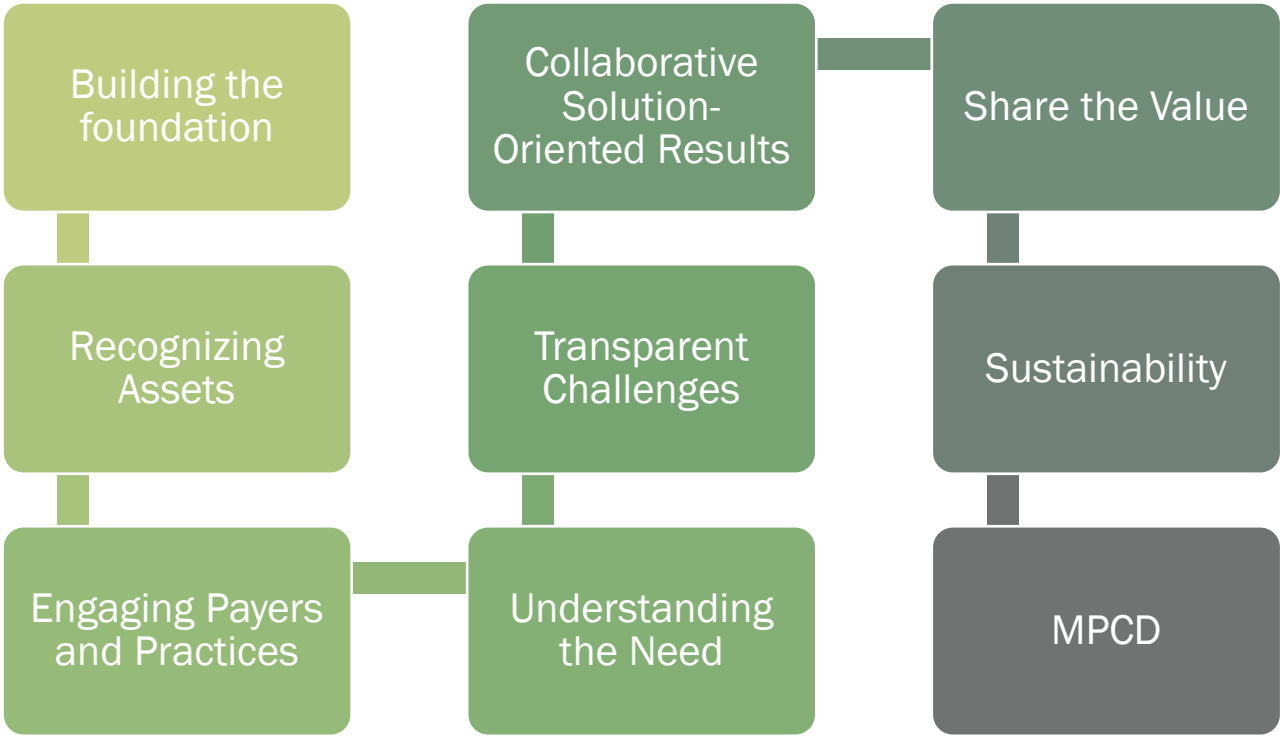
The Health Collaborative brings healthcare stakeholders together for the good of the community, and provides them with the actionable data they need.

Discussion

- MPCD Vision & Journey
- Payer and Practice Collaboration
- Recognizing the Value
- Data-driven results



the journey


Building the foundation
Recognizing Assets
Engaging Payers and Practices
Understanding the Need
Transparent Challenges
Collaborative Solution-Oriented Results
Share the Value
Sustainability
MPCD

Building the foundation

Recognizing Assets

Greater Cincinnati Health Council – 1957

- Fifteen Cincinnati-area hospitals voted to establish the Greater Cincinnati Hospital Council for the ***visionary shared goal of providing the best in hospital care and service to the community.***

The Health Collaborative (legacy org) – 1992

- A convener of multiple stakeholders in health and healthcare, including health systems, health plans, employers, consumers, and many others, in order to ***address widespread structural problems in Greater Cincinnati's health arena***.

