Medical Home Innovations

Pennsylvania

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SVP and Chief Medical Officer
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Independence

The Environment - Drivers of Change

Features of Health Care

- 60+ Hospitals; 5 Medical Schools
  - Significant physician employment
  - Considerable financial integration
  - Minimal clinical integration
- SCP:PCP ratio is 4:1
  - Disparity in reimbursement, resources, technology, staffing, morale
- Payer contracts reward volume
  - Mostly FFS (some HMO capitation)
- Minimal integrating technology
  - No HIE/HIO
  - Provider portal: admin > clinical support
- Payer programs to counter inertia
  - UM, CM, DM, DS, P4P, etc.

Observed Performance

- Top five MSA for utilization / cost
- Overall average quality despite Centers of Excellence
- Average satisfaction
  - Health Plan CAHPS scores
  - Hospital HCAHPS scores

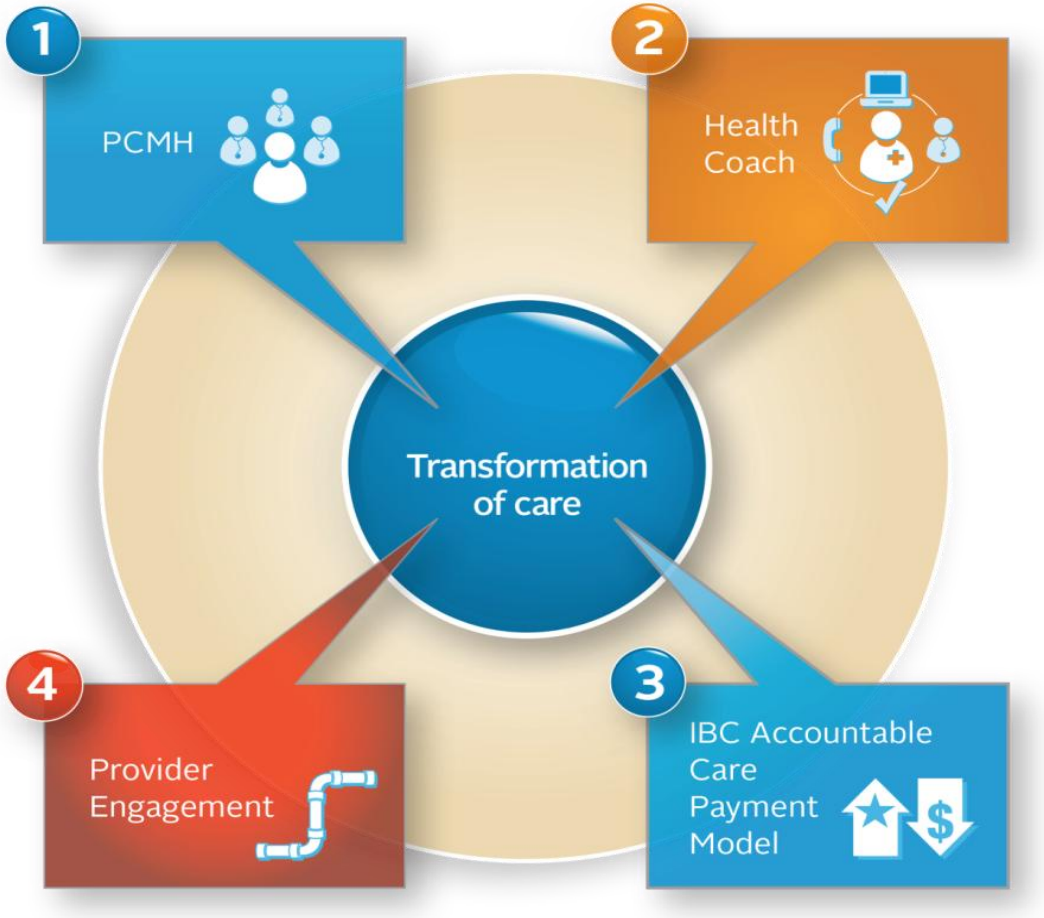
Market Reaction

- Purchasers demand
  - High Value Care
  - Public / Private Exchanges
  - Reference based pricing
- Payers and/or Providers
  - PCMH, ACO models
  - Product designs based on PCMH, ACO
  - Narrow Networks

