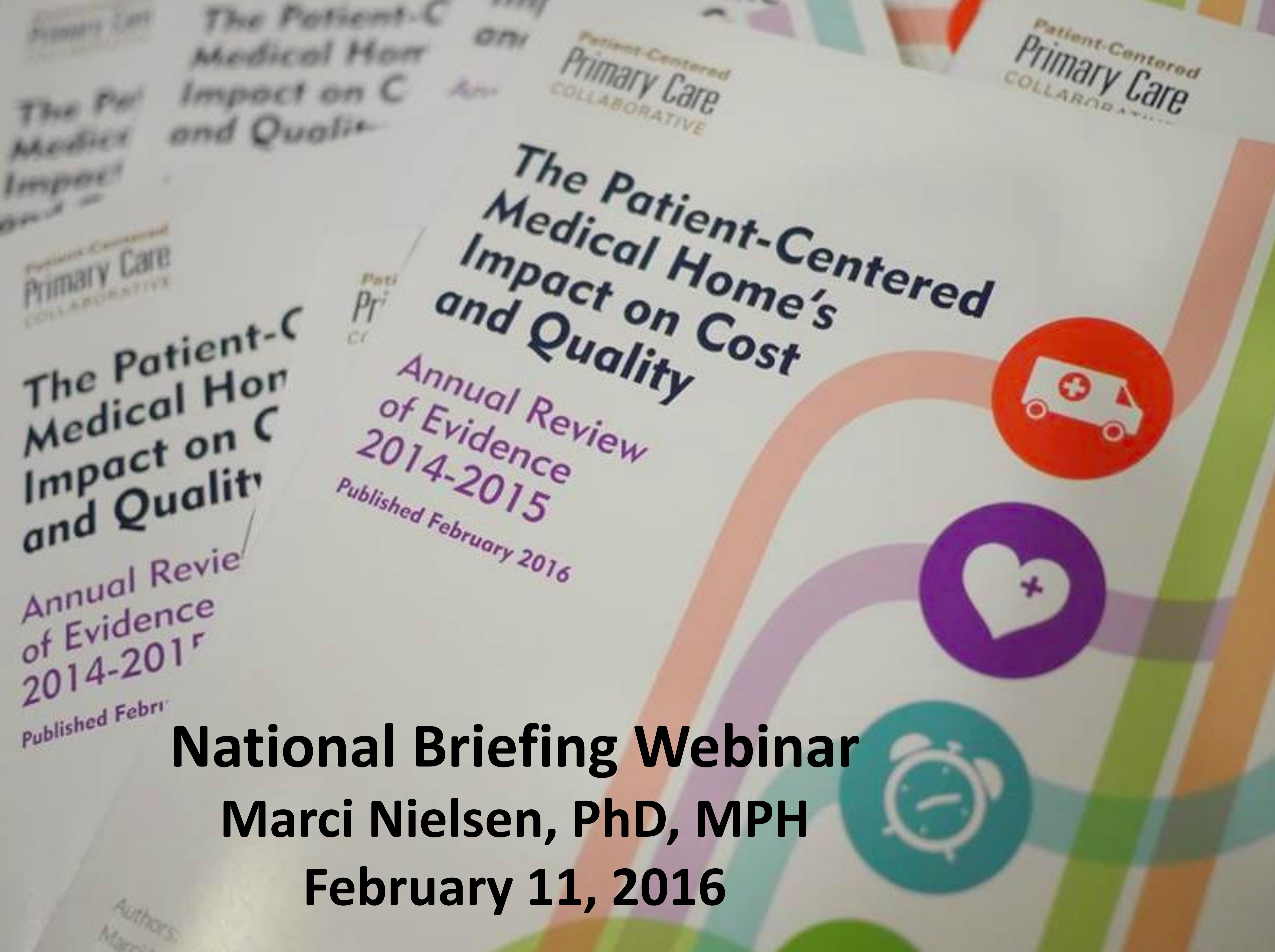
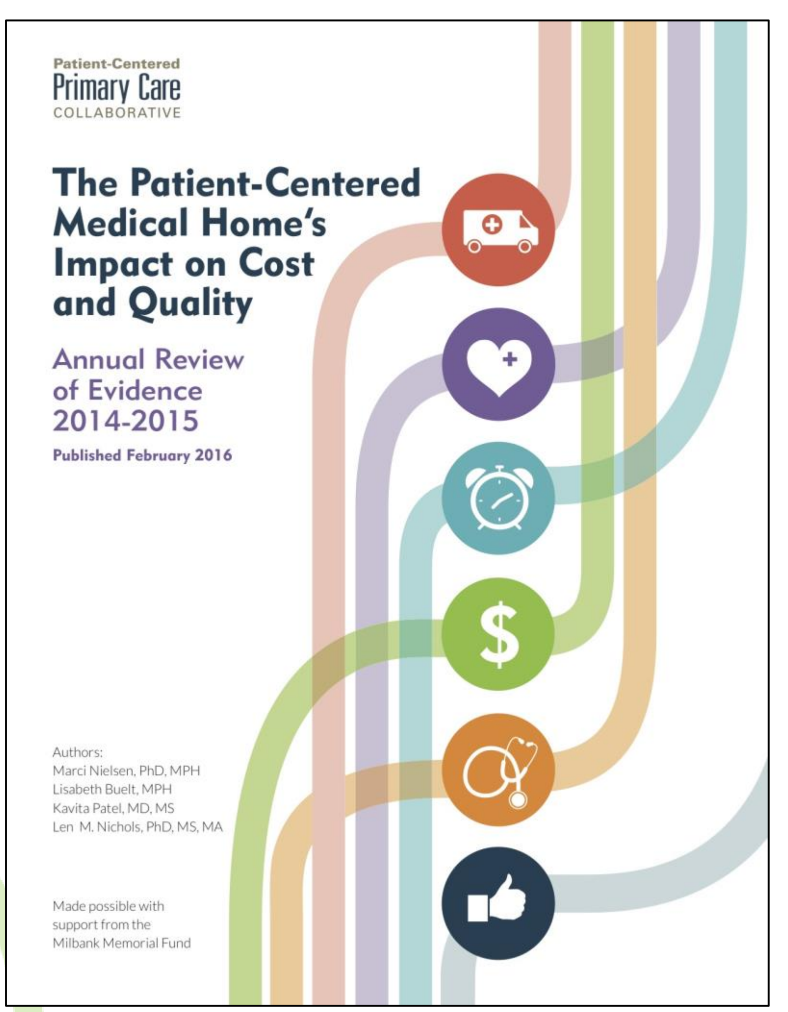

