



EXECUTIVE SUMMARY

Aligning Payers and Practices to Transform Primary Care: A Report from the Multi-State Collaborative

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Since the mid-2000s, a number of states have developed and implemented initiatives to transform their primary care delivery systems in order to improve the health of their populations and reduce costs. These initiatives bring together health care providers and payers in collaborative efforts to implement patient-centered medical homes and promote payment reform by aligning incentives across all payers. What the states have learned from their experiences is that primary care transformation can only be achieved through change to both systems—organizing and paying for care.

This report describes how the states went about transforming primary care and the factors that shaped their efforts. It offers lessons learned that could help guide similar efforts in other states. In particular, this report details the experiences of members of the Multi-State Collaborative (MC), a voluntary group composed of representatives of state-based primary care initiatives that are themselves collaborative. With support from the Milbank Memorial Fund (MMF) since 2009, the MC has provided a forum for its members to share data, participate in collaborative learning, and advocate for improved collaboration between the states and the federal government on primary care transformation. The MC began with five states in 2009 and had expanded to include 17 states by the spring of 2014 as the benefits of sharing information about their experiences with system transformation became evident.

This report is based on a 2013 observational study of the MC states, informed by a survey and interviews with MC leaders. It looks at the similarities and differences in the activities of each of the state initiatives and concludes with lessons learned. The findings have implications for primary care transformation efforts, in particular, and, more generally, state-convened provider payment reform initiatives.

I. STATE-BASED PRIMARY CARE TRANSFORMATION INITIATIVES

In the mid-2000s, states became interested in primary care transformation because of the growing evidence that primary care is central to a high-performing health system and the improved health of a population.¹

The patient-centered medical home (PCMH) was at the core of these efforts. First introduced by the American Academy of Pediatrics in the 1960s, the PCMH has been adopted by providers, professional societies, and payers in the public and private sectors as a model for primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.^{2,3} With the PCMH, patients are expected to receive integrated support services in a wide range of fields, including behavioral and mental health, substance abuse and addiction treatment, nutrition guidance, health coaching, targeted disease management, links to social and economic services, self-

management opportunities, and coordination of referrals and transitions of care. The PCMH also aspires to provide for the accurate and timely transfer of clinical information, promotes payment incentives aligned with quality (in sharp contrast to volume-based fee-for-service), and increases the capacity to achieve measurable outcomes that address population health within the primary care practice and community-based resources.

State initiatives intended to transform primary care, using the PCMH model as a working definition of a high-performing primary care practice, began to take form. Usually these were payer-led initiatives—either by private insurers or Medicaid. As the initiatives proliferated, providers and policymakers began to call for greater coordination of these disparate efforts.

II. HISTORY OF THE MULTI-STATE COLLABORATIVE

The MC began in 2009 when five New England states—Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont—sought ways to share with one another their states’ experiences in transforming their primary care delivery systems. The MMF provided support for a meeting of the group, which described itself as a “collaborative of collaboratives.” Discussion at this early meeting revealed a common set of concerns—from how to engage a broad range of partners (health care providers, payers, state government, foundations) to the need for accurate, timely, accessible, and useful data for evaluating patient care and provider effectiveness. The members were especially interested in getting the Centers for Medicare & Medicaid Services (CMS) to participate in their state-based multi-payer initiatives by sharing Medicare data—a notable gap in their efforts to align the compensation offered by all insurers to primary care providers.

With staff and financial support from the MMF, the MC has continued to share data and learning on issues related to primary care transformation and to advocate with CMS about improving collaboration between the states and federal government. New states have joined the group each year as evidence of the effectiveness of these primary care transformation initiatives has grown and members report the benefits of sharing information with their peers.

III. THE COMPELLING LOGIC OF A MULTI-PAYER PRIMARY CARE TRANSFORMATION INITIATIVE

The strength of a multi-payer primary care transformation initiative rests in part on the thinking that drives its formation. Although the details of the MC initiatives vary by state, all were formed based on the following principles:

- Health care cost containment (and therefore affordability) cannot be achieved without delivery system transformation across multiple aligned payers.

- Delivery system transformation is predicated upon access to high-quality primary care and supporting services.
- High-quality primary care is more likely to occur in a consistently supported and formally recognized PCMH setting.
- The creation and nurturing of primary care transformation can only be successful in a uniformly applied multi-payer model coupled with collaborative learning and team-based care.

Given these principles, isolated payer-specific reforms often struggle because of the nature of our multi-payer health care system. Since most primary care practices are reimbursed from a mix of commercial health plans and public programs (like Medicare and Medicaid) that differ across health care markets, practices resist full-scale transformation when payers are not in alignment. This is often because no single payer can invest enough to make transforming the entire practice cost-effective. Moreover, health plan-specific reforms face significant challenges because of the lack of external benchmarks and lessons provided by the experience of collaboration with other entities.

