Patient-Centered Primary Care COLLABORATIVE

FOR IMMEDIATE RELEASE
June 5, 2015

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To Meet the Triple Aim: PCMH Payment Incentives Matter

Statement from PCPCC Chief Executive Officer, Marci Nielsen, on New Pennsylvania Chronic Care Initiative Study

An important study regarding the patient-centered medical home (PCMH) model of care was published in JAMA Internal Medicine this week: *Effects of a Medical Home and Shared Savings Intervention on Quality and Utilization of Care*. RAND researcher Dr. Mark Friedberg and colleagues found that a large multi-payer PCMH program achieved significant reductions in unnecessary health care utilization as well as notable improvements in quality of care. This is welcome but not surprising news: when primary care practices are incentivized to curb costs and improve health and are given adequate time and support to implement the PCMH model of care, the results speak for themselves.

The study evaluated the northeast region of the Pennsylvania Chronic Care Initiative (PA-CCI), a PCMH pilot program that began in October 2009. During the three-year study period, PCMH practices performed better than non-PCMH comparison practices in all four examined measures of diabetes care, as well as breast cancer screening. In addition, PCMH practices had lower rates of patient hospitalization (-1.7), emergency department use (-3.2 to -4.7), and reductions in specialty care (-17.3), as well as an impressive increase in the rate of primary care visits (+77.5).

These findings are particularly significant because the same authors published an article in JAMA in February of 2014 that evaluated the same Pennsylvania program, but reported very different results. The 2014 study found that the PCMH model was unsuccessful in achieving reductions in cost or utilization, and failed to yield improvements in quality of care. The JAMA article generated widespread skepticism that the PCMH could deliver on the promise of better health care at a lower cost, despite the continued publication of positive findings linking the PCMH with the Triple Aim.

Although they used the same methods in both evaluations, in the most recent study – which looked at more mature PCMH practices in a different part of the state – authors suggest several factors contributing to their success.

- **PAYMENT INCENTIVES.** First, shared savings incentives for PCMH providers were incorporated that allowed practices to receive bonuses if total spending on patients was less than expected for the year.

- **TIMELY DATA.** Second, the practices received regular feedback from participating health plans, allowing for practices to continuously modify their efforts to meet benchmarks.

- **PRACTICE TRANSFORMATION FOCUS**. Third, financial incentives were NOT tied to early achievement of medical home recognition, which potentially allowed practices to focus more on process improvement and learning collaborative activities.

- **ELECTRONIC HEALTH RECORD ADOPTION.** Fourth, all practices entered into the pilot with an electronic health record in place, preventing distractions from improving patient care.

- **ADVANCED PRIMARY CARE.** Fifth, the practices were more advanced, per their NCQA recognition scores, which better positioned them to implement case management and other advanced capabilities.

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As a broad coalition of health care providers, purchasers, and patients dedicated to advancing the medical home, the PCPCC believes this significant contribution to the scientific evidence offers critical lessons. It also underscores recent achievements in payment reform. With the recent passage of bipartisan legislation to repeal and replace Medicare's Sustainable Growth Rate (SGR) physician payment formula, incentives for PCMH adoption as an approved care delivery and alternative payment model will be included in Medicare. This legislation will be fundamental in achieving goals announced this January by the Secretary of Health and Human Services, including tying 30 percent of Medicare payments to value through alternative payment models by 2016, and 50 percent by 2018.

Moving forward, the PCPCC will continue to aggregate PCMH program evaluations to expand upon the growing evidence base that associates the PCMH with the Triple Aim of achieving cost savings, while improving population health and quality of care. Friedberg's study, one of many, helps us understand key components of advanced primary care that are needed for practices to achieve success. These findings offer positive news for primary care practices, patients, families, and caregivers as well as purchasers and payers of the U.S. health system.

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About PCPCC: Founded in 2006, the Patient-Centered Primary Care Collaborative (PCPCC) is dedicated to advancing an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home (PCMH). The PCMH model embraces the relationship between primary care providers and their patients, families, and care-givers; promotes authentic communication and patient engagement; and coordinates whole-person, compassionate, comprehensive, and continuous team-based care; all of which are crucial to achieving meaningful health system transformation. The PCPCC achieves its mission through the work of its five Stakeholder Centers, led by experts and thought leaders who are dedicated to transforming the U.S. health care system through delivery reform, payment reform, patient engagement, and employee benefit redesign. Today, PCPCC's membership represents more than 1,200 medical home stakeholders and supporters throughout the United States.