Patient-Centered
Primary Care
COLLABORATIVE
The Patient-Centered
Medical Home's
Impact on Cost
and Quality
Annual Review
of Evidence
2014-2015
Published February 2016
National Briefing Webinar
Marci Nielsen, PhD, MPH
February 11, 2016

AGENDA



- PCPCC:
  - Who we are & what we do
- 2015 Annual Evidence Report:
  - What we studied & what we learned
- Paying for Value
  - Where delivery reform meets payment reform
  - What's Next?
- Q & A

Patient-Centered Primary Care (PCPCC)

Unifying for a better health system - by better investing in patient-centered primary care

PUBLIC:
Patients,
Families,
Caregivers,
Consumers
Communities

PAYERS:
Employees,
Employers,
Health plans,
Government,
Policymakers

GOOD HOUSEKEEPING
LIMITED WARRANTY to CONSUMERS
Since 1909
REPLACEMENT or REFUND if DEFECTIVE

Act
Plan
Study
Do

PROVIDERS: Primary care team, medical neighborhood, ACOs, integrated care

Capitol Hill Briefing hosted by:
The Primary Care Caucus
Co-Chairs
Honorable Joe Courtney (D-CT)
Honorable David Rouzer (R-NC)

Section One:
A CHANGING POLICY LANDSCAPE

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PCMH MODEL/FRAMEWORK

Person-Centered
Supports patients and families in managing decisions and care plans

Comprehensive
Whole-person care provided by a team

Coordinated
Care is organized across the 'medical neighborhood'

Committed to Quality and Safety
Maximizes use of health IT, decision support and other tools

