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Primary Care Transformation: Can Competitors Collaborate?

Issue Brief

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Executive Summary

The federal Comprehensive Primary Care (CPC) initiative, led by the Centers for Medicare and Medicaid Services (CMS), represents the most ambitious nationwide effort to strengthen primary care by aligning government and commercial payers. Seven years into the initiative, this issue brief attempts to assess how participating payers feel about the program and its progress by exploring the perspective of payers in three distinct regional markets in the Comprehensive Primary Care Plus (CPC+) program: Colorado, Oklahoma, and Greater Philadelphia.

Between 2008 and 2014, 17 multi-payer medical home initiatives were launched across the country. CMS took an important step in support of multi-payer alignment in 2012 with the debut of the CPC initiative, which brought together 39 private and public payers in seven regions of the country, including four states and three metropolitan areas. CMS substantially expanded its effort at multi-payer alignment in 2017 with the CPC+ program, whose goal was to reach 20 regions of the country and up to 5,000 medical practices.¹

Every region in which CPC+ operates has a distinct market of competing health plans, each with its own delivery system reform strategies, mix of primary care practice structures, culture of medical practices, and set of health care leaders. In two of the markets examined in this issue brief, the multi-payer effort extends back to 2012. In each market, the dynamics have played out differently and are described in this issue brief.

For this brief, Noam Levey interviewed payer representatives about their experiences implementing a primary care payment reform model and their interactions with one another and with the federal government. Despite the different market dynamics, several common findings about multi-payer work emerged:

- The participating payers' engagement remains strong.
- Sustained federal participation and leadership are critical.
- The payers have already learned lessons that could speed alignment elsewhere.
- Sustaining momentum in the future will be challenging.

The payers' experiences in these three diverse markets participating in the federal CPC program testify to the difficulty of this work. Even though many payers are interested in ways to accelerate change, some CPC participants in these markets retain a substantial interest in and commitment to sticking with the ongoing alignment efforts. At the same time, they stressed the need for continued federal leadership in advancing cooperation in the country's fragmented health care system.

Foreword

Economists have pointed out that behavior follows reimbursement. In regard to health care provider payment reform efforts, those reimbursements are usually not consistent, creating mixed signals and incentives for the participating providers. And when it comes to money, the alignment of efforts among competing health plans—which might actually increase the chances of payment reform’s success—is not instinctive.

This issue brief is the product of a set of qualitative interviews with participating payers in the Comprehensive Primary Care Plus (CPC+) program, to date the most ambitious primary care payment innovation led by the Centers for Medicare and Medicaid Services (CMS). The regions—which varied in the extent of their CPC+ experience, the number of participating payers, and their demographic and political characteristics—were chosen to illustrate the spectrum of CPC+ settings. Key payers in each market were asked about their experiences, including how the alignment efforts developed, the role of the federal government, and how the efforts were progressing.

By shedding light on the journey that some CPC+ payers have taken, Noam Levey’s issue brief both illustrates the commitment to and the importance of the CPC+ to the participating payers and provides crucial insights:

- Albeit time-consuming and technically challenging, the sometimes unlikely collaboration among competing regional payers is seen to be of high value to the partners.
- Despite the challenges, including the “innovation fatigue” affecting both practices and payers and the sometimes slower than hoped-for progress, regional payers are committed to continuing their efforts toward alignment.
- This effort is catalyzed by the federal government. The interviewees see the participation and infrastructure provided by Medicare as critical to the program’s credibility and sustainability.

Since 2009, the Milbank Memorial Fund has supported and nurtured a working group of states and regions actively engaged in Medicare’s and other multi-payer primary care transformation programs. The Multi-State Collaborative (MC) consists of local champions of multi-payer primary care transformation—primarily representatives of leading local and national payers and the neutral conveners who facilitate alignment among the payers in the local markets. The MC is a network of people

with a common commitment to comprehensive, high-quality primary care and multi-payer alignment toward that goal.

With that commitment in mind, this issue brief intends to inform, instruct, and engage health policymakers, delivery system leaders, and health services researchers regarding this challenging but essential work.

Although the Fund has supported the work of the CPC initiative and CPC+ through the MC, the Fund did not dictate this report's conclusions or otherwise exert editorial influence over the author.