HealthBridge – 1997

- A national leader in ***improving healthcare quality, cost-efficiency, and outcomes*** through better, more ***connected information*** across communities and regions

Partnership in 2012 – 1 CEO, separate boards

- 2012 partnership that combined the executive leadership and administrative operations of the three organizations, **while retaining separate Boards.**



The Health Collaborative

Merger in 2015

The strength of the merged organization gives members and community stakeholders alike more efficient and aligned access to:

- data and informatics capabilities of HealthBridge,
- multi-stakeholder collaboration championed by the Health Collaborative
- clinical care delivery improvement services of the Health Council.

who we are

THE HEALTH COLLABORATIVE

our vision

Greater Cincinnati is healthy by design and everyone is connected to quality, affordable healthcare

our mission

To lead data-driven improvement that results in healthier people, better care, and lower costs

We bring healthcare stakeholders together for the good of the community and provide them with the actionable data they need.



THE HEALTH COLLABORATIVE

Technology Services

hb/suite

- hb/360
- hb/exchange
- hb/insights
- hb/notify
- hb/direct

Population Health

THE HEALTH GENERATION GEN-H
GREATER CINCINNATI / N. KENTUCKY

THE HEALTH GENERATION GEN-H CONNECT
GREATER CINCINNATI / N. KENTUCKY
ADDRESSING THE NEEDS THAT IMPACT YOUR HEALTH

CHNA
Community Health Needs Assessment

Workforce Innovation

tap.health

tap.md

tap.hc

healthFORCE

Other Programs and Services

CPC+
Comprehensive Primary Care Plus

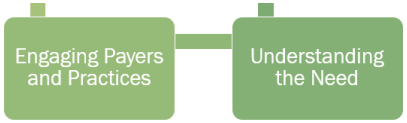
GREATER CINCINNATI dpc DISASTER PREPAREDNESS COALITION
THE HEALTH COLLABORATIVE

Tristate Trauma Coalition
THE HEALTH COLLABORATIVE

RC3
REGIONAL COVID COMMUNICATIONS CENTER

TEST AND PROTECT
Hamilton County CARES COVID-19 Testing

payer & practice engagement



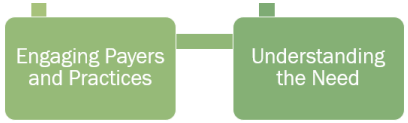
Project-based Engagement

- CPC Classic
- CPC+
- Employer Program
- Payer Convening

Data-based Engagement

- Data Workgroup- payers and practices
- Bi-monthly individual calls
- Data Coaching- payers and practices

providing options is important



BENEFITS OF CURATED LEVEL

- Access to curated data
- One static view
- Report sent to practice and/or system
- PF customization
- PF coaching during calls/visits

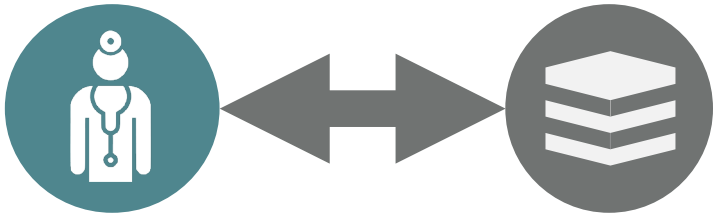
BENEFITS OF ALL-ACCESS LEVEL

- **All Curated Level services**
- Access to all data via portal
- Access to benchmarks and filtering options
- Participation in THC data workgroup
- Data views at patient/practice/system level
- Customization reports via self-service option

business model: “claims data co-op”

Collaborative Solution-Oriented Results

Transparent Challenges

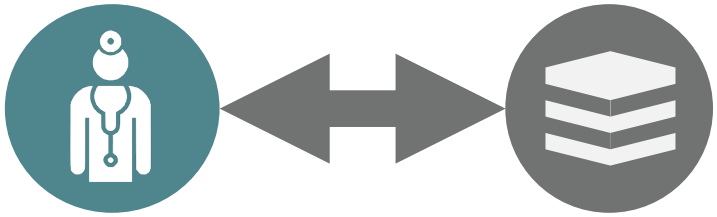


- Investment
- Co-ownership
- “Their data” = “Our data”
- One source of truth
- Uniform definitions
- Personalized support

