THE HEALTH COLLABORATIVE

# “Comparing CPC “Classic” Outcomes: Different Populations - Different Responses; Different Stakeholders – Different Angles.”

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# The Health Collaborative: What We Bring

**Role #1:**

Practice Learning and Diffusion

**Role #2:**

All Payer Claims Data Analytics

- Benchmarking
- Attribution Tracking

**Role #3:**

Convening

# PCMH + Payment Reform

- **75** practices and **350** providers
- **Multi- payer:** 9 health plans + Medicare
- **500,000** estimated commercial, Medicaid and Medicare enrollees

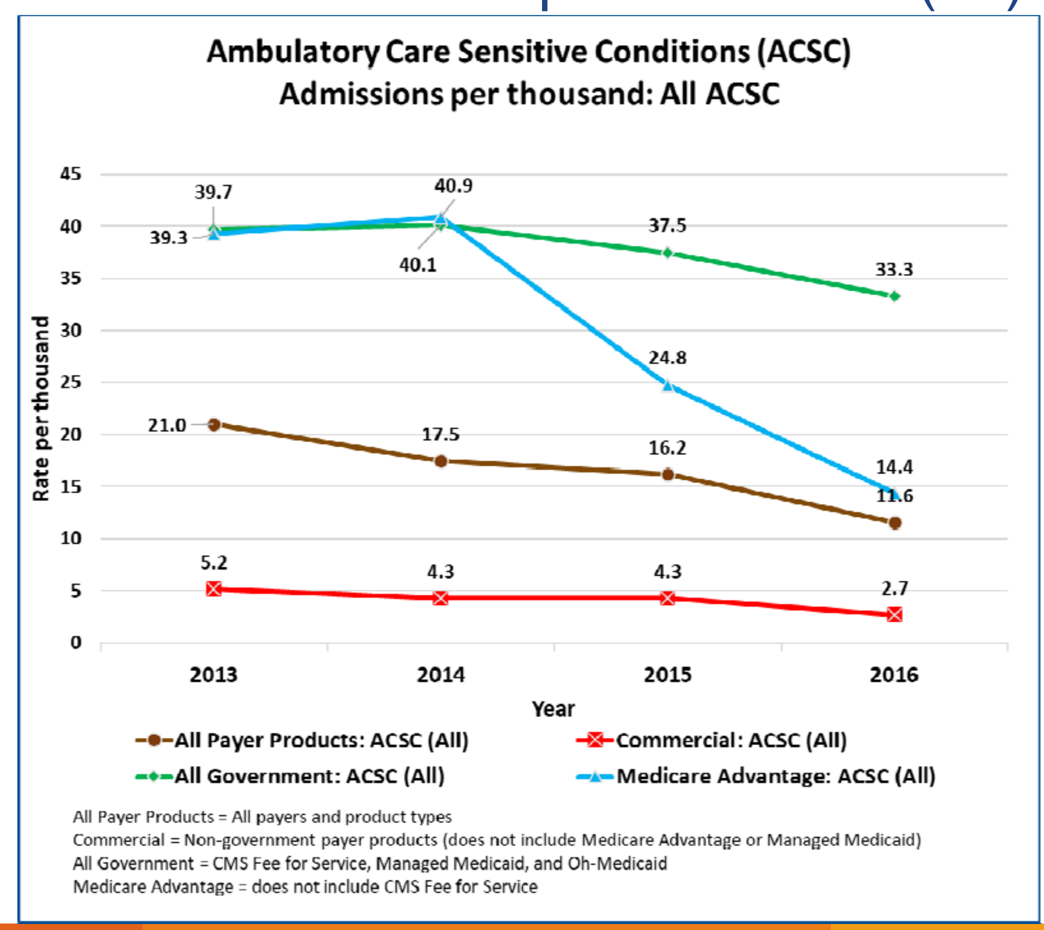
# Different Populations - Different Responses