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Introduction

State and federal health officials have undertaken a series of initiatives in recent years to strengthen primary care by coordinating the work of multiple payers in health care markets across the country. These efforts emerge from a growing appreciation of the importance of high-quality primary care and the barriers to delivery system improvement presented by health care's multi-payer financing structure. Clinicians, payers, and independent experts alike increasingly recognize that primary care is a key building block in a health care system that can improve patients' health and achieve better value. In America's highly fragmented system of provider reimbursement, primary care practices are more likely to improve quality and control costs if payers set a common set of standards and expectations. Even so, bringing together payers, including commercial insurers and government programs, has been challenging, as the experience with the federal Comprehensive Primary Care (CPC) program has demonstrated.

In most CPC markets, insurance companies were accustomed to competing vigorously with one another and rarely, if ever, collaborating. Each payer often had its own primary care strategy. Building trust was difficult and time-consuming. Although payers have labored to construct new systems for sharing and analyzing data, meeting the standards set by the Center for Medicare and Medicaid Innovation, which oversees the initiative, has not been easy and has led to impatience and even questions about the strategy's efficacy.

This brief offers the perspectives of payers in three markets in the federal Comprehensive Primary Care Plus (CPC+) program, in the hope that their experiences will be helpful to the ongoing policy discussion.

The CPC+ program, led by the federal Centers for Medicare and Medicaid Services (CMS), represents the most ambitious nationwide effort to make multi-payer alignment work. CPC+, which debuted in 2017 and builds on the CPC initiative launched by CMS in 2012, is currently being tested in 18 regions. It involves more than 50 payers and some 3,000 medical practices.² This paper examines the experiences of payers in different CPC+ markets.

The challenges of multi-payer alignment have been tackled slightly differently in each of the three markets examined here—Colorado, Oklahoma, and greater Philadelphia—because each market is organized differently and has different political cultures, each with its own mix of local and national payers and differing levels of engagement by the private and public sectors. A number of common themes have nonetheless emerged in interviews with participants in the three markets:

- There is significant interest in continuing to work on payers' alignment efforts, despite the challenges and sometimes slow progress.
- Payers are looking for continued federal leadership, as some individual payers would likely not cooperate without the framework of a federal initiative like CPC+.
- Most payers appear to appreciate that building trust among payers takes time, even though they believe that the technical issues of aligning payers could be resolved more quickly.
- Several payers, particularly in the two markets that were in the CPC initiative, are looking for ways to sustain the waning momentum behind the effort.

The CPC+, now in the third year of a five-year test period, will eventually be formally evaluated. The evaluation, and CMS's own assessment of the program, will focus on whether CPC+ is achieving its goal of strengthening primary care to improve outcomes for patients and to control costs. This issue brief is not, of course, a substitute for that work. Moreover, it does not address how the transformation of medical practices is progressing at the clinical or administrative level or what impact that is having on patients. Rather—since the payers' participation and alignment are intrinsic to the initiative—the brief focuses on the perspectives of the payers participating in the CPC+ and their reflections on how alignment is progressing as a foundation for the transformation of primary care.

Development of Multi-Payer Alignment

In the 11 years since the nation's leading primary care medical specialties issued their "Joint Principles of the Patient-Centered Medical Home," a broad national consensus

has emerged concerning the importance of strengthening primary care as a foundation for improving health outcomes and controlling costs.^{3,4,5} This has spawned an explosion of initiatives over the last decade by commercial and government payers to track the performance of primary care practices and provide new incentives for them to achieve quality and efficiency targets.⁶ Although well meaning, these efforts were frequently not coordinated, which added new and often frustrating administrative burdens to already overburdened primary care practices.