Strategy From A Payer's Perspective

Meeting the Purchaser's Requirements

1. Strengthen primary care
2. Enhance care management
3. Align incentives
4. Empower with technology and information



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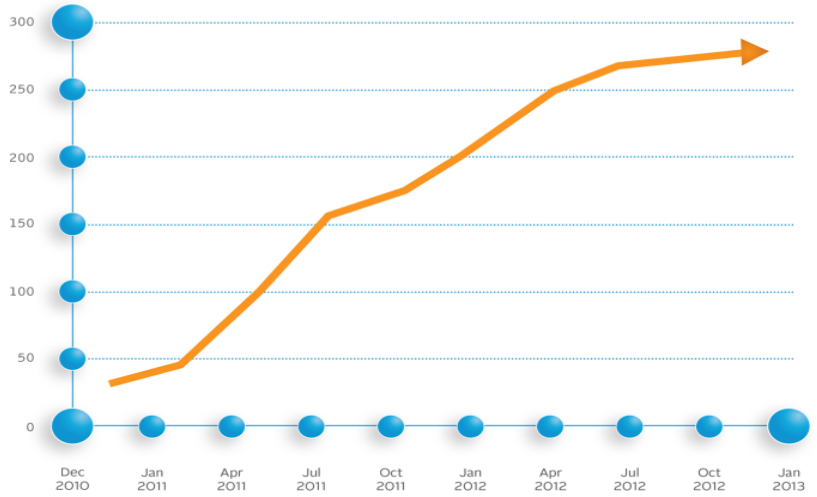
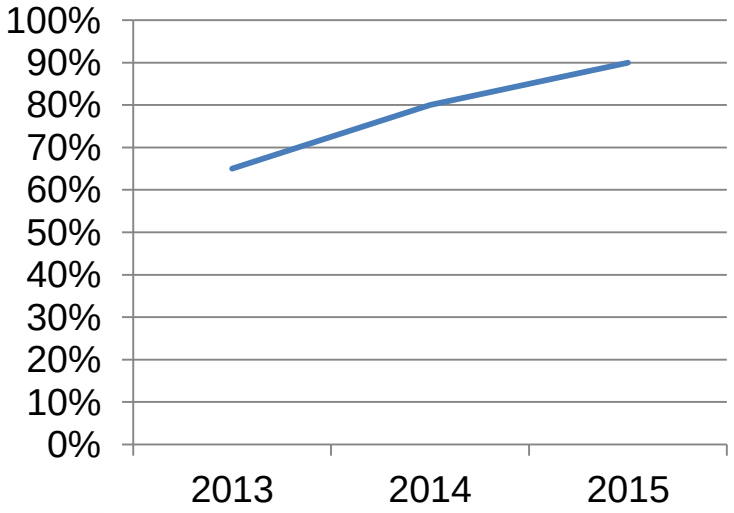
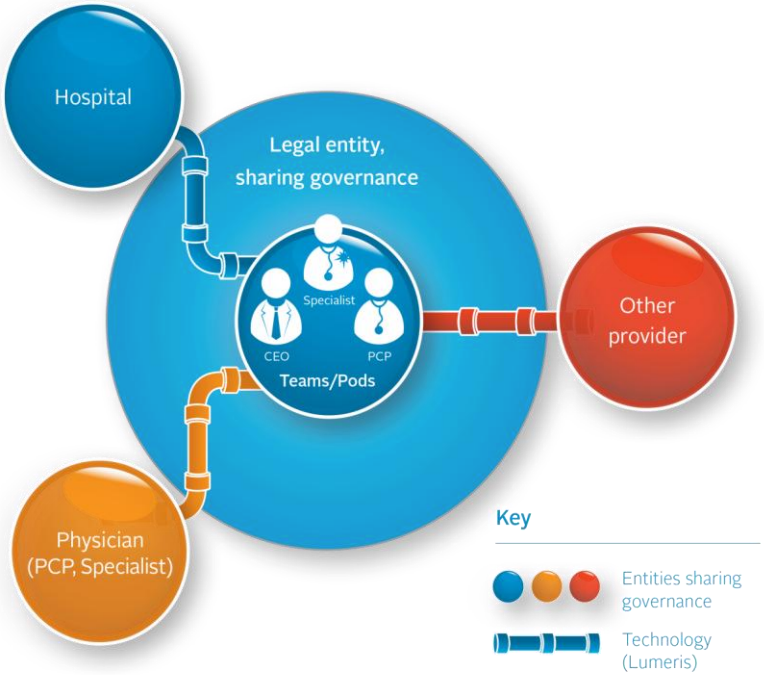
PCMH Dashboard - ACO Dashboard