| | ACSC | | | Inpatient Discharges | | | ED visits | | | Total Cost | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2013 | 2016 | Change from 2013 to 2016 | 2013 | 2016 | Change from 2013 to 2016 | 2013 | 2016 | Change from 2013 to 2016 | 2013 | 2016 | Change from 2013 to 2016 |
| **Payer Mix** | rate per thousand | | (%) | rate per thousand | | (%) | rate per thousand | | (%) | $ per member per year | | (%) |
| **All** | 21.0 | 11.6 | -44.8% | 121.5 | 81.8 | -32.7% | 306.3 | 251.3 | -18.0% | $5,677 | $5,159 | -9.1% |
| **Commercial** | 5.2 | 2.7 | **-48.1%** | 45.4 | 32.5 | -28.4% | 180.1 | 162.4 | -9.8% | $4,205 | $4,236 | **0.7%** |
| **Medicare Advantage (MA)** | 39.3 | 14.4 | **-63.4%** | 192.1 | 90.5 | -52.9% | 359.3 | 184.0 | -48.8% | $8,345 | $5,243 | **-37.2%** |
| **All Government (excludes MA)** | 39.7 | 33.3 | -16.1% | 218.1 | 205.9 | -5.6% | 489.9 | 509.8 | 4.1% | $7,028 | $7,512 | 6.9% |

***Results are not risk-adjusted**

- **Employers** are looking for a solution too
- **Social determinants of health** are just that: “social” *(80% of health outcomes due to social factors)*
- Primary care + community support can **screen**, **refer**, & **coordinate** SDOH as they do for chronic disease
- The more experienced CPC practices are beginning to show evidence of this; it is an **acquired skill**

# CPC Classic: Ambulatory Care Sensitive Condition Admissions per thousand (All)



# Payers Saw Savings and Then Some

- Significant quality of care improvement.
- Committed to value based payment models.
- The multi-payer approach of CPC is necessary
- Funds spent on care management were more effective.
- Able to demonstrate to their large self-funded customers that the investment was better than break-even while not reducing quality.

# The Physician Survey Said:

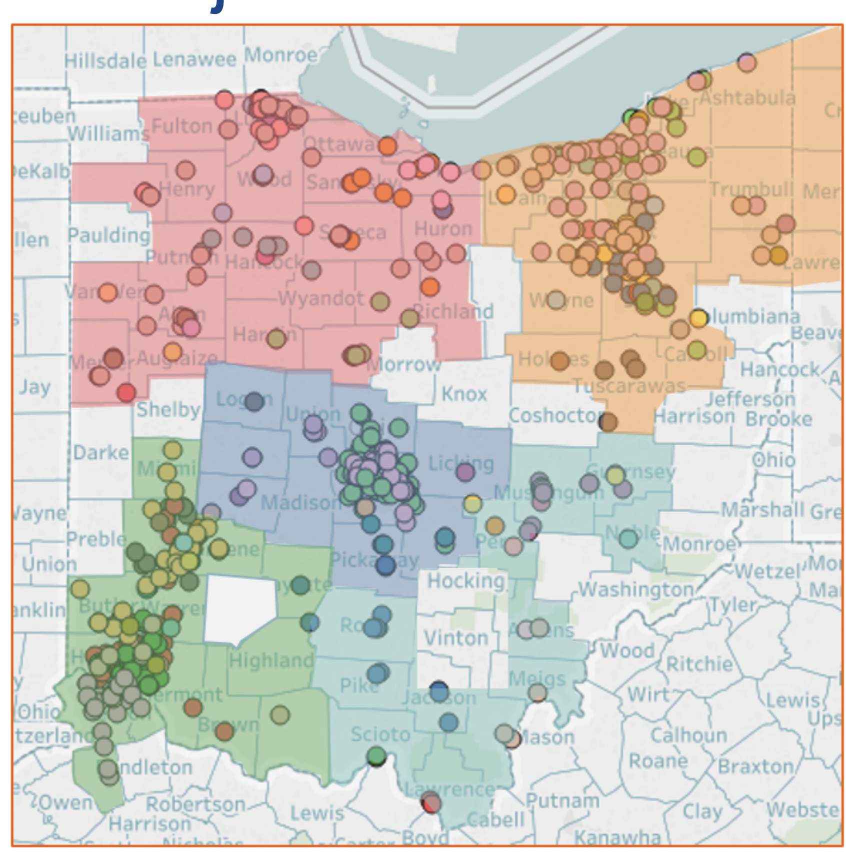
- No one wanted to return to straight FFS payment
- Increased professional satisfaction from providing comprehensive care management to their patients.
- Did not reduce their work time but the time they spent felt more productive.
- 2-3 year learning curve.
- Financial considerations not top of mind.

