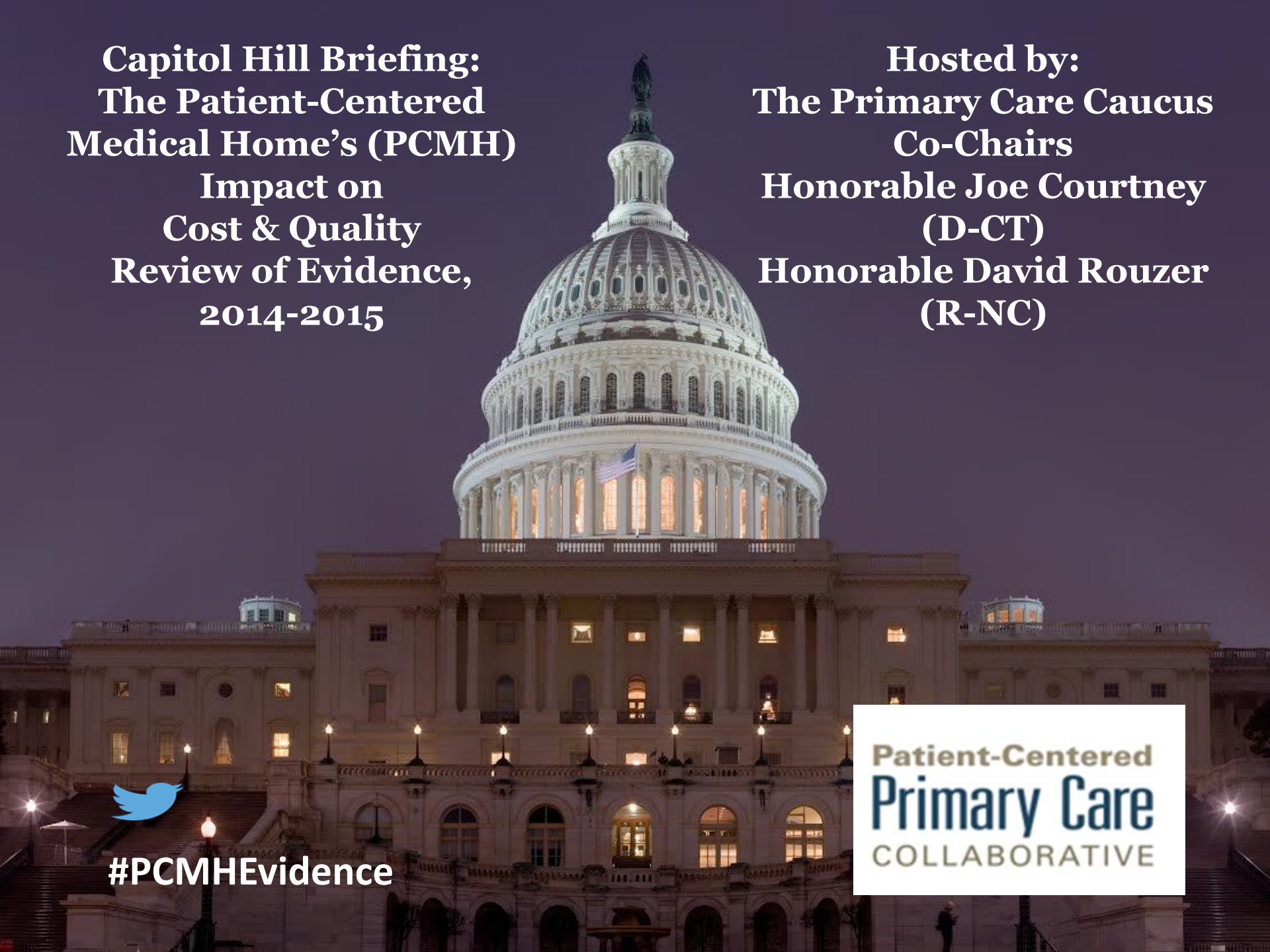


Capitol Hill Briefing: The Patient-Centered Medical Home's (PCMH) Impact on Cost & Quality Review of Evidence, 2014-2015

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

#PCMHEvidence

Patient-Centered Primary Care COLLABORATIVE

WELCOME & OPENING REMARKS

- **DOUG HENLEY, MD, FAAFP**
  - Chair of the PCPCC Board of Directors
  - Executive Vice President and CEO, American Academy of Family Physicians