Metric	Current count
Commercial HMO Members in PCMH	199,363 (40%)
Medicare HMO Members in PCMH	30,408 (40%)
Number of Practices recognized as PCMH	297 (31%)
Number of Unique Physicians in PCMH	1,492 (41%)



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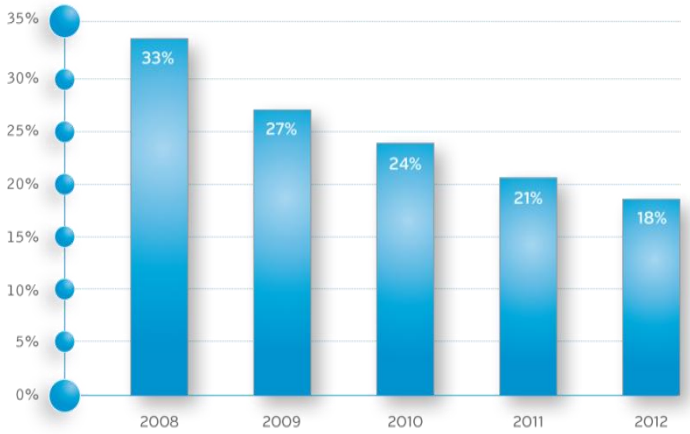
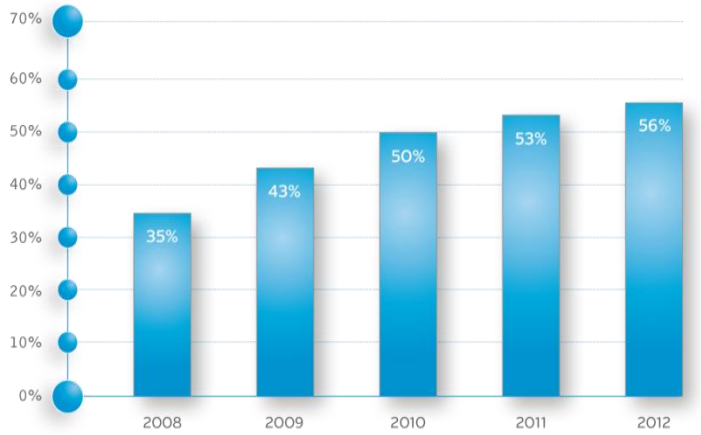
PCMH Impact on Quality - Diabetes

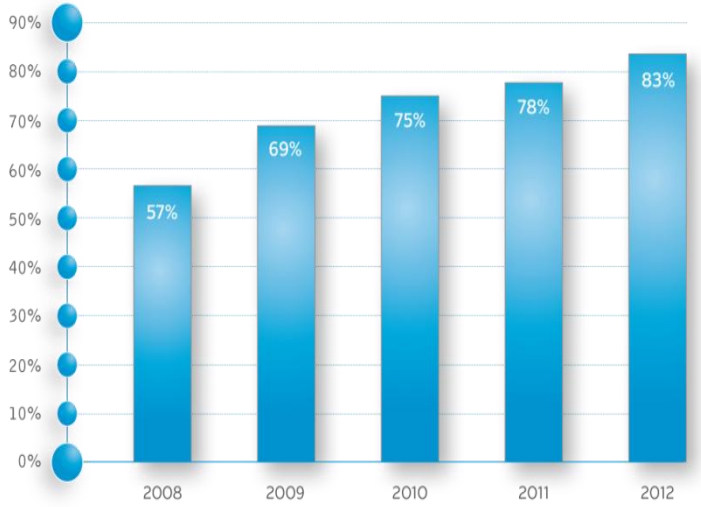
% with A1C>9 (45% improvement)



% with LDL < 100 (60% improvement)



% with BP < 140/90 (45% improvement)