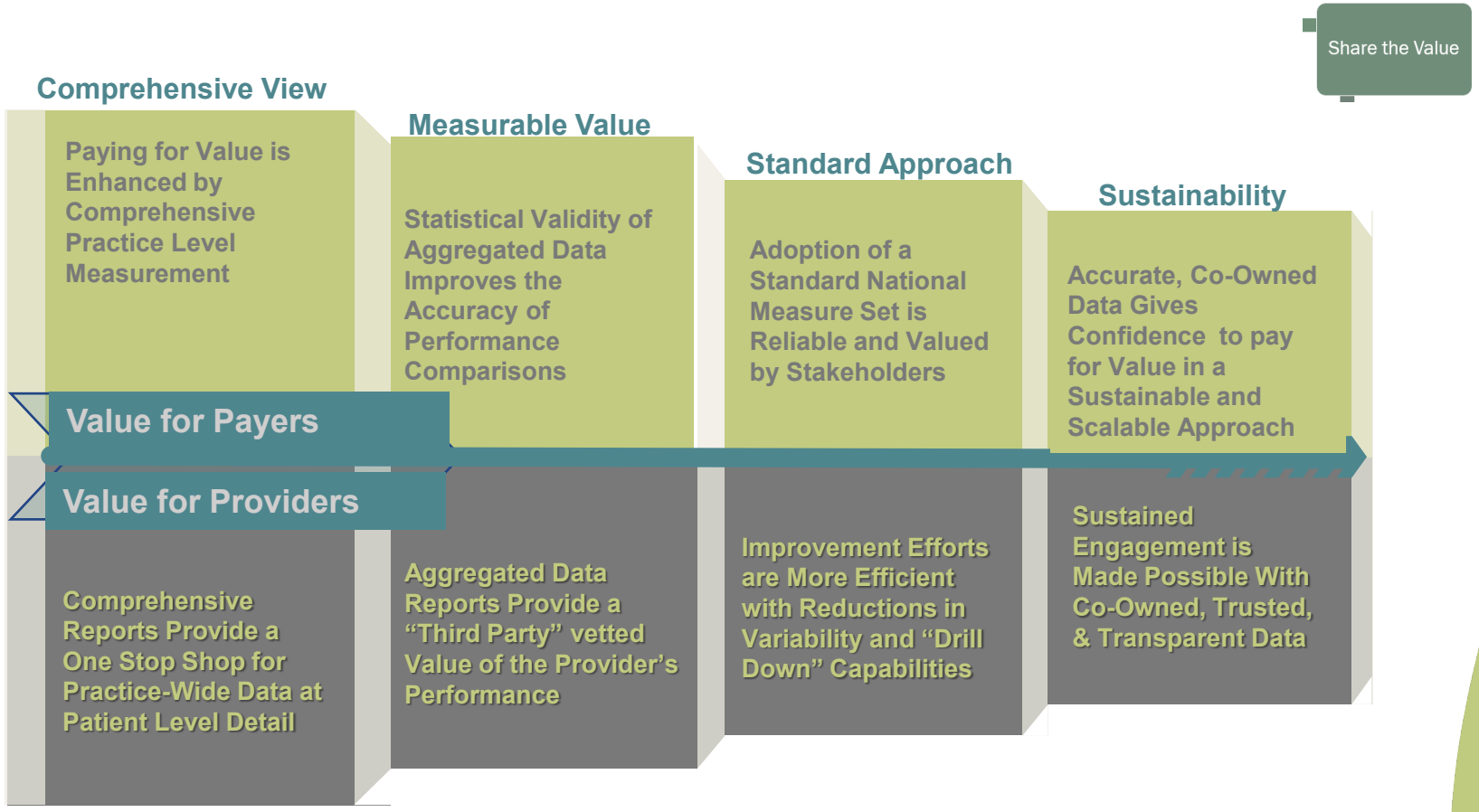
challenges

Collaborative Solution-Oriented Results

Transparent Challenges



- Risk Model
- Attribution
- Data lag
- Conflicting priorities
- Project-based
- Customer support & user experience