*If the non-financial advantages had not been realized, pay alone would have been insufficient.*

# Comprehensive Primary Care Plus (CPC+) Scope of Project

CPC+ Ohio-N.Ky

- 5 year advanced primary care medical home model
- ~560 individual "brick and mortar" practices
- ~2600 providers
- 14 Payers
- 2.5 million patients
- Payment Streams
  - Fee-For-Service
  - Care Management Fee (CMF)
  - Performance-Based Incentive Payment

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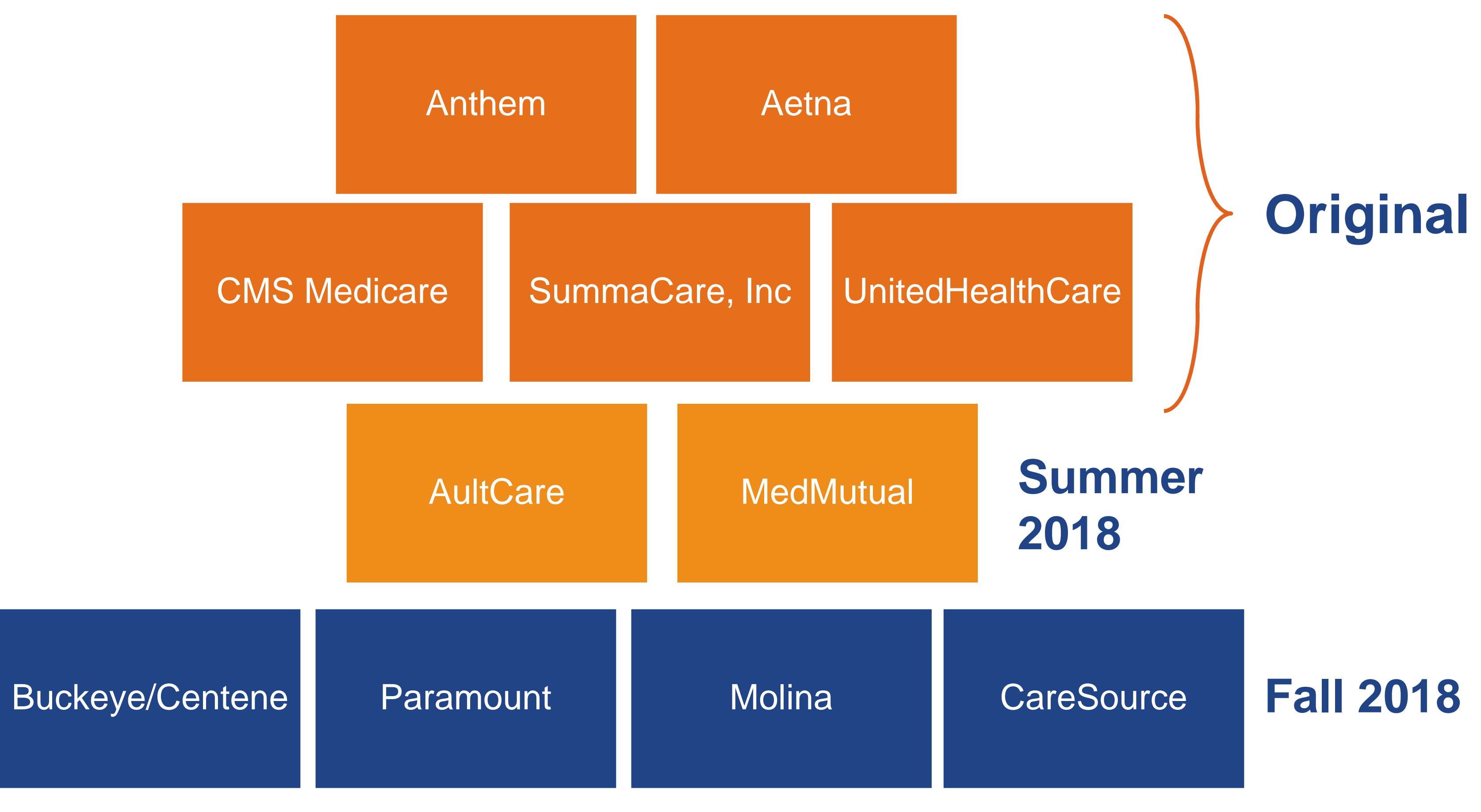
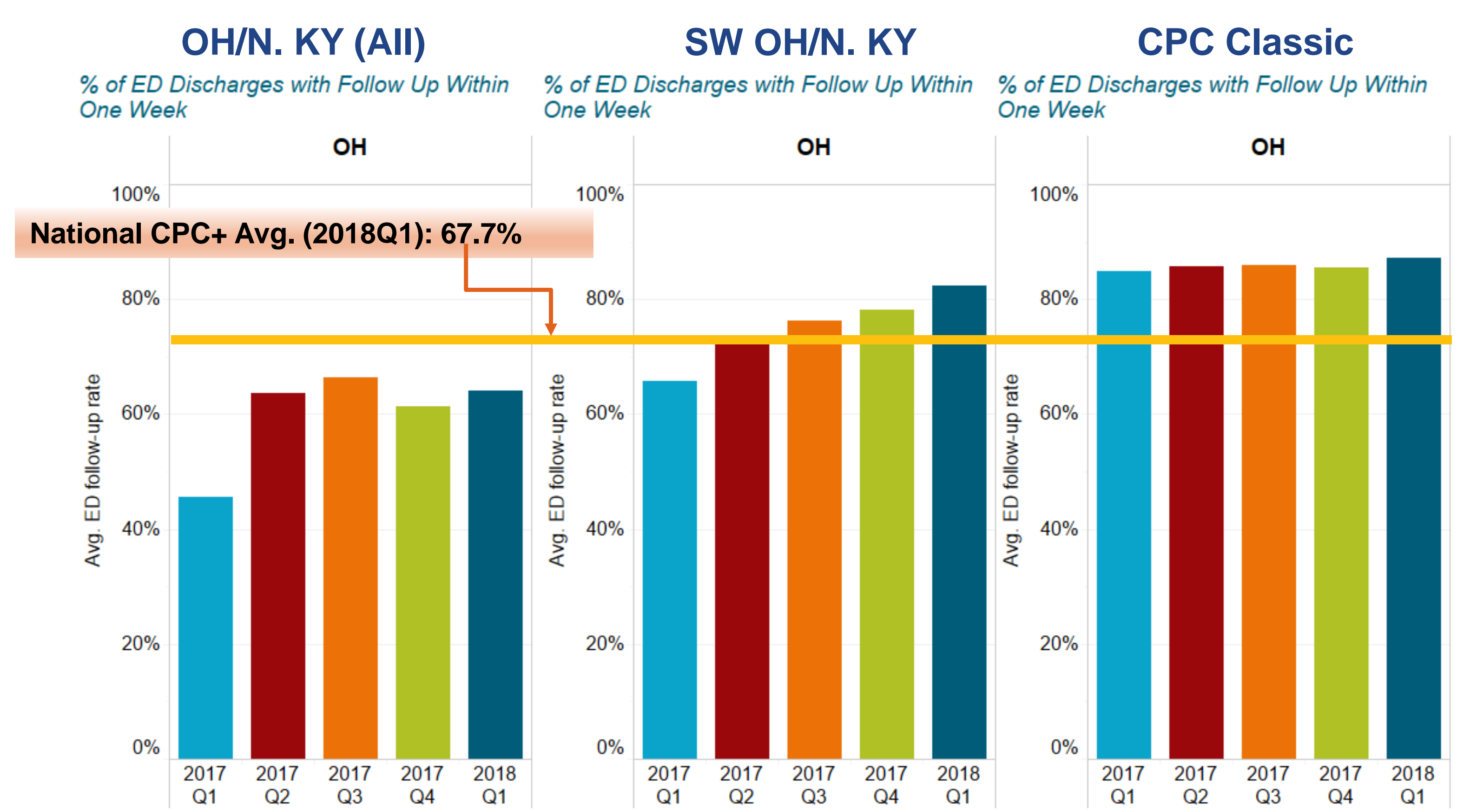
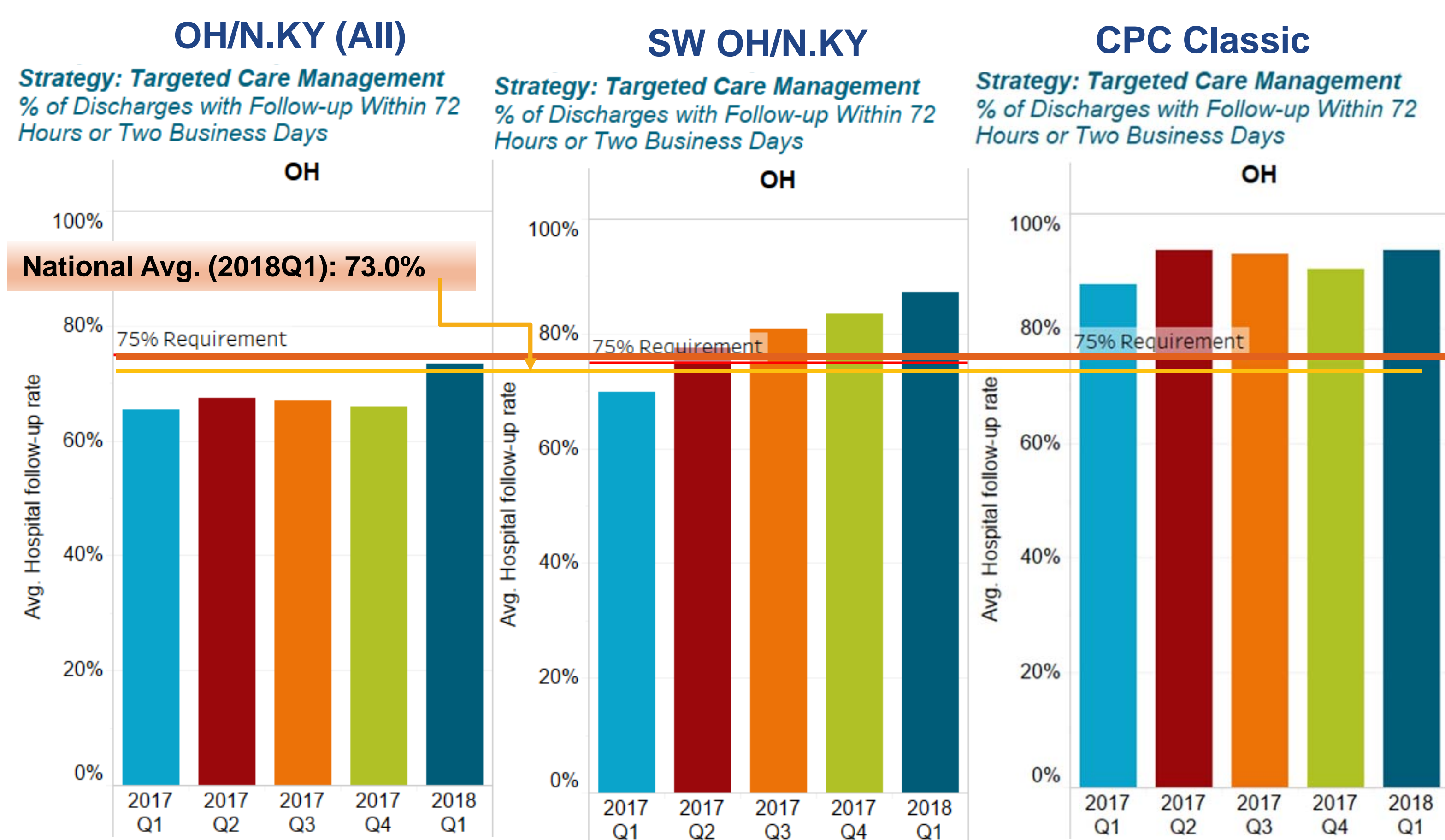
# Participating Health Plans