When payers do align, the opportunities for transformation grow significantly. Each of the MC initiatives had the following components:

1. Innovative payment reforms to support primary care
2. Multiple payer participation
3. State government convening role
4. Standards for PCMH identification
5. New staffing models for team-based primary care
6. Technical assistance to practice sites
7. Common measurement of performance
8. Collaborative learning

Collectively, these eight components constituted the core of multi-payer primary care transformation initiatives. This report examines similarities and differences in the activities of each of the MC members in light of these eight components and offers some concluding lessons.

IV. STATE-BASED MULTI-PAYER PRIMARY CARE TRANSFORMATION INITIATIVES: SUMMARY OF SIMILARITIES AND DIFFERENCES

Governance plays a critical role in the success of individual state multi-payer initiatives. In almost all the cases described in this report, state government had a leadership role in convening and overseeing the initiative, although the specific authority varied between Medicaid, the commercial health insurance regulator, and the state Department of Public

Health. In each instance, health care organizations and commercial insurers rounded out the balance of the project governance. Outreach to business, patients, and community providers was less common, despite the general assumption that public engagement will ultimately be needed if primary care transformation initiatives are to be sustainable. Customer demand for these kinds of transformed, high-functioning medical practices will be critical in the long term. Finally, the accountability structure of each initiative varied and included the legislature, the executive branch, and an external advisory body.

Within the eight components that characterized each state initiative, there were similarities and differences:

- **PAYMENT REFORM:** All state initiatives contained some elements of payment reform for primary care and used a wide spectrum of options to align financial incentives with process and outcome measures. State initiatives tended to have a mix of payment mechanisms, including enhanced fee-for-service, capitation, pay-for-performance, and, in a few cases, shared risk. Most initiatives had incorporated a recognition standard for the PCMH—at a minimum—as a condition for any payment or for enhanced payment. Beyond this standard there was no evidence of consensus on the nature or size of incentive.
- **MULTIPLE PAYER PARTICIPATION:** Primary care practices expressed concern about the fractured nature of the payment system as it exists today. All states' initiatives had successfully obtained participation from multiple commercial payers and Medicaid, although the level of participation varied considerably. Medicare participated in some of these initiatives through its Multi-Payer Advanced Primary Care Practice (MAPCP) and Comprehensive Primary Care (CPC) initiative projects. Participation of Medicare was described as absolutely essential for the states where it occurred.
- **STATE GOVERNMENT CONVENING ROLE:** There was universal agreement that active engagement of high-level state authority was key to the successful implementation of these initiatives.
- **STANDARDS FOR PCMH IDENTIFICATION:** The majority of state initiatives—eight—used the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) recognition. Two state initiatives—Minnesota and Michigan—developed and implemented their own standards.
- **NEW STAFFING MODELS:** There was agreement that the introduction of care teams to treat populations within the practice and to coordinate with community resources was critical to primary care transformation. Enhanced support services varied widely by each state initiative in terms of new staff roles and specific actions performed.
- **TECHNICAL ASSISTANCE:** Most state initiatives attested to the importance of practice facilitation (or coaching) models, with two-thirds describing them as “essential.” Some state initiatives were further along in developing these models than others. The

quest for accurate, timely, and accessible health information was a common goal and challenge for all MC state initiatives, and many looked at ways to leverage resources for health information technology to support primary care transformation.

- **COMMON MEASUREMENT OF PERFORMANCE:** Each MC state initiative took stock of its own performance and measurements in the areas of cost, quality, and patient satisfaction for the purpose of system improvement and ongoing evaluation. Performance measurement required a significant infrastructure, which MC state initiatives steadily developed. The nature and comprehensiveness of the performance measurement activities varied considerably, but state leaders spoke to the importance of sharing outcome measures as a way of building trust and healthy competition. All state leaders expressed frustration with the challenges of developing consensus measures and credible feedback mechanisms for health care providers—particularly for cost and utilization measures.

In spite of these challenges, MC members reported that system performance measurement was possible. In fact, two MC state initiatives showed significant improvements in savings in medical costs after recent and extensive self-evaluation. This corroborated reviews of other (non-multi-payer) primary care transformation initiatives.

- **COLLABORATIVE LEARNING:** All MC state initiatives implemented some version of collaborative learning into their primary care practice transformation efforts, although the collaboratives themselves took many forms.

V. LESSONS LEARNED

The following lessons can be drawn from an analysis of the survey results and interviews:

1. THE LOGIC OF A MULTI-PAYER EFFORT TO SUPPORT PRIMARY CARE TRANSFORMATION IS IRREFUTABLE.

High-performing primary care is necessary but not sufficient for a well-performing delivery system. Primary care transformation can only be attained by coordinating efforts across payers.

2. STATE LEADERSHIP AT THE HIGHEST LEVEL POSSIBLE IS NECESSARY FOR THE SUCCESS OF MULTI-PAYER PRIMARY CARE TRANSFORMATION.