Share the Value
Comprehensive View
Paying for Value is Enhanced by Comprehensive Practice Level Measurement
Measurable Value
Statistical Validity of Aggregated Data Improves the Accuracy of Performance Comparisons
Standard Approach
Adoption of a Standard National Measure Set is Reliable and Valued by Stakeholders
Sustainability
Accurate, Co-Owned Data Gives Confidence to pay for Value in a Sustainable and Scalable Approach
Value for Payers
Value for Providers
Comprehensive Reports Provide a One Stop Shop for Practice-Wide Data at Patient Level Detail
Aggregated Data Reports Provide a "Third Party" vetted Value of the Provider's Performance
Improvement Efforts are More Efficient with Reductions in Variability and "Drill Down" Capabilities
Sustained Engagement is Made Possible With Co-Owned, Trusted, & Transparent Data

benefits

Share the Value

Providers and health plans measure progress towards performance-based goals



- Care teams are equipped with data
- Value-based reimbursement
- Comprehensive view of entire attributed population in one report across multiple payers
- Patient-level detail
- Optimize workflow
- Customization – self-service or by data coaches
- Dedicated data coaches

integrated practice and data coaching

Share the Value

primary care transformation

Optimizing Health Outcomes through Practice Improvement

Continuous Improvement

We coach clinical teams to plan, implement, analyze, and integrate changes that improve workflows and outcomes while reducing errors. Grounded in improvement science, we use data to help you make meaningful changes.

Peer Convening

Our skilled facilitation team convenes peers to share challenges and techniques, and to develop best practices together. In addition to region-wide events, we strategically organize groups by clinical role, care delivery topic, or clinical outcome measure.

Data Coaching

In addition to **hb/Insights** claims data analytics, our team is equipped to assist you in interpreting claims data, understanding measures, and revealing insights at the practice, provider, and patient level.

Grant Support

Because the Practice Transformation team is highly skilled in project management and quality improvement, they often assist with externally funded efforts and collaborations with stakeholders.