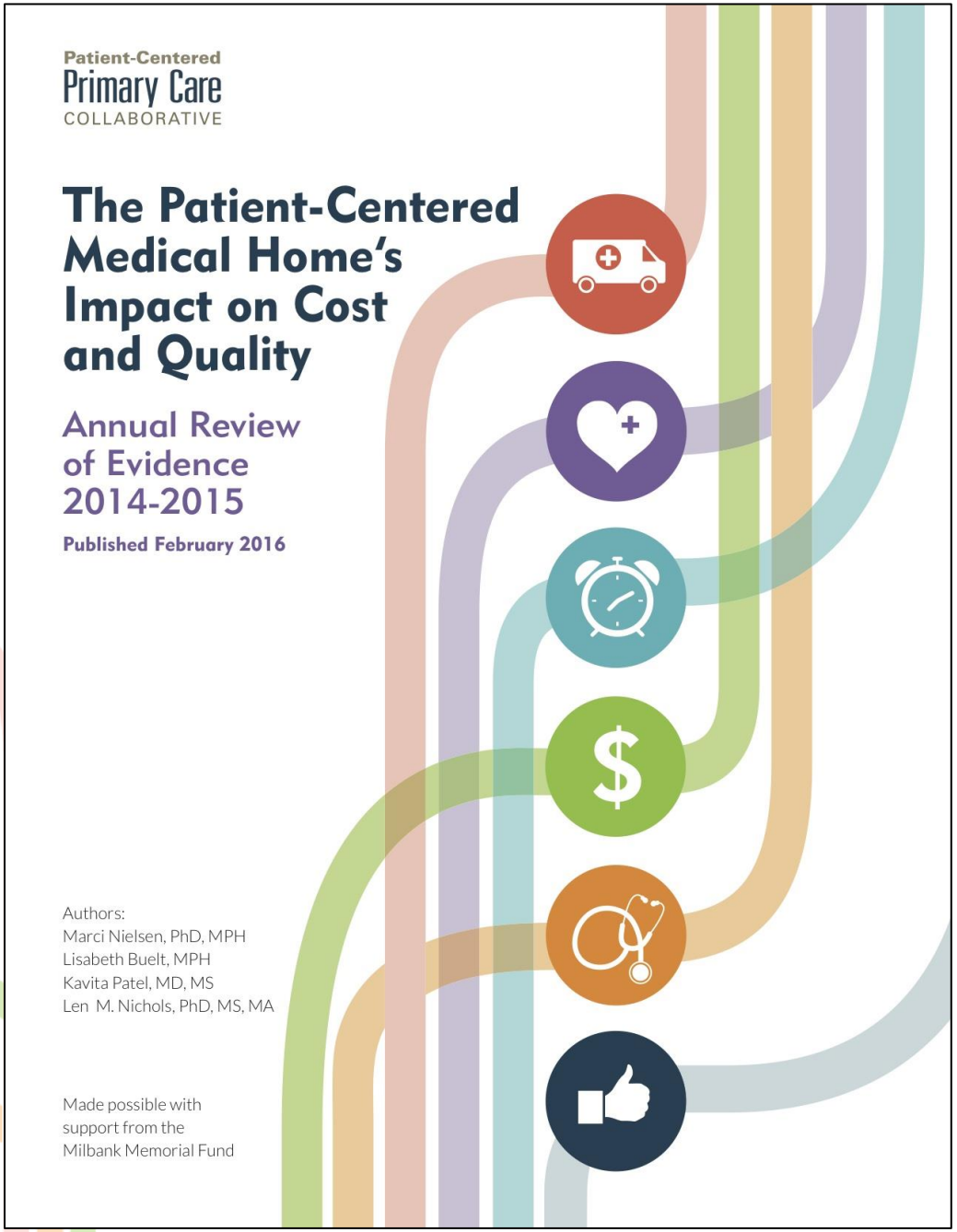
PANELISTS

- **MARCI NIELSEN, PHD, MPH**
  - CEO of the Patient-Centered Primary Care Collaborative
- **ALISSA FOX**
  - Senior Vice President, Office of Policy and Representation, Blue Cross Blue Shield Association
- **CHRISTOPHER KOLLER, MA, MS**
  - President, Milbank Memorial Fund
- **LEN NICHOLS, PHD, MS, MA**
  - Director, Center for Health Policy Research and Ethics, George Mason University

#PCMHEvidence

BlueCross BlueShield Association

An association of independent Blue Cross and Blue Shield companies



AGENDA

- Overview of the 2015 PCPCC Evidence Report
- Discussion of findings & implications, in light of payment reform and the Medicare Access and CHIP Reauthorization Act (MACRA)