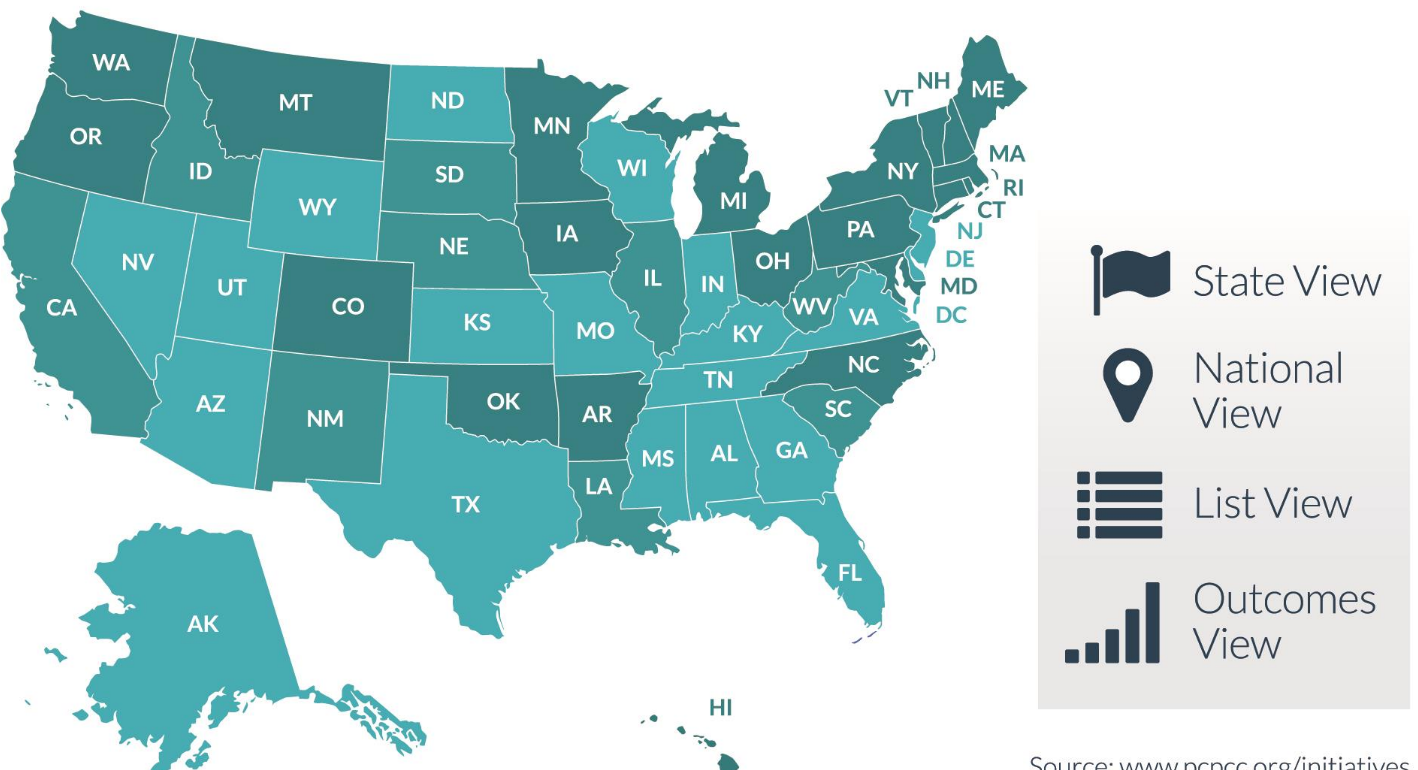
Accessible
Care is delivered with short waiting times, 24/7 access and extended in-person hours

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality (AHRQ). *Patient-centered medical home resource center, defining the PCMH.* Retrieved from http://pcmh.ahrq.gov/page/defining-pcmh