snapshot of key performance indicators

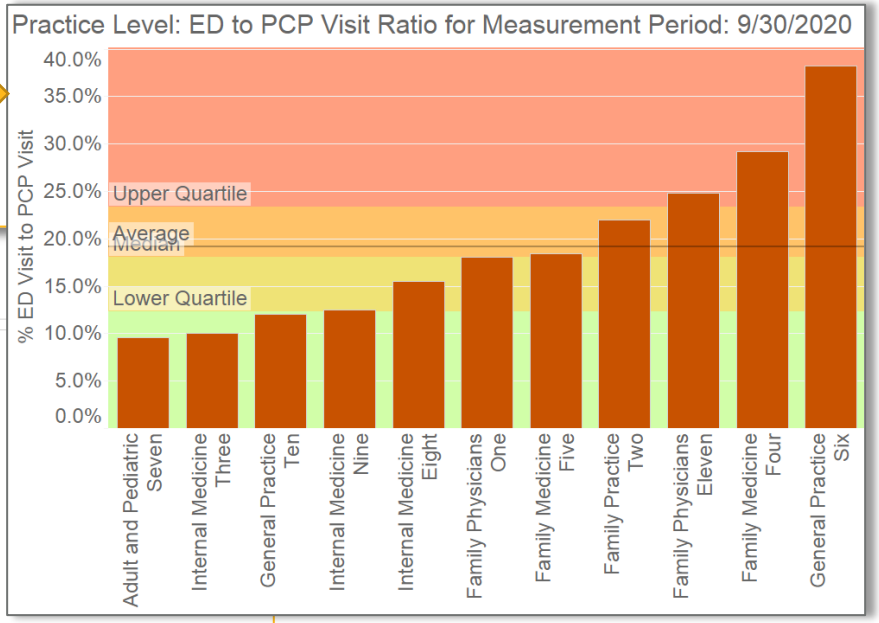
Share the Value

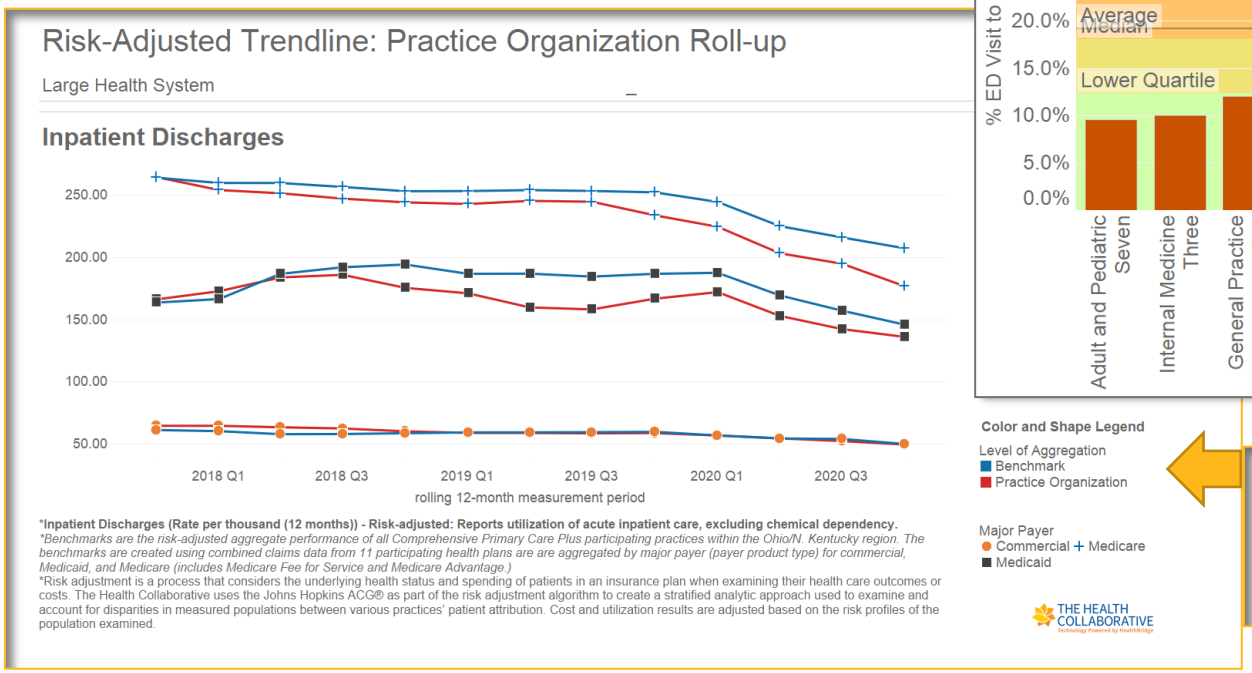


Views for leadership and practice management

Share the Value

Comparing practice performance (Practice Level)





Risk adjusted trends compared to a regional benchmark (Organization Level)

provider view: high utilizer detail (patient level)

Share the Value

High Utilizer Dashboard - **Outpatient ED Visits (EDV)**
Measurement Period: **2020-12-31** Practice Organization: **Health System**
Practice: **< Practice Name>** - CPCID: **All** Provider: **< Provider last name>**
Payer: **All** Major Payer: **All**

THE HEALTH COLLABORATIVE

Practice Organization Unadjusted Measure Results

Measure Name	Practice Organization	Major Payer	2020 Q4
Outpatient ED Visits (EDV)	Health System	Commercial	129.98
		Medicaid	772.80
		Medicare	143.48