Source: State Registry

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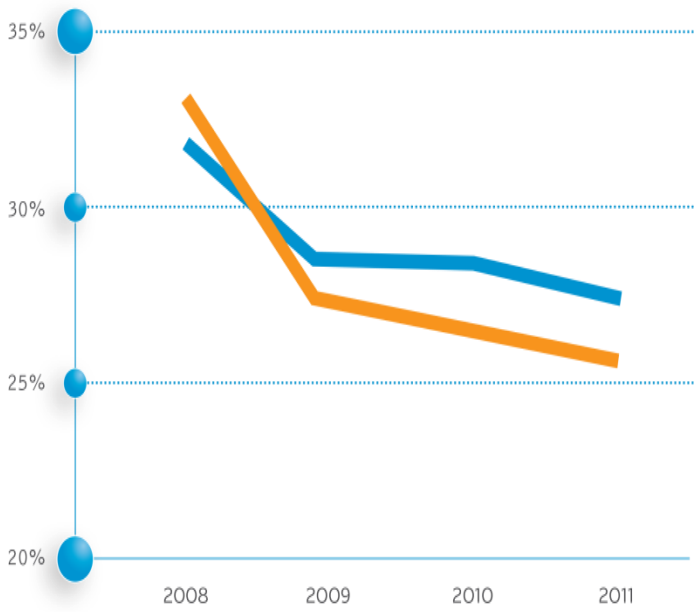
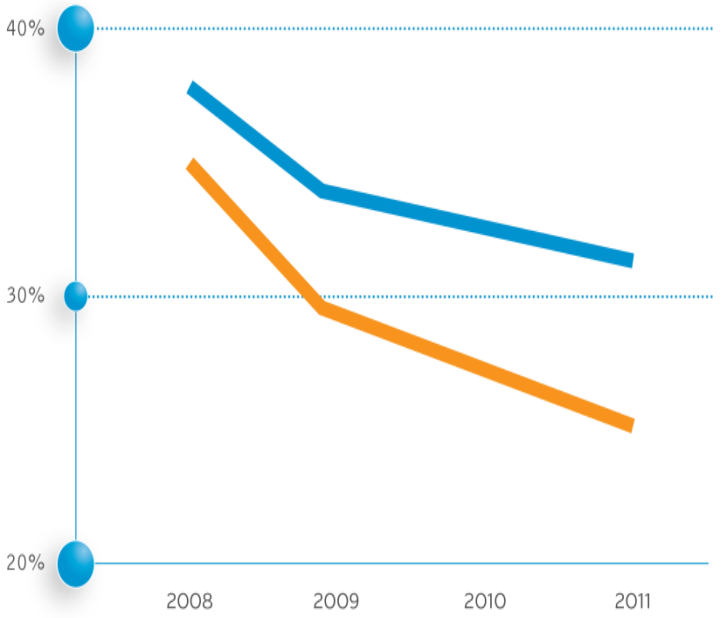
The Impact of PCMH - Cancer Screening

Composite Cancer Screenings Gaps in Care on Chronic and Non-Chronic Cases and Controls