# Emergency Department Follow-up within One Week



# Hospital Follow-up Upon Discharge within 72 Hours



# CPC+ Claims Outcomes: 2017 First Year Preliminary Results

| Ohio CPC+ Region | Major Payer | Measure | % Change from 2016 to 2017 |
|---|---|---|---|
| OH (All) | Commercial | ACSC Composite | -12.2% |
| | Medicare and MA | ACSC Composite | 1.9% |
| | Commercial | ED Visits | 5.4% |
| | Medicare and MA | ED Visits | 2.5% |
| Southwest OH | Commercial | ACSC Composite | -22.3% |
| | Medicare and MA | ACSC Composite | -5.3% |
| | Commercial | ED Visits | -3.6% |
| | Medicare and MA | ED Visits | 4.1% |
| CPC Classic Practices ONLY | Commercial | ACSC Composite | -36.5% |
| | Medicare and MA | ACSC Composite | -9.9% |
| | Commercial | ED Visits | -7.1% |
| | Medicare and MA | ED Visits | 1.4% |

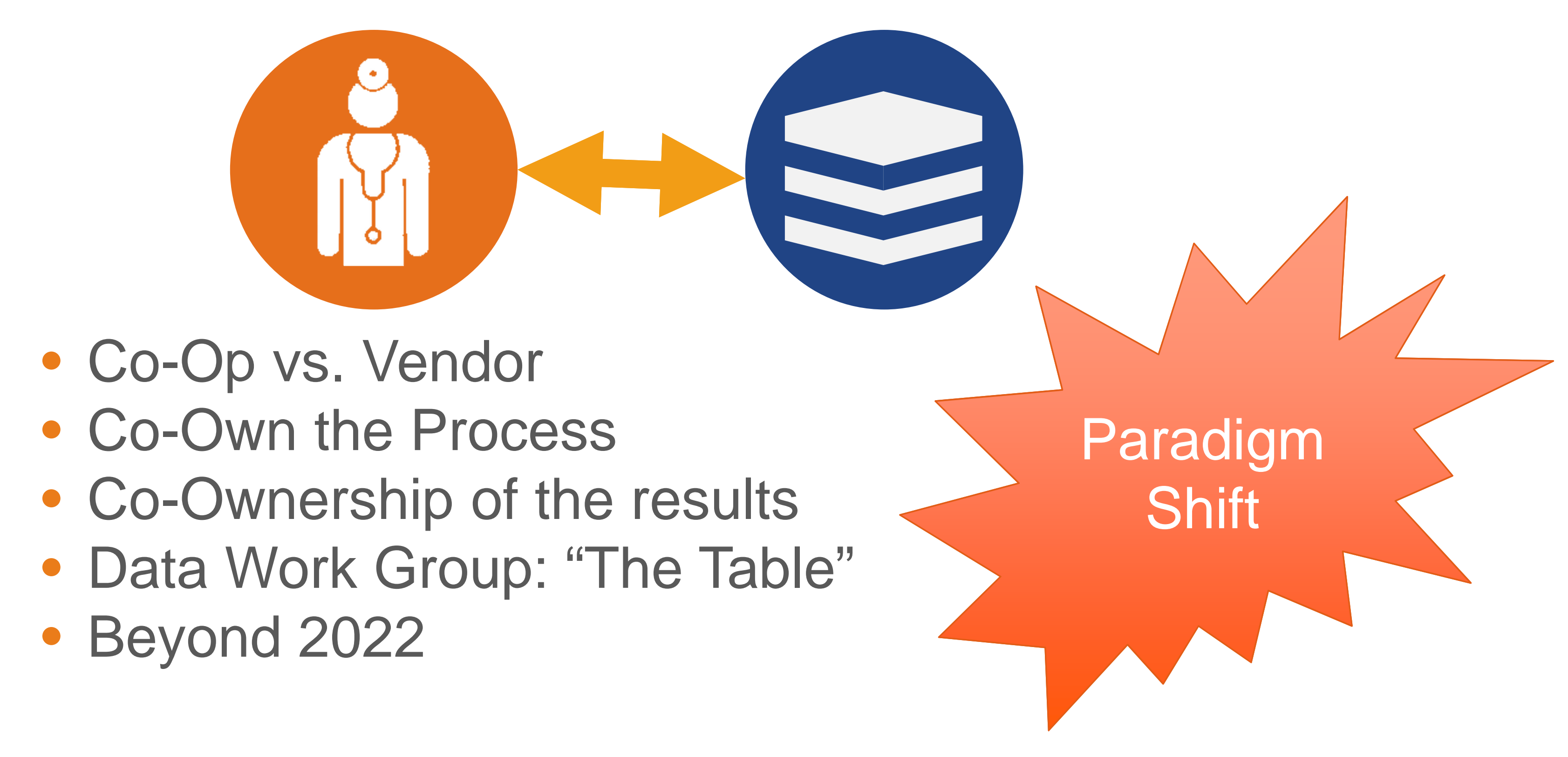
ACSC Composite = Ambulatory Care Sensitive Conditions (12 chronic diseases)