Patient Level: High Utilizer List

# of Top Utilizers to View
40

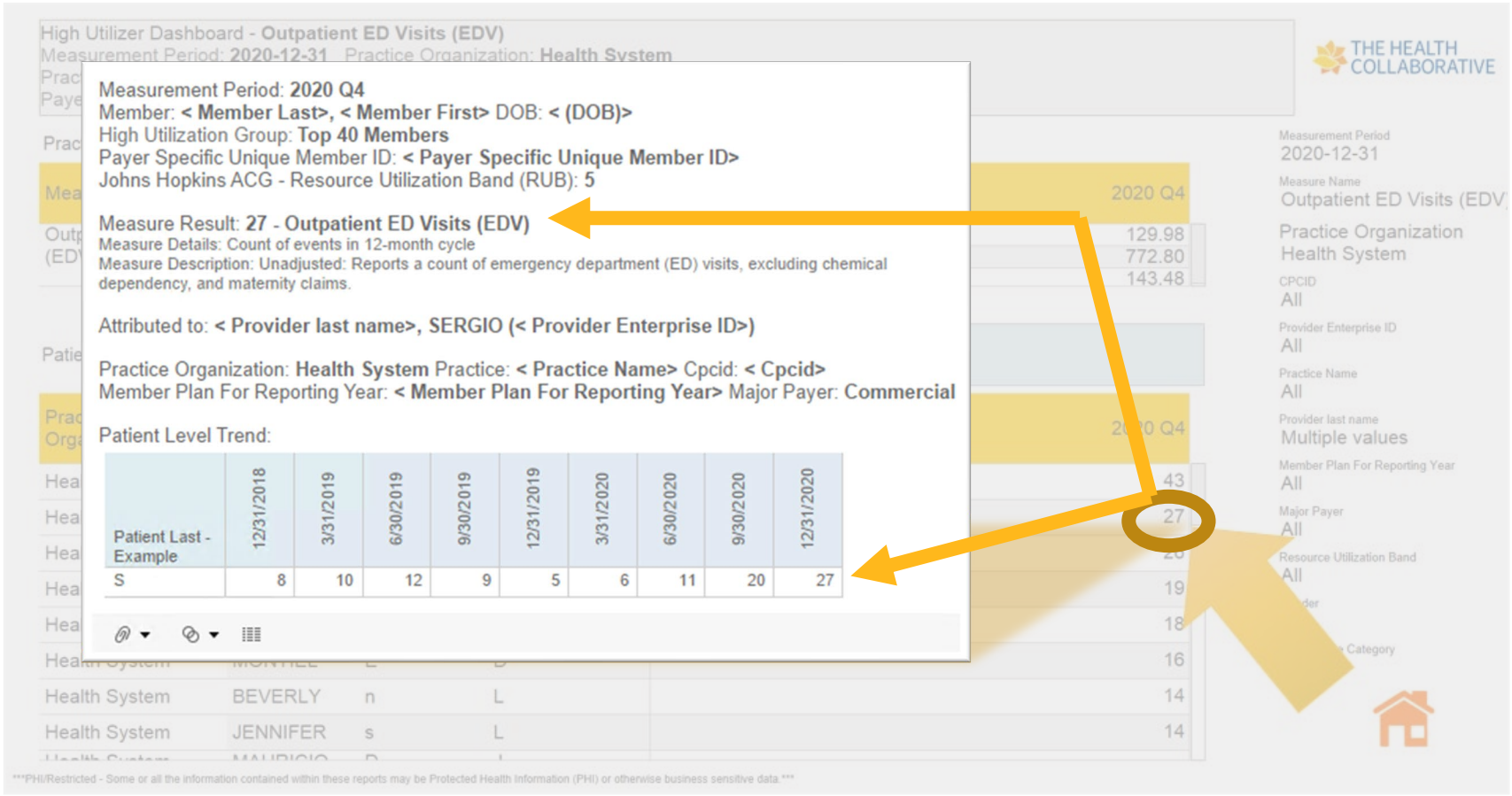
Practice Organization	Provider first name	Patient Last - Example	Patient First - Example	2020 Q4
Health System	MATTHEW	Y	H	43
Health System	SERGIO	S	T	27
Health System	BEVERLY	H	R	26
Health System	REID	E	S	19
Health System	BORNA	s	D	18
Health System	MONTIEL	E	D	16
Health System	BEVERLY	n	L	14
Health System	JENNIFER	s	L	14