One proposed solution to this problem is more structured coordination among private and government payers.^{7,8} Efforts at multi-payer alignment began at the state level, with initiatives in various states from Vermont and Massachusetts to North Carolina, Nebraska, and Idaho. Between 2008 and 2014, 17 multi-payer medical home initiatives were launched across the country.⁹

CMS took an important step to support multi-payer alignment in 2012 with the debut of the CPC initiative, a program developed by CMS's Center for Medicare and Medicaid Innovation. The CPC initiative brought together 39 private and public payers in seven regions of the country, including four states and three metropolitan areas. The goal was to facilitate the transformation of 502 primary care practices in the seven selected regions.¹⁰ CMS substantially expanded its effort at multi-payer alignment in 2017 by launching the Comprehensive Primary Care Plus (CPC+) initiative, whose goal was to reach 20 regions of the country and up to 5,000 medical practices.¹

Under CPC+, CMS pays participating primary care practices a fee over and above the traditional Medicare fee-for-service payments to help the practices transform their practices. A critical component of the CPC initiative is enlisting local payers—both commercial plans and, in some cases, state Medicaid agencies—in a coordinated effort to support primary care. In each participating region, CMS and the participating payers have signed a memorandum of understanding “to document a shared commitment to align on payment, data sharing and metrics.”¹¹ CMS does not provide funding to payers for participating in CPC+, but the agency has supported the alignment efforts by, among other things, helping payers convene locally and nationally.

Payers participating in multi-payer efforts have generally supported the initiatives. A 2014 report by the Milbank Memorial Fund based on surveys of payers in 11 states participating in the Fund's Multi-State Collaborative (MC) noted that “all MC members were fully committed to demonstrating the efficacy of their individual and combined efforts.”⁷ Two years later, CMS saw an increase in payers' participation as the federal agency moved from the CPC initiative to CPC+.

Nevertheless, independent studies of multi-payer efforts have not, for the most part, found unequivocal evidence of improvements in the quality of care being delivered by participating primary care practices. Nor has the research clearly shown that the practices have

substantially lowered overall costs of care. A formal evaluation of the CPC initiative by Mathematica Policy Research, published in June 2018, concluded that in the first four years of the program, there were “no significant differences” between the growth of Medicare spending at practices participating in the CPC initiative and spending growth in non-participating practices. It is important to note, though, that the Mathematica study was limited to patients in fee-for-service Medicare, a subset of the patients whose doctors were participating in the CPC initiative. Mathematica’s researchers also could not identify any significant differences in several important quality metrics, including 30-day hospital readmission rates and the frequency with which diabetic patients received recommended screenings such as eye exams and hemoglobin A1c tests.¹² Mathematica’s first annual report about CPC+, published in April 2019, also found minimal changes in quality, utilization, and cost, though the authors noted “primary care transformation takes time.”¹³

Studies of other initiatives, including several at the state level, have been more encouraging. But as a 2017 review of the current literature on primary care transformation, by the Patient-Centered Primary Care Collaborative and the Robert Graham Center, pointed out, the results overall still appear mixed.¹⁴

The results, particularly the recent evaluation of the CPC initiative, have disappointed some advocates of multi-payer alignment. At the same time, these results have fueled interest in ways to accelerate change.

Three Diverse Markets

This issue brief examines the experiences of three CPC+ regions to gather a range of perspectives from payers and other participants in diverse regions of the country. What follows is a short description of each initiative and how it has unfolded.

Colorado

Colorado is one of the seven CPC+ markets that were also part of the original CPC initiative model that debuted in 2012.¹⁵ This state is also distinguished as a market in which the state government has been a leader in bringing together payers and pushing for greater alignment to improve quality.

This effort dates back at least a decade. In 2008, the state convened the Colorado Multi-payer Patient-Centered Medical Home Pilot, one of the nation’s first multi-payer medical home pilots.¹⁶ Three years later, the state began its Accountable Care Collaborative initiative, which focused on improving primary care for Medicaid beneficiaries.¹⁷

Colorado’s CPC efforts have been among the country’s more ambitious, as its payers have tried to broaden their alignment efforts by taking on more than what the CPC mandated. Among other things, these payers agreed to build a very robust data aggregation tool from scratch. They also have collaborated on a trail-blazing initiative to help a quarter of the

state's primary care practices integrate behavioral and physical health, supported by a CMS State Innovation Model (SIM) grant that Colorado received in 2014.¹⁸ Colorado's effort has also been among the most labor intensive, reflecting the large number of payers in the state that have participated and the mix of national and local health plans, as well as the state's Medicaid program. According to one participant, "Payers have paid a lot of attention to building new kinds of relationships."