Composite Cancer Screenings Gaps in Care On Chronic PCMH and Non-PCMH in Philly



PCMH

Non-PCMH

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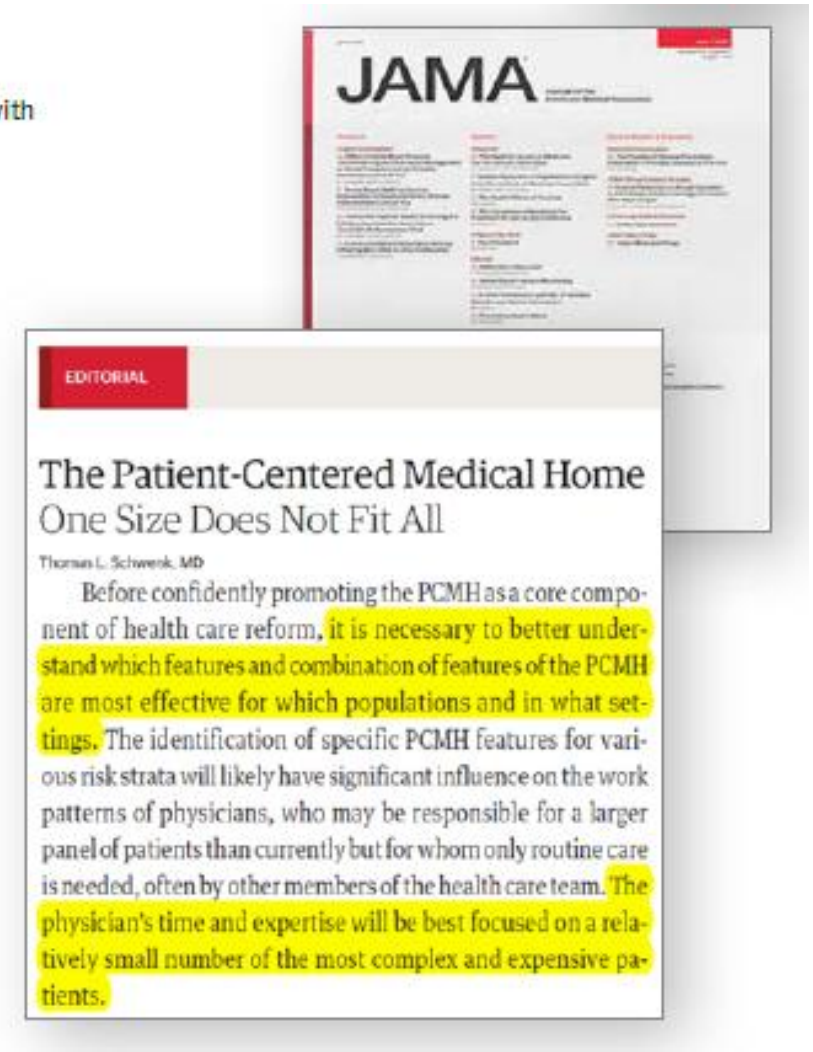
PCMH Impact on Quality and Cost

- PCMH was supported by the PA Chronic Care Initiative.
- Emphasis on assisting in restructuring of practices to improve care for patients with chronic conditions.
- Our results show that care for members with chronic conditions has improved.

IBC continues to monitor and assess the **PCMH initiative** and is currently working with

NCQA

to identify the features and combination of features that make practices most effective.


JAMA

EDITORIAL

The Patient-Centered Medical Home
One Size Does Not Fit All

Thomas L. Schwenk, MD

Before confidently promoting the PCMH as a core component of health care reform, it is necessary to better understand which features and combination of features of the PCMH are most effective for which populations and in what settings. The identification of specific PCMH features for various risk strata will likely have significant influence on the work patterns of physicians, who may be responsible for a larger panel of patients than currently but for whom only routine care is needed, often by other members of the health care team. The physician's time and expertise will be best focused on a relatively small number of the most complex and expensive patients.

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PCMH Impact on Quality and Cost

- Significant reduction over time in inpatient admissions and cost for chronically-ill and high-risk members.