Measurement Period
2020-12-31
Measure Name
Outpatient ED Visits (EDV)
Practice Organization
Health System
CPCID
All
Provider Enterprise ID
All
Practice Name
All
Provider last name
Multiple values
Member Plan For Reporting Year
All
Major Payer
All
Resource Utilization Band
All

PHI/Restricted - Some or all the information contained within these reports may be Protected Health Information (PHI) or otherwise business sensitive data.

provider view: high utilizer detail (patient level)

Share the Value



comprehensive primary care plus

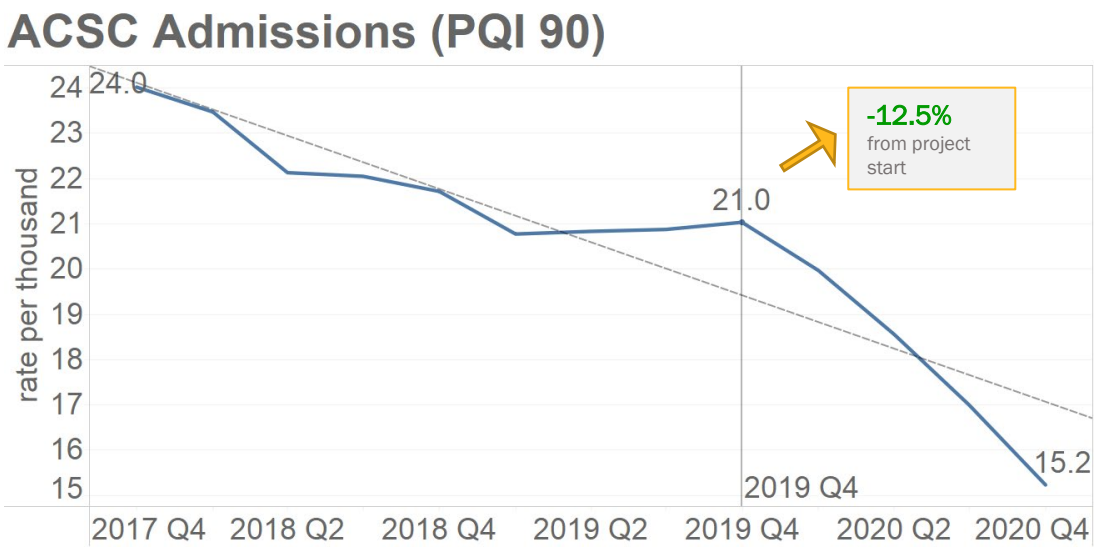
Share the Value

Data-Driven Improvement in Population Health

CPC+
Comprehensive Primary Care Plus

Ambulatory Care Sensitive Conditions (ACSC)

- Diabetes with short-term complications
- Diabetes with long-term complications
- Uncontrolled diabetes without complications
- Diabetes with lower-extremity amputation
- Chronic obstructive pulmonary disease*
- Asthma
- Hypertension
- Heart failure*
- Angina without a cardiac procedure
- Dehydration
- Bacterial pneumonia
- Urinary tract infection



MPCD Future

One data hub for various projects



HIE-Clinical and Claims Integration

- longitudinal patient record, historical perspective + real-time results

Employer models

- Support and promote a healthy workforce by connecting employees to resources

Data-driven population health

- Understand population segments, identify those at risk and apply interventions

Practice coaching and transformation support

Next Steps

- Finalize payer and practice support models
- Complete measure specifications
- Enhance clinical and claims integration
- Secure payer and practice participation
- Continue engagement efforts

THE HEALTH COLLABORATIVE

thank you!

Tiffany Mattingly, VP, Clinical Strategies
tmattingly@healthcollab.org

The Health Collaborative brings healthcare stakeholders together for the good of the community, and provides them with the actionable data they need to help their patients.

2022 Change in Action Webinar Series



January 13
Social Determinants of Health

April 7
Interoperability

July 7
Quality Measurement

October 6
Multi-Payer Collaboration

DR. ROBERT BREE COLLABORATIVE

WHA WASHINGTON HEALTH ALLIANCE