# Why it is Important?

- What do we want practices do with the data?
- VBP: He who measures value… controls payment
- Business models matter
- A source of truth
- Proof of concept

***We can forge a more meaningful partnership, or we can maintain the same adversarial dialogue***

# Business Model: “Claims Data Co-Op”



# Data Work Group: “The Seat at The Table”

- The **Neutral Space**
- Working committee to ensure the effective design and implementation of **claims-based measures** and **reports** for practices and payers
- Provides Structure for Convening beyond 2022
- Provider/Payer Dialogue
- Serves in data governance

# Engage by “Solution”

- One Stop for Comprehensive Performance
- Part Ownership of the Process; “Seat at the Table”
- Benchmarking
- Actionable Data; Translating to Care Manager Work Lists
- Make Integral to Practice Transformation; Just in Time Data
- Hands on Data Coaching
- Avoid Administrative Burden for Data Entry

# “Nesting” it in the Market

- Ohio State Innovation Model (SIM)
- Accountable Health Coalition (AHC)
- Opioid Work
- Synergy with Health Information Exchange (HIE)
- Foundation for All Payer Claims Database (APCD)

*This why Trusted Local Conveners are Critical; Relationship and Environmental Knowledge*

# Ohio CPC and CPC+: Similarities and Differences

## Ohio CPC

**~600 Practices**

- Data Reports: ODM
- Practice Classification: Medicaid ID (~114)
- Measure Specifications: HEDIS, 28 measures
- Includes Pediatrics and FQHC's

**~400 Practices**

- Built on PCMH: Team-Based Care
- Practice Transformation is a priority
- Care management fees on top of FFS
- Significant investment in care management fees
- Depend on Critical Mass
- Recognizing the importance of data
- Data provided at patient-level detail
- Recognizing need for a uniform report

## CPC+

**~560 Practices**

- Data Reports: CMS, ODM, The Health Collaborative
- Practice Classification: Practice Site (brick and mortar)
- Measure Specifications: align with MIPS, 16 measures
- Adults only

# Thank You!
# Discussion?

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# Measures That Matter:

| Category | Measures |
| --- | --- |
| Cost | ED Cost<br>Inpatient Cost<br>Pharmacy Cost<br>Primary Care Cost<br>Specialist Cost<br>Total Cost |
| Quality | Low Back Pain<br>PCR<br>PQI CHF<br>PQI COPD<br>PQI Composite |
| Utilization | ED Visits<br>Inpatient Bed Days<br>Inpatient Discharges<br>Primary Care Visits<br>Specialist Visits |

# New Measures That Matter:

Add by end of 2018

- Mammograms
- Pap Smears
- Live Births <2500gms
- Well Child 1st 15 mos.
- Well Child 2-6 yr
- Adolescent Well-Care
- HbA1c Testing
- Eye Exam Performed

Planned by end of 2019

- BP Control
- BP Control Diabetes
- COPD Exacerbation/Corticosteroid
- Medication management Asthma
- Multiple Antipsychotics in Children
- Statin Therapy for CV Disease
- Follow up after Hospitalization for Mental Illness
- Colonoscopy

# Policy Implications: Primary Care

- Primary Care as Broker, Interpreter, Consultant
- Coordinated Care is Cost Effective Care
- Primary Care as Gateway (not Gatekeeper)
- Patient Incentives (not penalties)
  - Less out of pocket
  - Greater eligibility
  - Other perks; get creative

*Reward those who help resources go farther*

# Policy Implications: Support of Primary Care

- Assessment of Social Determinate Risk becomes as routine as Clinical Risk
- Practices' Care Management is integrated with Social Services just like Behavioral Health Services
- CMF Payment is weighted according to SDOH risk scores on a par with BH risk scores