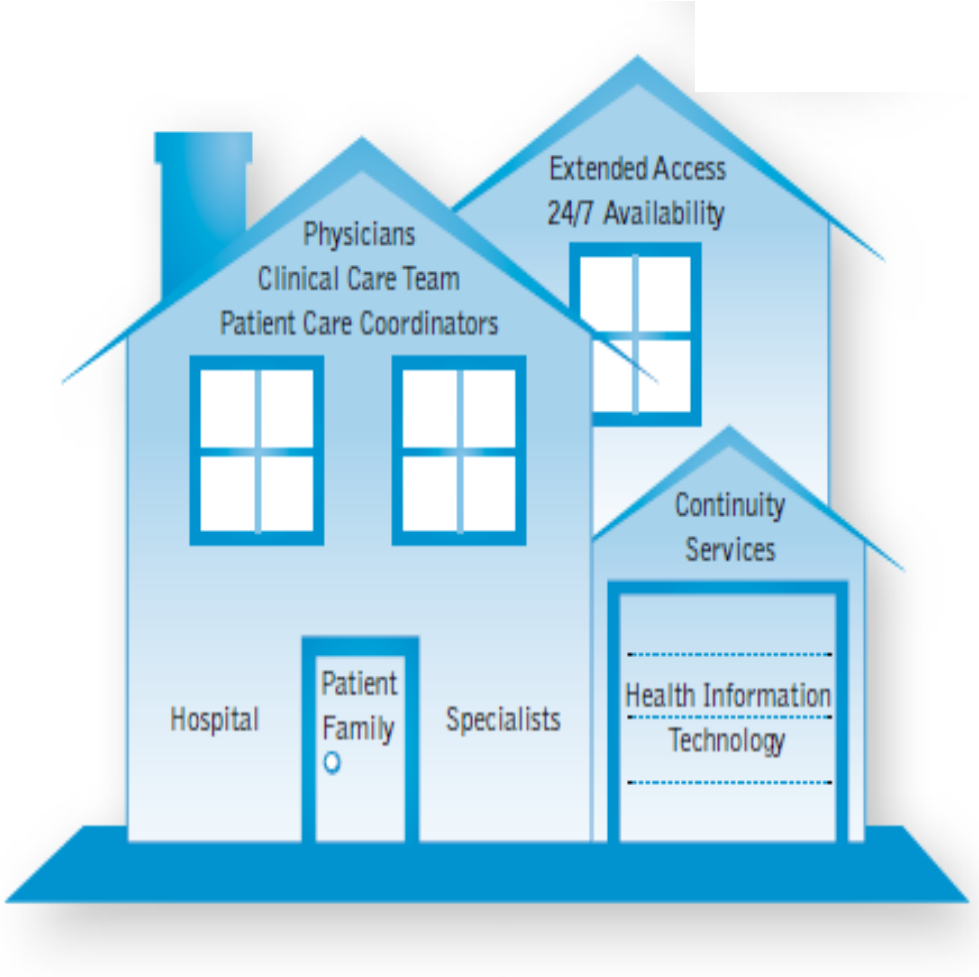
  American Journal of Managed Care.

- High risk members affiliated with a PCMH had 11% lower total costs. Primarily attributed to a reduction in Inpatient costs.

  American Journal of Managed Care.

- Diabetic members affiliated with a PCMH had 21% lower total costs. Primarily attributed to a reduction in Inpatient costs.

  Journal of Public Health Management and Practice.



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Medical Homes and Cost and Utilization Among High-risk Patients

Susannah Higgins, MS; Ravi Chawla, MBA; Christine Colombo, MBA; Richard Snyder, MD; and Somesh Nigam, PhD

The patient-centered medical home (PCMH) has been advanced as a promising framework for transforming primary care. In 2007, the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association issued the "Joint Principles of the Patient-Centered Medical Home," which outlined the PCMH model. The medical home model emphasizes a team-based approach to primary care, in which a physician-leader coordinates care from other providers across multiple sites and specialties. It encourages increased access, both in terms of expanding practice hours and opening new channels of communication with patients. Organizations like the Patient-Centered Primary Care Collaborative have initiated numerous pilot programs aimed at studying the impact of the PCMH adoption,[1] and the PCMH model was written into the Patient Protection and Affordable Care Act of 2010 as an area for study.[2]

A number of previous studies have shown early promise for the PCMH model as a vehicle for controlling costs and improving the quality of healthcare delivered by primary care practices,[3-6] including for targeting subpopulations such as children with special health needs.[7] However, reviews often point to the incomplete nature of this work, citing methodological concerns,[5,7-8] insufficient time for practices to implement reforms, and inadequate policy support beyond the level of individual practices.[4] This study aims to contribute to this literature by comparing the effects of adopting the PCMH model on the healthcare cost and utilization in the nonpediatric population, using propensity score matching in order to reduce variability in the PCMH and non-PCMH groups studied. Additionally, the analysis employs difference-in-differences regression analysis in order to further control for remaining differences in patients' characteristics as well as cost and utilization at baseline.

This study aims to assess the impact of PCMH adoption on the patients identified as having the greatest health risks. While the Joint Principles envision the PCMH model as being applicable to all patients, other pilots have targeted only high-risk patients with complex needs.[9] The high cost of care associated with relatively few individuals makes such targeting a potentially powerful mechanism: one study noted that virtually all of