The number of payers participating in CPC+ has declined since several plans have merged, left the market, or, in the case of Cigna, pulled out of the CPC effort nationally.¹⁹ Colorado faces other challenges as well. For example, the long duration of the state's efforts have led to several changes in key personnel and to the need to find new ways to sustain momentum.

Results from the first year of CPC+, which are limited to Medicare's fee-for-service patients, showed that medical practices generally outperformed the national average for utilization and slightly underperformed it for quality, according to data collected by CMS.²⁰

Oklahoma

Oklahoma is another original CPC initiative market that moved into CPC+. The alignment efforts by the payers in this state, however, have developed slightly differently than those in Colorado, reflecting differences in both the local health care market and the political environment.

The state government helped initiate efforts to develop Oklahoma's Patient Centered Medical Home movement. When CMS advertised the CPC initiative, private-sector actors took the lead, in part because of the state leaders' reluctance to undertake a new initiative that could cost the state money. Two local health plans then successfully brought in the state Medicaid program to participate.²¹ Oklahoma's CPC efforts also highlight the important role that individual leadership can play. Several of the key figures in the Oklahoma effort had known one another for many years. In addition, the local CPC initiative has been heavily supported by David Kendrick, MD, a national leader in health care informatics who is also a faculty member at the University of Oklahoma's School of Community Medicine. Indeed, Dr. Kendrick began developing a data aggregation tool even before the advent of CPC and has helped drive payer alignment in Oklahoma.²²

The CPC efforts, which began around the greater Tulsa metropolitan area, showed some of the most promising early results in the nation, as the market in the first year saw the largest reduction in Medicare expenditures and service use among all the original the CPC initiative regions.²³ The Oklahoma effort, however, has faced greater challenges as the initiative expanded statewide for CPC+. Many medical practices in the state are small, and often distrustful of federal government initiatives, according to several payers. Adding to these challenges, a number of key personnel involved in the initial effort have retired or left their positions.

CMS data for the first year of CPC+ show that Oklahoma's medical practices were at the national average for quality but underperformed on utilization.²⁰

Greater Philadelphia

The CPC initiative in greater Philadelphia is newer than the initiatives in Colorado and Oklahoma, as the payers in the region did not participate in the CPC initiative. Also, unlike the other two markets, which have multiple payers, only two health plans are participating in greater Philadelphia: Aetna, a national for-profit insurance company, and Independence Blue Cross, a large, local, nonprofit plan.

Pennsylvania's state leaders once were leading champions of multi-payer alignment, having initiated one of the earliest and largest medical home pilots.²⁴ But the state's engagement flagged considerably with a change of administration in 2011, and despite yet another change in 2015, the state's Medicaid agency is not participating in the CPC+ effort.

Building trust was initially difficult for payers in greater Philadelphia, because both Aetna and Independence Blue Cross have a long history of vigorous competition in the market and both had created their own proprietary programs to support the transformation of primary care. Data sharing among only two payers also presented specific problems. As one official explained, "We had to make a lot of investment in collaboration."

Despite starting after the Colorado and Oklahoma initiatives, the greater Philadelphia CPC effort has accelerated quickly, as both payers have dedicated substantial time and effort to building a foundation to share data and support local medical practices. Data from the first year of CPC+ show participating medical practices slightly outperforming the national average on quality and utilization.²⁰

Payer Perspectives on the Alignment Effort

Despite the differences in the three markets, the payers and other participants in the three CPC+ markets, with a few exceptions, expressed generally consistent views of the payer alignment effort.

Payers' engagement remains strong.

In all three markets, the payers indicate a continued interest in CPC+ interventions as tools to improve primary care, despite the model's long development process, the substantial investment of resources, and the sometimes slow pace of change. This appears to reflect a number of different considerations, including positive financial returns, the payers' longer-term interest in improving quality and value, and a recognition that the process is inherently difficult and time-consuming.

For some health plans, the payoff already is clear. One commercial payer noted that per-member per-month costs are lower in their CPC+ practices than in practices not participating in the program. This is consistent with findings from a recent survey of the expe-

riences of health plans that participated in the Southwest Ohio/Northern Kentucky CPC region.²⁵ It also suggests a more complicated financial picture than that in the June 2018 final evaluation of the CPC initiative. That evaluation was limited to an analysis of the impact of the CPC initiative on Medicare’s fee-for-service patients, who make up a fraction of the patients affected by the initiative.