PCMH EXPANDING RAPIDLY: BUT STILL AN EARLY INNOVATION

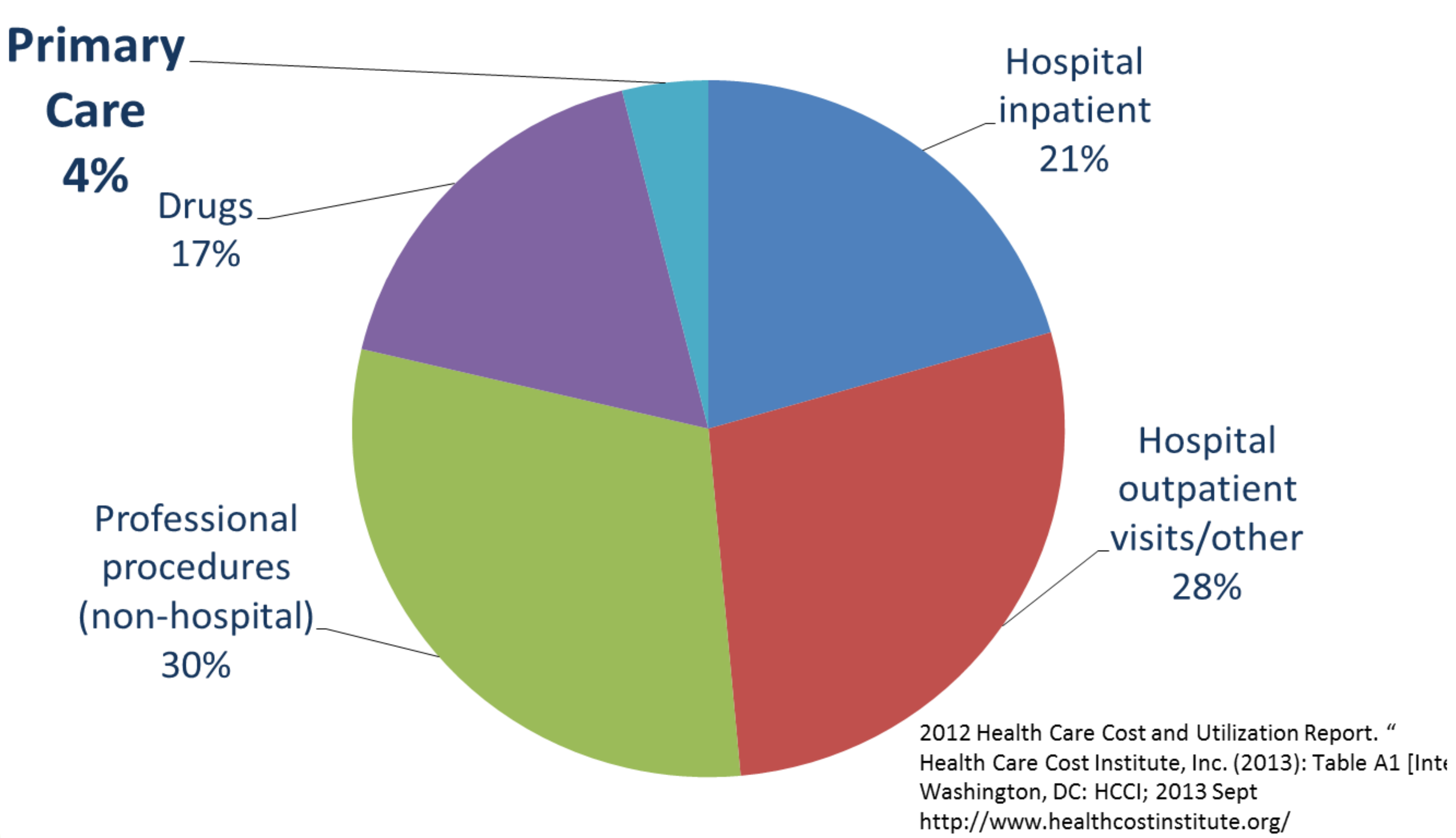
Primary Care Innovations and PCMH Map

In 2014, the PCPCC unveiled a new searchable, publicly available database that tracks the increasing number of primary care innovations and PCMH initiatives taking place across the country.



Source: www.pcpcc.org/initiatives

PAYING NOW… OR… PAYING LATER



2012 Health Care Cost and Utilization Report. "
Health Care Cost Institute, Inc. (2013): Table A1 [Inte
Washington, DC: HCCI; 2013 Sept
http://www.healthcostinstitute.org/

PAYMENT REFORM AND MEDICARE

Health & Human Services

- Shift 30% of Medicare FFS payments to value through APMs by 2016, 50% by 2018
- Created of Health Care Payment Learning & Action Network
- Investment in Multi-payer Efforts

https://hcp-lan.org/

Congress

- Passage of Medicare Access and CHIP Reauthorization Act (MACRA)
  - Merit-based Incentive Payment System (MIPS)
  - Alternative Payment Models (APMs)

http://doctorwhostories.wikia.com/wiki/The_Macra_Terror_(TS)