Only a government entity, most often a state, can neutrally convene private and public stakeholders without undermining existing insurer-led initiatives or violating antitrust provisions.⁴

The public sector can make the conclusive case that scarce funds consumed by expensive and escalating health care costs are being diverted from other essential functions of state government. Officials from state agencies such as Medicaid,

Health and Human Services, and Public Health Departments can serve as thought and implementation leaders.

3. A MULTI-PAYER APPROACH IS KEY TO ENGAGING CLINICIANS AND PAYERS ALIKE.

The multi-payer approach not only provides sufficient resources to primary care practices but also aligns those resources with appropriate and consistent incentives to health care providers and aligns policy priorities with system improvement through transformation. Joining forces, especially in combinations that are not traditional—such as putting together commercial insurers who usually compete with one another or Public Health and Medicaid agencies that do not always work synergistically—lends a credibility that empowers all involved. Medicare participation was catalytic for those collaboratives that benefit from CMS's support.

4. RELIABLE DATA AND MEASUREMENT, ESSENTIAL TO SUCCESS, REMAIN A CHALLENGE.

The collection, cleaning, analysis, and distribution of accurate and timely information are paramount. While inroads have been made, all MC members struggled with the complexity and costs involved in providing and effectively using vital data collection tools.

5. TRANSPARENT SHARING OF EXPERIENCE AND INFORMATION LEADS TO EFFECTIVE LEARNING.

There is consensus that the open exchange of experience and information enabled participants to benefit from the lessons of others. The Learning Health System collaborative model was embraced enthusiastically from individual primary care practices (the micro-level) to the national setting (the macro-level). MC members took that concept and made it a part of their daily work.

6. THESE COLLABORATIVES ARE IMPROVING OUTCOMES FOR POPULATIONS IN SIGNIFICANT AND SUSTAINABLE WAYS, WITH VARYING LEVELS OF SUCCESS, AND THIS TRANSFORMATION TAKES TIME AND ENERGY.

Support for the work of these initiatives was indicated by the growth in the number of practice sites involved in the initiatives and the number of states undertaking such work. This was illustrated in the nearly tenfold increase in patient participation in the MAPCP since the demonstration began in July 2011.

Only recently have the most experienced MC state initiatives been able to report on the statistically significant positive impacts of their interventions. The timing of hoped-for results can be a challenge in a pressure-filled environment where outcomes are desired within a short period, such as an electoral cycle.

The collaborative model has some weaknesses in its design. Collective governance can lower performance standards and inhibit constructive competition. It can be expensive and take time to align performance measurement with timely, accurate feedback.

Initiative leaders reported that process sustainability and quality improvement were dependent on people changing the way they do things, such as lifestyles for patients and workflow for health care providers. This report also documented significant variations in the activities undertaken by the initiatives in each of the eight component areas. Some approaches were proving to be more effective than others. Initiative leaders reported being committed to learning which activities actually improve performance. In design and intent, the work of the MC should speed up this process.

7. THE BUSINESS CASE FOR PRIMARY CARE TRANSFORMATION MUST BE DEFINED AND DEFENSIBLE TO POLICYMAKERS, PURCHASERS, AND PATIENTS.

Not enough time had lapsed or experience acquired to make the case definitively for or against the particular strategies for each component at the time the survey was completed. However, the case for transformed primary care and the correctness of this policy direction were clear. The question is no longer whether these interventions are effective, but rather how to improve, refine, and spread them.

8. THE FINDINGS OF THIS REPORT HAVE IMPLICATIONS FOR FUTURE PAYMENT REFORMS.

Single-payer experiments in payment reform—whether from public payers or private insurers—have some inherent weaknesses. They target a health care provider or practice but only pay for a portion of the patients, and they rely primarily on narrow payment incentives for such activities as care coordination. They focus less attention on theories of change involving adult learning and system improvement and fail to address evidence regarding the social determinants of health, an indication that the true cost drivers are outside the medical care system.

In contrast, the local and state-based multi-payer collaboratives studied in this report have the advantage of being able to address these weaknesses, while facing the challenges documented here. Given the fundamental multi-payer nature of health care in the United States, their lessons bear examination.

Notes

- 1 Starfield B., Shi L., Macinko J. 2005. Contribution of Primary Care to Health Systems and Health. *The Milbank Quarterly* 83(3):457–502; doi: 10.1111/j.1468-0009.2005.00409.x.
- 2 American College of Physicians. 2007. *Joint Principles of a Patient-Centered Medical Home Released by Organizations Representing More Than 300,000 Physicians*. (Accessed June 11, 2014: <http://www.acponline.org/pressroom/pcmh.htm>.)
- 3 American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. 2007. *Joint Principles of the Patient-Centered Medical Home*. (Accessed June 11, 2014: http://www.acponline.org/running_practice/delivery_and_payment_models/pcmh/demonstrations/jointprinc_05_17.pdf.)
- 4 Wirth B., Takach M. 2013. *State Strategies to Avoid Antitrust Concerns in Multipayer Medical Home Initiatives*. The Commonwealth Fund.

THE AUTHOR

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