Some of the large national health plans have not yet calculated the specific return on investment for CPC, in part because the program represents a small part of larger initiatives to move to value-based contracting. The plans’ representatives nonetheless insist that they regard CPC as a valuable tool to support independent primary care practices. They believe that these independent practices do a better job of holding down costs and avoiding the unnecessary utilization of medical services than do practices affiliated with major medical systems. “If independent practices want to stay independent, we want to support them,” one official at a national health plan said.

In addition, the CPC model offers an alternative to pushing smaller practices into risk-based contracts as a way to promote practice transformation. Several plan officials expressed the concern that many of these small practices, particularly in the rural parts of Oklahoma and Colorado, could even close their doors, leaving patients without access to a primary care provider. “We have to be very careful about assessing the ability of these providers to take on risk,” said an official at another national plan.

Nearly all the payers—public and private—explained that they also see CPC as consistent with broader institutional efforts to strengthen primary care. In both Colorado and Oklahoma, the CPC initiatives grew directly out of previous work that both states had undertaken. For many individual payers, CPC built on existing programs that the payers were operating themselves to incentivize primary care practices to improve quality and control utilization. “We saw CPC as an opportunity to accelerate this process,” said a health plan official.

Across the three markets, payers expressed eagerness for swifter progress, particularly in achieving measurable improvements in patient care. But there was widespread recognition that the complexity of aligning payers, gathering and disseminating data, and persuading medical practices to use the data to transform how they care for patients demands patience. “This is a lab and, in a lab, sometimes you mix chemicals together and you don’t know what is going to happen,” the chief medical official at one plan pointed out. Few seem eager to walk away from years of investment in the process.

Sustaining federal leadership is critical.

As is often the case with initiatives designed and operated by CMS, the CPC initiative and CPC+ programs engender complicated and sometimes conflicted feelings by participants. Several payers interviewed for this brief volunteered ideas about what the federal agency could do differently. Their suggestions were sometimes contradictory. However, national and local health plans agreed that CMS had been indispensable to helping payers align

their policies. “Changes that have happened with CPC would not have happened on their own,” one official maintained.

Medicare’s sheer size makes CMS the most important payer in many markets. This in turn means that commercial payers often look to the federal government for signals as they adjust their payment strategies. Besides its heft, CMS also is uniquely positioned to provide a framework for payers in which to convene. Many health plan officials noted that before the advent of CPC, competing plans simply had no reason to work together in their markets, as the institutional culture at most plans valued competition over cooperation. “Left to our own devices, we would not get around the campfire and sing kumbaya,” one official quipped. The CPC initiative and/or CPC+ gave the plans a reason to begin to talk with one another and, with Medicare leading the way, made them feel more comfortable taking a chance on being a part of a new collaboration, officials said.

As importantly, the CPC offered the prospect of federal funding to advance the practice transformation efforts that many plans were already exploring on their own. The amount of money—most of which supports primary care practices’ transformation and improvement, and some of which helps defray the costs of payers’ collaborative work—is modest. Nonetheless, it is welcome, according to health plan officials. “No one is going to turn down free money from CMS,” said one official.

In states with strong government engagement in health policy, such as Colorado, multi-payer alignment efforts may have progressed without federal support. But as CPC+ participants in greater Philadelphia noted, efforts that depend on state leadership are vulnerable to changes in gubernatorial administrations, making stable federal leadership vital. In other states, such as Oklahoma, where increasing public investment in health care is politically complicated, the opportunity to access federal support has also proved critical, according to public-sector and private-sector CPC participants there.

Health plan representatives in several markets said that they were continuing to be questioned by their legal departments about how much cooperation is permissible without the risk of being accused of engaging in anticompetitive behavior. This remains an obstacle that slows down work on alignment, they said. Several expressed hope that CMS could provide clearer guidance about what is and is not allowed. “The government really didn’t create any safe harbors for us,” said one health plan official.