PAYMENT REFORM & PCMH

- Fee-for service fails to compensate for PCMH scope of services – esp for small and independent practices
  - Numerous Alternative Payment Models (APMs) can support PCMH
  - Evidence does not point to single payment model that best supports PCMH

Payment Innovation Models

Payment model	Description [25]
Enhanced Fee-for-Service (FFS)	Increased FFS payments to practices that are recognized and/or functioning as PCMHs
FFS with PCMH-specific billing codes	Practices can bill for new PCMH-related activities (i.e. care coordination)
Pay-for-Performance	Practices are paid more for meeting process measures (HEDIS), utilization targets (ED use, generic prescribing), and/or improving patient experience
Per-Member-Per-Month (PMPM) Payments	Practices are paid a capitated monthly fee in addition to typical FFS billing, often adjusted for PCMH recognition level, or degree of care coordination expected
Shared Savings	Practices are rewarded with a portion of savings if the total cost of care for their patient panel increases more slowly than a preset target and quality thresholds are met
Comprehensive or Population-based Payment	Partial or complete risk for total cost of care (risk adjusted), to include new models of "direct primary care"

Section Two:

NEW EVIDENCE FOR PCMH AND INNOVATIONS IN PRIMARY CARE

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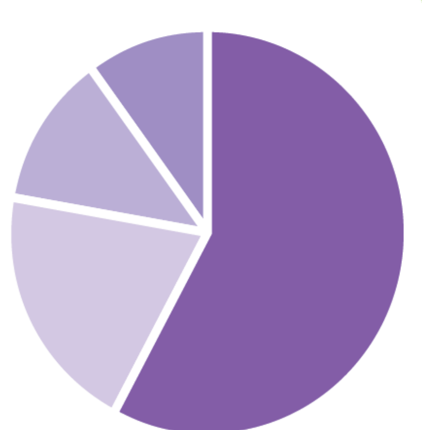
METHODS

INCLUSION CRITERIA

- **Predictor variable**:
  - "Medical home"
  - "PCMH"
  - "Advanced primary care"
- **Outcome variable**:
  - "Cost" or
  - "Utilization"
- **Date published:**
  - Between Oct 2014 and Nov 2015



- 17 peer-reviewed studies
- 4 state government evaluations
- 6 industry reports
- 3 independent evaluations of federal initiatives

LIMITATIONS

- Several reports published this year fall **outside** the scope of our **inclusion criteria**
  - We track these studies on our PCMH Map
- Does not include studies focused on **disease-specific, non-primary care** medical homes
- Generally **include only** the measures that reach **statistical significance**
- Studies included **vary significantly**
- ***DEFINING & MEASURING PCMH REMAINS A CHALLENGE***

RESULTS: TRENDS

(n^1 = Improvement in measure/n^2 = Measure assessed by study)

Aggregated Outcomes from the 30 Studies

21 of 23 studies that reported on cost measures found reductions in one or more measures

23 of 25 studies that reported on utilization measures

found reductions in one or more measures

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DETAILS: Utilization

23 of 25

studies that reported on utilization measures

found reductions in one or more measures

MEASURES OF UTILIZATION

- Emergency department (ED) use
  - All cause ED visits
  - Ambulatory care sensitive condition (ASCS) ED visits
  - Non-urgent, avoidable, or preventable ED visits
  - ED utilization
- Hospitalization
  - All cause hospitalizations
  - ACSC in-patient admissions
  - In-patient days
- Urgent care visits
- Readmission rate
- Specialist visits
  - Ambulatory visits for specialists

"ED USE" (Peer reviewed studies n=17)

- Studies below reported on "ED use"
  - 13 measures were ED use reductions, 1 measure was ED use increase
  - California Health Care Coverage Initiative
  - CHIPRA Illinois study
  - Colorado Multi-payer PCMH pilot
  - Medicare Fee-For-Service NCQA study
  - Pennsylvania Chronic Care Initiative
  - Rochester Medical Home study
  - UCLA Health System study
  - Texas Children's Health Plan
  - Veterans Affairs PACT study *(AJMC)*
    - *Reported higher ED use for one measure, and ACSC hospitalizations per patient*

DETAILS: Cost

21 of 23 studies that reported on cost measures found reductions in one or more measures