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Objectives: Evaluate the effects of
tered medical home (PCMH) mode
costs and utilization in the nonpedi
tion, particularly among high-risk p
Study Design: Longitudinal case-co
comparing per member per month (
and utilization per 1000 patients for
enrolled in PCMH and non-PCMH pra
2009 to 2011.
Methods: Commercial health mainten
nization members in nonpediatric pra
adopted the PCMH model in 2009 wer
to patients in nonpediatric practices th
adopt the model until 2011 or later. Pro
score matching was used to identify a p
similar controls, and difference-in-differ
regression analysis was used to compar
and non-PCMH patients relative to basel
Analysis was conducted using the compl
of matched patients (N = 6940 cases and
controls), then using the 10% of patients w
highest DxCG risk scores (N = 654 cases a
controls).
Results: There were no significant cost or u
tion differences for the overall population,
cost decreased significantly more for the PC
group than for controls in the high-risk grou
years 1 and 2 (reductions of $107 and $75 PM
driven by lower inpatient costs. The PCMH gr
experienced a significantly greater reduction
inpatient admissions in all 3 years (61, 48, an
hospitalizations per 1000).
Conclusions: PCMH practices had significantly
reduced costs and utilization for the highest ris
patients, particularly with respect to inpatient
care. As high-risk members represent a high-co
group, the most benefit can be gained by target
ing these members.

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For author information and disclosures, see end of text.

Patient-Centered Medical Home Impact on Health Plan Members With Diabetes

Qiuyan Cindy Wang, PhD; Ravi Chawla, MBA; Christine M. Colombo, MBA; Richard L. Snyder, MD; Somesh Nigam, PhD

KEY WORDS: diabetes mellitus, medical costs, patient-centered care, utilization

Objective: To compare costs and utilization for patients with diabetes enrolled in patient-centered medical home (PCMH) practices and non-PCMH practices. **Design:** Commercial Health Maintenance Organization members with diabetes who enrolled between 2008 and 2011 in 26 Pennsylvania-based PCMH practices that were recognized by the National Committee for Quality Assurance in 2009 were compared with similar patients in 97 non-PCMH primary care practices. A difference-in-differences longitudinal research design was used to analyze differences between both groups on per-member, per-month costs and utilization. The statistical models controlled for baseline practice and patient-level characteristics through 2-step propensity score matching. The regression analysis on program effect further controlled for within-practice variation. Sensitivity analyses were also conducted on patients with type 1 and type 2 diabetes separately, and a third analysis was limited to diabetic patients enrolled in practices within Philadelphia. **Results:** Adoption of the PCMH reduced overall medical costs for diabetic patients by 21% in year 1. This reduction was driven largely by inpatient costs, which fell by 44%. Reductions in emergency department visits, outpatient costs, and specialist visits were also seen in subsequent years among patients enrolled in PCMH practices. Additional sensitivity analyses indicated that adoption of the PCMH model yielded similar results when analyzing patients with type 2 diabetes as well as for diabetic patients enrolled in PCMH practices located within the city of Philadelphia. **Conclusions:** The cost of care for patients with diabetes can be reduced by securing care at a PCMH practice. Immediate results were seen in reduction of inpatient costs, which indicate that these patients enrolled in PCMH practices were using less costly inpatient services.

J Public Health Management Practice, 2013, 00(00), 1–9

The Centers for Disease Control and Prevention recently estimated that approximately 25.8 million Americans are living with diabetes, and that the total costs associated with the disease had reached $174 billion in the United States for 2007 alone. Given that $116 billion of these costs were accounted for in direct medical expenditures, and that diabetes is cited as a major cause of kidney failure, blindness, heart disease, and stroke,[1] improving the quality of care for these individuals is a major priority of the health care system. However, managing the costs associated with treating diabetes and its complications remains a perplexing issue for payers. As currently structured, the health care system is better suited to treating acute episodes of illness, rather than actively managing chronic illness to prevent crises which require escalation of the intensity of care.[2,3] Primary care doctors perform an essential

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Parts of this study were presented in poster form at the 24th National Forum on Quality Improvement in Health Care, Orlando, Florida, December 10-12, 2012 and at the 6th Annual Mid-Atlantic Healthcare Informatics Symposium, Philadelphia, Pennsylvania, April 26, 2013.

The authors declare no conflicts of interest.