Report published with support from:

Milbank Memorial Fund

AUTHORS

Marci Nielsen, PhD, MPH
- *Chief Executive Officer, PCPCC*

Lisabeth Buelt, MPH
- *Policy and Research Manager, PCPCC*

Kavita Patel, MD, MS
- *Nonresident Senior Fellow, Economic Studies, The Brookings Institution*

Len M. Nichols, PhD, MS, MA
- *Director, Center for Health Policy Research and Ethics, George Mason University*

#PCMHEvidence

REVIEWERS

Christine Bechtel, MA
Bechtel Health; National Partnership for Women & Families

Asaf Bitton, MD, MPH
Brigham and Women's Hospital & Harvard Medical School

Jean Malouin, MD, MPH
University of Michigan

Mary Minniti, BS, CPHQ
Institute for Patient- and Family-Centered Care

Bob Phillips, MD, MP
American Board of Family Medicine

Sarah Hudson Scholle, DrPH, MPH
National Committee for Quality Assurance

Lisa Dulsky Watkins, MD
Milbank Memorial Fund Multi-State Collaborative

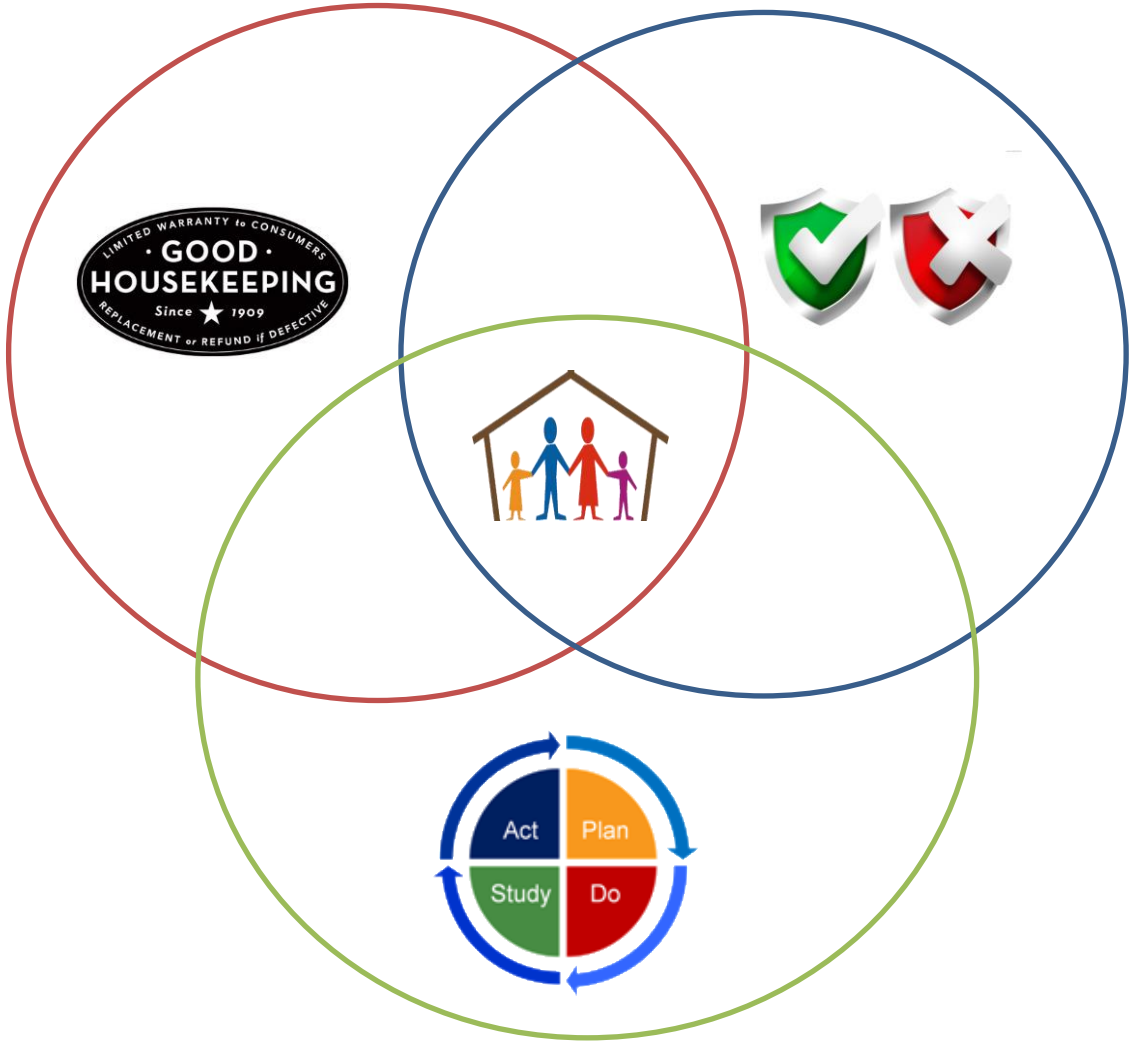
PCMH MODEL/FRAMEWORK

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

PCPCC MISSION:

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

PUBLIC:
Patients,
Families,
Caregivers,
Consumers
Communities



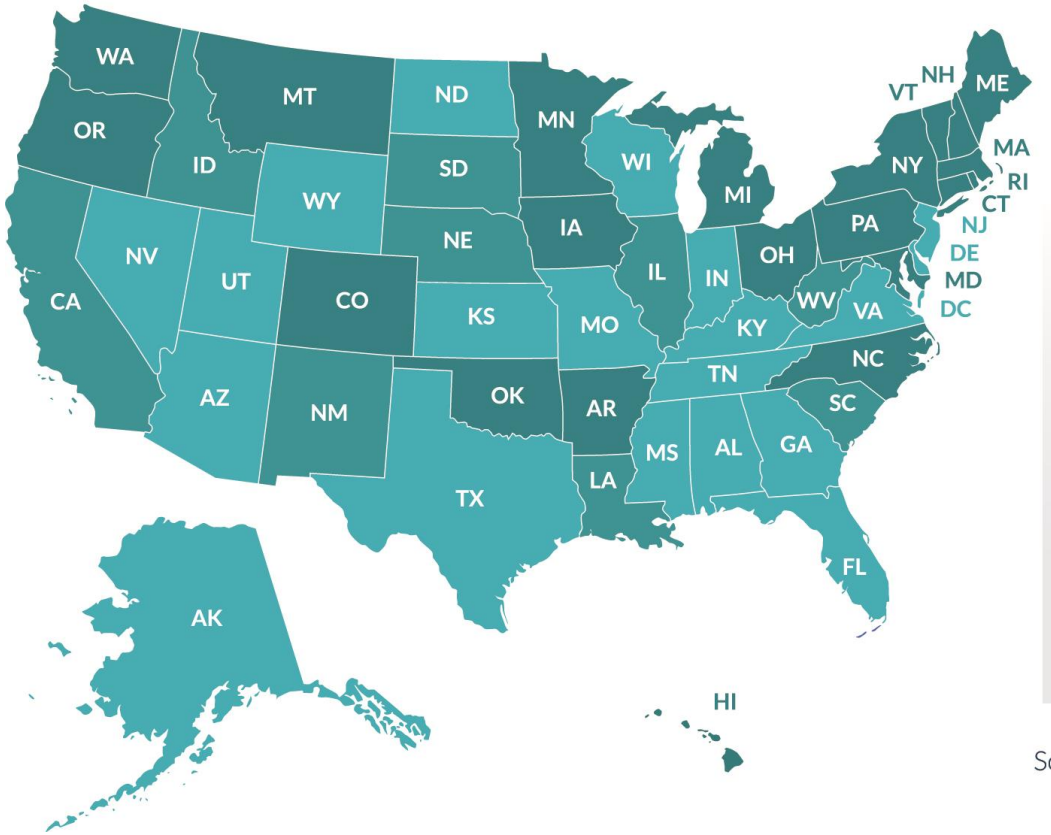
PAYERS:
Employees,
Employers,
Health plans,
Government,
Policymakers

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

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.