MEASURES OF COST

- Total cost of care
  - Net or overall costs
  - Total PMPM spend
  - Total PMPM for pediatric patients
  - Total PMPM for adult patients
- Total Rx spending
- ED payments per beneficiary
- ED costs for patients with 2 or more comorbidities
- PMPM spending on inpatient
- Inpatient expenditures (PMPY)
- Outpatient expenditures (PMPY)
- Expenditures for dental, social, and community based supports

"TOTAL COST" (Peer reviewed, n=17)

- Studies below reported "Total cost of care"
  - 10 measures were total cost of care savings, one measure was no net savings
  - Geisinger Health System PCMH
  - Blue Cross Blue Shield of Michigan Physician Group Incentive Program (*Health Affairs*)
  - Blue Cross Blue Shield of Michigan Physician Group Incentive Program (*Medical Care Research & Review*)
  - Colorado Multi-payer PCMH pilot
    - No net savings over 2 year study
  - Pennsylvania Chronic Care Initiative *(American Journal of Managed Care)*
  - UCLA Health System study
  - Vermont Blueprint for Health

DETAILS BY STUDY

Location/Initiative	Cost & Utilization	Additional Outcomes	Payment Model Description
Colorado Multi-payer PCMH pilot[48] ***Published:*** *Journal of General Internal Medicine,* October 2015 ***Data Review:*** *April 2007-March 2009 (pre-intervention baseline); April 2009-March 2012 (post-intervention)* *Study evaluated cost, utilization and quality measures*	• No net overall cost savings in study period, possibly due to offsetting increases in other spending categories **Two years after initiation of pilot, PCMH practices (vs. baseline) had:** • Reduction in ED costs of $4.11 PMPM (13.9%; $p<0.001$) and $11.54 PMPM for patients with 2 or more comorbidities (25.2%; $p<.0001$) • ~7.9 % reduction in ED use ($p=0.02$) • 2.7% reduction in primary care visits ($p=.006$) for patients with 2 or more comorbidities **Three years after initiation, PCMH practices showed sustained improvements with:** • Reduction in ED costs of $3.50 PMPM (11.8%; $p=0.001$) and $6.61 PMPM for patients with 2 or more comorbidities (14.5%; $p=.003$) • 9.3% reduction in ED visits ($p=0.01$) • 1.8% reduction in primary care visits ($p=.06$) for patients with 2 or more comorbidities • 10.3% reduction in ACSC inpatient admissions ($p=0.05$)	**PCMH pilot practices were associated with:** • Increased cervical cancer screening rates after 2 years (12.5% increase, $p<.001$) and 3 years (9.0% increase, $p<.001$) • Lower rates of HbA1c testing in patients with diabetes (.7% reduction at 3 years, $p=.03$) • Lower rates of colon cancer screening (21.1% and 18.1% at 2 and 3 years respectively $p<.001$) • Decreased primary care visits (1.5% at 3 years, $p=.02$)	**PMPM** fees based on the level of NCQA accreditation that each practice attained **Pay-for-performance** program, which awarded bonuses to practices based on meeting both quality and utilization benchmarks This is a **multi-payer** initiative

REFERENCE: Rosenthal, M.B., Alidina, S., Friedberg, M.W., Singer, S.J., Eastman, D., Li, Z., & Schneider, E.C. (2015). A difference-in-difference analysis of changes in quality, utilization and cost following the Colorado Multi-Payer Patient-Centered Medical Home Pilot. Journal of General Internal Medicine.

DESCRIPTION: Authors conducted difference-in-difference analyses evaluating 15 small and medium-sized practices participating in a multi-payer PCMH pilot. The authors examined the post-intervention period two years and three years after the initiation of the pilot.

Section Three:

DISCUSSION OF FINDINGS AND IMPLICATIONS

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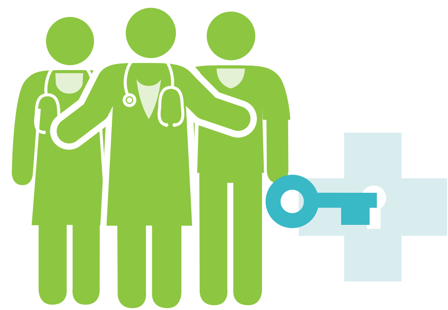

KEY FINDING

- **CONTROLLING COSTS BY PROVIDING THE RIGHT CARE**
  - POSITIVE CONSISTENT TRENDS:
    - By providing the right primary care "upstream," we change how care is used "downstream"
    - Consistent reductions in high-cost (and many times avoidable) care, such as: emergency department (ED) use and hospitalization, etc
    - Cost savings evident – but assessment of total cost of care required (while assessing quality, health outcomes, patient engagement, & provider satisfaction)

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"'Nature' refers to the health care ecology of the region including practice size, practice culture, and patient population, whereas 'nurture' refers to the intervention design and its components (including technical assistance, provider participation, PCMH incentive payments, and shared savings incentives, etc.)."