There appears to be more disagreement about how prescriptive CMS should be in what health plans can and cannot do to advance alignment and help medical practices improve care. For example, one executive at a national health plan noted that CMS could accelerate progress by providing more detailed rules for implementing CPC+. In contrast, several health plan officials in Oklahoma felt that the tighter rules in CPC+ had stifled innovation and sapped some enthusiasm for practice transformation there. Among other things, officials at these health plans cited new rules requiring people participating in strategic planning and training activities to have an official relationship with CMS. This in turn has

made it more difficult to maintain the innovative effort that they initiated in the CPC initiative. That effort brought together a wide range of experts to develop strategies for helping primary care practices.

Payers have learned lessons that could speed alignment elsewhere.

CPC participants in all three markets acknowledged that the process of building trust among health plans that have been competing against one another for years is extremely time-consuming. One health plan official said that when she explained to colleagues on a conference call that CPC+ would require data sharing with a competitor, her email inbox began “exploding” with indignant messages demanding to know how this could even be under consideration. Payers in all three markets reported that they eventually established strong working relationships with their peers, but only after years of working together and meeting regularly. “It definitely takes time to build relationships and trust,” one official observed.

Several plans nevertheless said they are interested in ways to step up the pace of change. They suggested there may be opportunities to accelerate payers’ alignment by speeding the resolution of technical issues that took months or even years to work through.

Data aggregation, for example, is a critical building block for payers’ alignment and primary care transformation. But it has presented substantial legal, technological, and contracting problems for payers. In Colorado, where payers decided to hire a vendor to design and build their own data aggregation tool, the process of writing technical specifications, seeking and evaluating bids, selecting a vendor, and then constructing the tool took more than a year. At each step, the health plan and state officials working on CPC had to secure approval from their organizations’ leadership before taking the next step forward. “Everyone had to go through their own ‘Mother, may I?’ process,” observed one participant. Adding to the complexity in Colorado, officials at UnitedHealth Group, one of the CPC payers, had to recuse themselves from the selection process when UnitedHealth’s subsidiary, Optum, bid on the data aggregation contract. When Optum was not selected, UnitedHealth representatives then had to convince the corporate headquarters to remain engaged in the Colorado effort.

A similarly lengthy process was necessary in several markets to select a convener whom all the payers could trust. Even seemingly more straightforward technical issues such as aligning quality metrics have taken time to resolve. In Philadelphia, the two health plans had to agree on a common diabetes measure after they discovered they were using different hemoglobin A1c levels to track whether medical practices were successfully managing their diabetic patients. At one of the plans, lawyers even wondered whether sharing quality data would violate HIPAA protections.

Several officials working on CPC noted that resolving these issues should now be quicker and easier for new payers and new markets interested in payer alignment. Data aggregation tools developed in Oklahoma, Colorado, and other CPC markets, for example, could essen-

tially be taken off the shelf and deployed elsewhere, and quality metrics that have been synchronized in various CPC markets could similarly provide templates for other payers.

Sustaining momentum is difficult.

Even though the payers interviewed for this brief expressed their commitment to the alignment initiatives, many acknowledged the difficulty of sustaining the effort. Several of the payers have been working on CPC since its inception, which has fed what one official involved in the effort called “collaboration fatigue.” This has been reinforced in some cases by the slow pace of change. “We all get frustrated sometimes,” confessed another participant, noting how slowly medical practices appear to be changing.

Enthusiasm for CPC+ appeared higher at health plans in Philadelphia, where the experiment is newest. In both Colorado and Oklahoma, many of the architects of the original payer alignment effort have moved on to other jobs, making maintaining the institutional commitment to the process more difficult. In Colorado, although many of the same payers are still at the table, only one of the people who originally convened for the CPC initiative work is still there. “The collaboration is not as strong as it was in the beginning,” one official in Oklahoma pointed out, adding that federal rules have also sapped some of the enthusiasm among the participants. “It feels like there is less of an opportunity to be innovative and creative at the payer level.”

Several health plan representatives also noted that their organizations have been looking at the business case for continuing the alignment efforts. As noted earlier, this feeling is not universal, as most payers appear to remain interested in CPC+. But an official with one national health plan noted that the work is costly. “CPC+ is something that requires investment,” he said. A representative of a second national plan cited the high cost of data aggregation and questioned whether the health plans would remain at the table if CMS pulled back its investments. “I’m not sure this is something that is sustainable on its own yet,” the official said.