State View

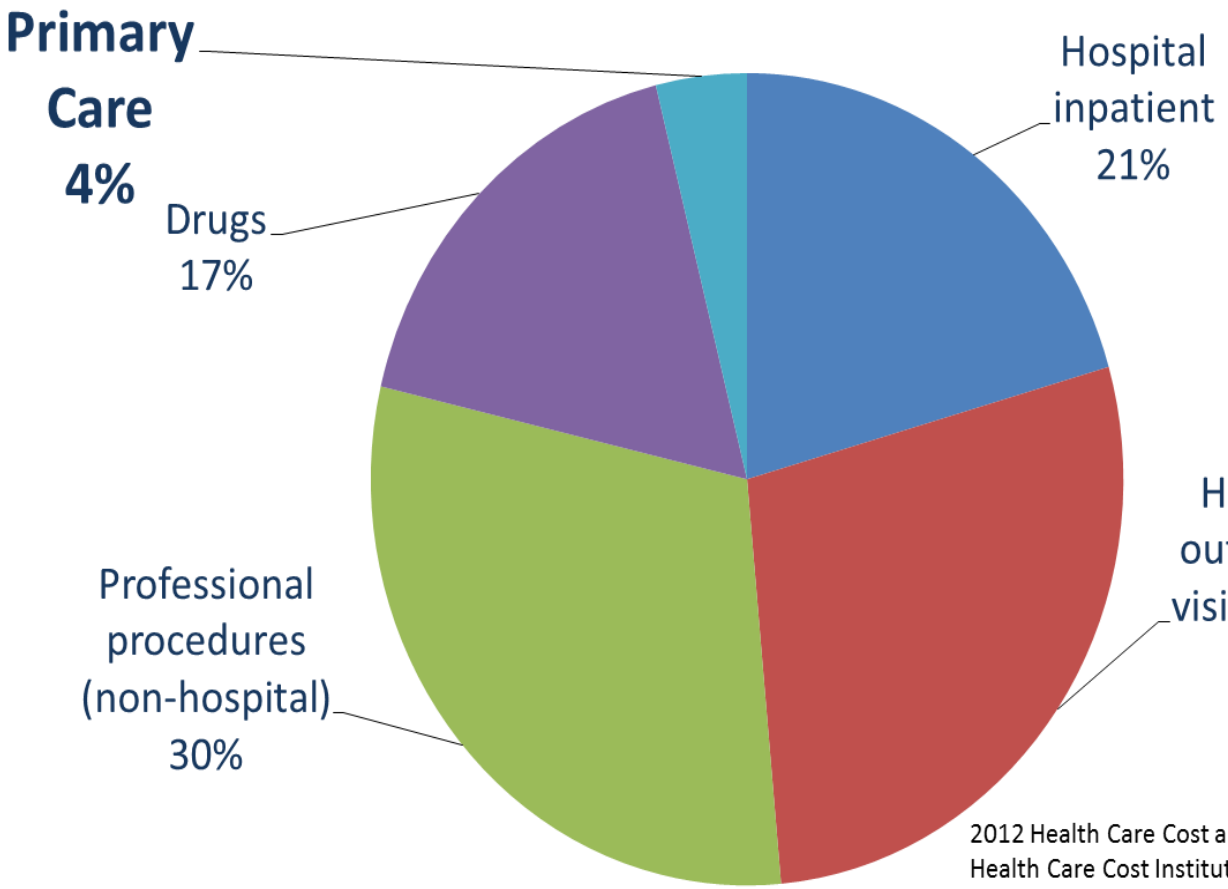
National View

List View

Outcomes View

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/

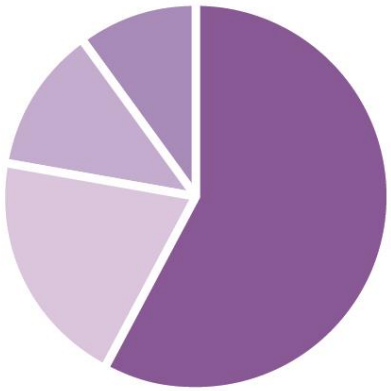
#PCMHEvidence

METHODS

INCLUSION CRITERIA:

- Predictor variable:
  - Medical home
  - PCMH
  - Advanced Primary Care
- Outcome variable:
  - Cost or
  - Utilization
- Date published:
  Between Oct 2014 and Nov 2015

30 total studies



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

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

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.

KEY FINDINGS

- **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)
- **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
- **ASSESSING AND PROMOTING VALUE**
  - BETTER MEASURES & DEFINITIONS:
    - Variation across study measures -- and PCMH initiatives – make for challenging evaluations and expectations (patients, providers, payers)

#PCMHEvidence

> "'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.)."