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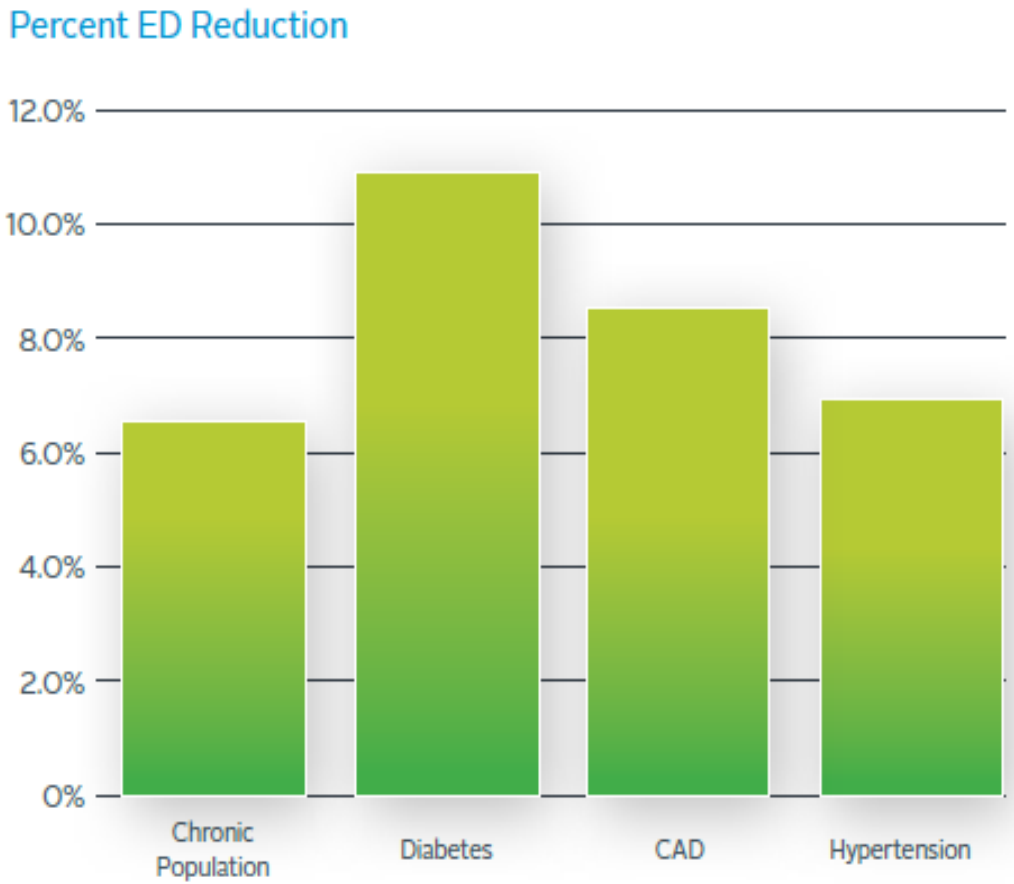
PCMH Impact on Quality and Cost – ED Use



ED reduction associated with switching to PCMH.

* Based on all-payer data

280 Practices*

459K Members*

193K Chronic*

266K Non-Chronic*

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New Product Designs

Important information about the Patient-Centered Medical Home benefits plan design option

Dear Valued Provider:

You are receiving this letter because our records indicate that your practice is designated as a Patient-Centered Medical Home (PCMH). If you are no longer a PCMH or have questions about this designation, please contact Elizabeth Coughlin at 215-241-2005.

I am are writing to remind you of the PCMH benefits plan design option that we introduced in January 2013 for certain employer groups with HMO or Direct POS plans. With this benefits plan design option, members who select a PCMH as their primary care physician (PCP) will incur lower cost-sharing.

About the PCMH benefits plan design option

Please note the following regarding this benefit plan design option:

- Identifying PCMH members and copayments:
  - **Member ID cards.** ID cards are issued to members who have this benefits plan design option that include a Patient-Centered Medical Home indicator and list two different copayment amounts depending on the member's PCP selection. See sample ID card below.

  - **NaviNet® Benefits Snapshot.** To verify member eligibility and copayment amounts, please use the NaviNet web portal. To do so, select *Eligibility and Benefits Inquiry* from the Plan Transactions menu, enter the search criteria for the member, and then select the appropriate member from the search results. Once on the Eligibility and Benefits Details screen, click on the *Benefit Snapshot* link to view the member's PCMH-specific copayment.
    It is important that you reference the Benefit Snapshot screen as the Eligibility and Benefits Detail screen does not include details on PCMH eligibility and copayment information.

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Questions

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