Conclusion

As federal policymakers and payers around the country continue to seek ways to strengthen primary care to improve outcomes and control costs, the substantial frustration that the pace of change is not more rapid is understandable. Efforts to align public and private payers to send common signals to primary care practices in the hope that this will help physicians better manage their patients have been long and arduous.

The experiences of payers in three diverse markets participating in the federal CPC initiatives bear testament to the difficulty of this work. Although many payers are interested in ways to accelerate these changes, the CPC participants in these three markets still maintain a substantial interest in and commitment to sticking with the ongoing alignment efforts. They also stressed the need for assurances that the federal government will maintain a leadership role in advancing cooperation in the country’s fragmented health care system.

Note on Methodology

This brief drew on extensive interviews with current and former CMS officials; conveners in Colorado, Oklahoma, and greater Philadelphia; outside consultants working on CPC+; and state Medicaid officials and representatives of every commercial health plan but one in the three markets discussed here. With a few exceptions, the interviews were conducted on background with the understanding that interviewees would not be identified by name and that comments would not be attributable to individual payers.

Among those interviewed at length were representatives of the following payers: Colorado Medicaid, UnitedHealth Group, Anthem, Aetna, Independence Blue Cross, Oklahoma Medicaid, Blue Cross Blue Shield of Oklahoma, and CommunityCare.

The conveners interviewed include Pam Curtis, director of the Center for Evidence-based Policy at Oregon Health & Science University and convener in Colorado; Erik Muther, vice president of Discern Health and convener in greater Philadelphia; and David Kendrick, MD, CEO of MyHealth Access Network and convener in Oklahoma.

Other interviewees include Richard Baron, MD, president and CEO of the ABIM Foundation and lead architect of the CPC initiative; Craig Jones, MD, partner with Capitol Health Associates and contractor to Deloitte for the CPC+ Data Aggregation & Alignment project; and Lisa Dulsky Watkins, MD, director of the Milbank Memorial Fund Multi-State Collaborative.

The issue brief also drew on the reflections and observations shared by a number of payers from other CPC markets and others involved in supporting the CPC initiative who gathered for a Multi-State Collaborative meeting in Kansas City on September 11 and 12, 2018.

Notes

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- ¹⁹ The nine payers that originally participated in the CPC initiative included: Aetna, Anthem Blue Cross Blue Shield of Colorado, Cigna, ColoradoAccess, Colorado Choice Health Plans, Colorado Medicaid, Humana, Rocky Mountain Health Plans and UnitedHealthcare. The remaining payers in CPC+ include Anthem Blue Cross Blue Shield of Colorado, Rocky Mountain Health Plans, UnitedHealthcare and the state Medicaid program.
- ²⁰ CPC+ 2017 Quality and Utilization Performance Results. Comprehensive Primary Care Plus. Centers for Medicare & Medicaid Services. <https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus>. Accessed April 5, 2019.
- ²¹ The Oklahoma effort, which began around greater Tulsa, initially involved three payers: Blue Cross Blue Shield of Oklahoma, CommunityCare Oklahoma and the Oklahoma Medicaid program.

²² For more information about Kendrick's work and his nonprofit health information network, MyHealthAccessNetwork, see <https://myhealthaccess.net>. Accessed April 5, 2019.

²³ For a summary of Oklahoma's accomplishments with the Comprehensive Primary Care Initiative, see <https://www.pcpcc.org/initiative/oklahoma-comprehensive-primary-care-initiative>. Accessed April 5, 2019.

²⁴ Pennsylvania Chronic Care Initiative (CCI) Statewide. Patient-Centered Primary Care Collaborative. <https://www.pcpcc.org/initiative/pennsylvania-chronic-care-initiative-cci>. Accessed April 5, 2019.

²⁵ Shonk RF, Sessums LL. The comprehensive primary care initiative: another side of the story. *Health Affairs Blog*. December 4, 2018. <https://www.healthaffairs.org/doi/10.1377/hblog20181130.132681/full/>. Accessed April 5, 2019.

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