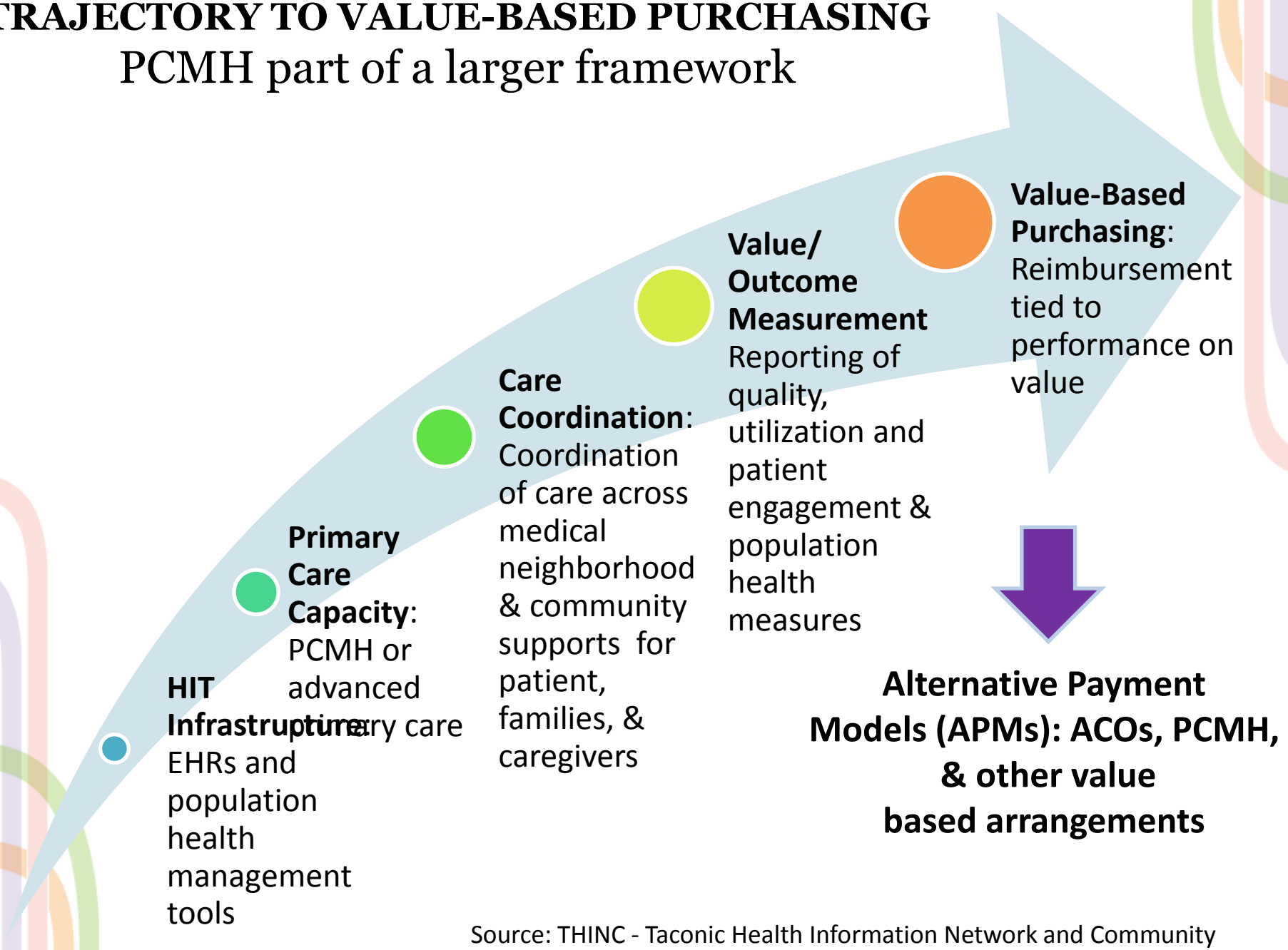
WHY DO SOME MEDICAL HOMES WORK WHILE OTHERS DON'T?

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

TRAJECTORY TO VALUE-BASED PURCHASING

PCMH part of a larger framework



Source: THINC - Taconic Health Information Network and Community

QUESTIONS FOR THE PANELISTS TRUE/OR FALSE? *(Shadow or no?)*

- ALISSA: "Advanced primary care and medical homes must be recognized as foundational to ACOs and other integrated delivery reforms."
  - Experience of private payers?
- CHRIS: "Alignment of payment and performance measurement across public and private payers is key to garnering support for value-based payment models."
  - Lessons from multi-payer collaboratives to scale & spread PCMH framework?
- LEN: "Measurement and recognition for PCMHs must be aligned and focused on value for patients, providers, and payers."
  - Because "medical home" is not well understood by the public, CMS has an important opportunity to unify stakeholders around the value of PCMH -- to patients, providers, and payers -- well as to researchers evaluating the model. How should we defining value?

THANK YOU

WWW.PCPCC.ORG