WHY DO SOME MEDICAL HOMES WORK WHILE OTHERS DON'T?

NATURE VS. NURTURE: Factors Driving PCMH Practice Success in 2 Regions of Pennsylvania[73]

		Southeast Region	Northeast Region
Nature	Practices	• Mostly small, independent practices • A few very large academic medical centers and FQHCs	• Several "right-size" (medium-sized) practices • Solo practices often belonged to larger medical group • Strong relationship with hospitals
	Patient population	• Many had significant economic hardship	• Less diverse, fewer with economic challenges
Nurture	Quality improvement focus	• QI focused almost exclusively on diabetes care	• Focused on multiple chronic conditions
	Implementation	• Fairly rushed implementation, 1st region in the initiative to launch • Only 1/3 of practices had EHRs at the beginning of implementation	• Had opportunity to learn from other regions • All practices had EHRs at beginning of implementation
	Payment model	• Practices received PMPM **after** earning NCQA recognition • Payments not contingent upon hiring care manager	• Practices were not required to have NCQA recognition until 18 months into implementation **2 streams of payment:** • 1 for care management and • 1 for practice transformation
		No opportunity for shared savings until year 4 (after initial JAMA study[72] was published)	Opportunity for shared savings tied to quality improvement
	Payer support	In many practices, no data and no technical support provided	Provided practices with ED and inpatient notification and reports from the beginning of implementation

KEY FINDING

- **ALIGNING PAYMENT AND PERFORMANCE**
  - BEST OUTCOMES FOR MULTI-PAYER EFFORTS:
    - Most impressive cost & utilization outcomes among multi-payer collaboratives with incentives/performance measures linked to quality, utilization, patient engagement, or cost savings … more mature PCMHs had better outcomes
    - No single best payment model emerged, but extended beyond fee-for-service

Trajectory to Value-based Purchasing:
PCMH part of a larger framework

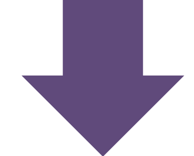
HIT Infrastructure: EHRs and population health management tools

Primary Care Capacity: PCMH or advanced primary care

Care Coordination: Coordination of care across medical neighborhood & community supports for patient, families, & caregivers

Value/ Outcome Measurement Reporting of quality, utilization and patient engagement & population health measures

Value-Based Purchasing: Reimbursement tied to performance on value



Alternative Payment Models (APMs): Supporting ACOs, PCMH, & other value based arrangements

Source: THINC - Taconic Health Information Network and Community

APM FRAMEWORK WORK GROUP

Population-Based Accountable APMs (Categories 3 and 4)

Category 1	Category 2	Category 3	Category 4
Category 1 Fee for Service – No Link to Quality & Value	**Category 2** Fee for Service – Link to Quality & Value	**Category 3** APMs Built on Fee-for-Service Architecture	**Category 4** Population-Based Payment
	A Foundational Payments for Infrastructure & Operations **B** Pay for Reporting **C** Rewards for Performance **D** Rewards and Penalties for Performance	**A** APMs with Upside Gainsharing **B** APMs with Upside Gainsharing/Downside Risk	**A** Condition-Specific Population-Based Payment **B** Comprehensive Population-Based Payment

- **The LAN's Alternative Payment Model Framework and Progress Tracking (APM FPT) Work Group was successful in developing a Framework for categorizing APMs.**
- **Within the APM framework, population-based-payment models fall into categories some of 3 and 4.**

MACRA – MIPS & APMS

Providers Must Choose FFS + PFP[1] or Accountable Care

Merit-Based Incentive Payment System (MIPS)

2015:H2 – 2019: 0.5% annual update

2020 – 2025: Frozen payment rates

2026 and on: 0.25% annual update

2018: Last year of separate MU, PQRS, and VBPM[2] penalties

2020: -5% to +15%[2] at risk

2022 and on: -9% to +27%[2] at risk

2019: Combine PQRS, MU & VBPM programs: -4% to +12%[2] at risk

2021: -7% to +21%[2] at risk

Advanced Alternative Payment Models[3]

2015:H2 – 2019: 0.5% annual update

2020 – 2025: Frozen payment rates

2026 and on: 0.75% annual update

2019 - 2024: 5% participation bonus

2019 - 2020: 25% Medicare revenue requirement

2021 and on: Ramped up Medicare or all-payer revenue requirements

1. Pay for performance.
2. Value-based payment modifier.
3. Positive adjustments for professionals with scores above the benchmark may be scaled by a factor of up to 3 times the negative adjustment limit to ensure budget neutrality. In addition, top performers may earn additional adjustments of up to 10 percent.
4. APM participants who are close to but fall short of APM bonus requirements will not qualify for bonus but can report MIPS measures and receive incentives or can decline to participate in MIPS.

Source: Medicare Access and CHIP Reauthorization Act of 2015; Advisory Board research and analysis. PATEL, KAVITA, APA Presentation, November 2015

MULTI-PAYER COLLABORATIVES: Beyond early evaluations

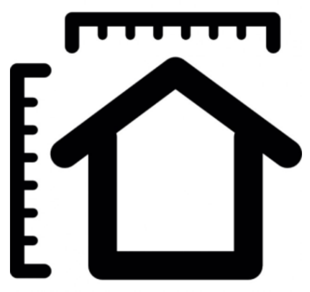
COMPREHENSIVE PRIMARY CARE INITIATIVE (CPC)

- 5 out of 7 regions reported cost and/or utilization improvements
- Arkansas
- Colorado
- Hudson Valley New York
- New Jersey
- Oregon

MULTI-PAYER ADVANCED PRIMARY CARE DEMONSTRATION (MAPCP)

6 out of 8 MAPCP states found cost and/or utilization improvements

- Michigan
- Pennsylvania
- New York
- North Caroline
- Rhode Island
- Vermont



KEY FINDING

Assessing and Promoting Value

– BETTER MEASURES & DEFINITIONS:

- Variation across study measures -- and PCMH initiatives – make for challenging evaluations and expectations (patients, providers, payers)

Payment Reform to Define PCMH

The Centers for Medicare and Medicaid Services (CMS) will define PCMH certification for the purpose of payment incentives as part of the Medicare Access and CHIP Reauthorization Act (MACRA). This provides an important opportunity to unify around a clear PCMH definition and recognition process that offers measurable value and impact to patients, providers, and payers, as well as to researchers evaluating the model.

TRANSFORMING CLINICAL PRACTICE INITIATIVE GOALS

1. Support more than 140,000 clinicians in their practice transformation work
2. Improve health outcomes for millions of Medicare, Medicaid and CHIP beneficiaries and other patients
3. Reduce unnecessary hospitalizations for 5 million patients
4. Generate $1 to $4 billion in savings to the federal government and commercial payers
5. Sustain efficient care delivery by reducing unnecessary testing and procedures
6. Build the evidence base on practice transformation so that effective solutions can be scaled

SELECT PCPCC TCPI GOALS

- Define and support patient-practice partnerships
- Promote clinic-to-community linkages

SAVE THE DATES

- **Safety Net Medical Home Grantee Symposium** *(CareFirst BlueCross BlueShield of Maryland, co-hosted by PCPCC)*
  - March 15, 2016; 9:00am – 3:00pm
  - The Newseum, 555 Pennsylvania Ave NW, Washington, DC 20001
- **PCPCC's March National Briefing webinar**
  - Thursday, March 31st at 1:00pm ET
  - "The Primary Care Imperative: New Evidence Shows Importance of Investment in Patient-Centered Medical Homes" *(Authored by National Business Group Health and the PCPCC)*
- **National Medical Home Summit** *(Co-hosted by the PCPCC)*
  - June 6 & 7th
  - Grand Hyatt, Washington DC
- **Celebrate the PCPCC'S 10 year Anniversary – Annual Meeting & Awards Dinner**
  - November 9th and 10th, Grand Hyatt, Washington DC

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by becoming executive member at:
www.pcpcc.org