Patient-Centered
Primary Care
COLLABORATIVE

The Patient-Centered Medical Home's Impact on Cost and Quality

Annual Review of Evidence 2014-2015

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Executive Summary

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EXECUTIVE SUMMARY

For nearly a decade, the Patient-Centered Primary Care Collaborative (PCPCC) has advocated a vision of an effective and efficient U.S. health system built on a strong foundation of primary care and the patient-centered medical home (PCMH) (or "medical home," used interchangeably throughout this report). The PCPCC's mission is to serve as the **unifying voice of advanced primary care** to improve delivery and payment systems. We do this by **convening** diverse stakeholders — including patients, providers, payers, and many other interested partners; **communicating** timely and accurate information to key influencers and the public; and **advocating and educating** about priority issues that show promise in improving health care delivery for all stakeholders.

The PCMH is an innovation in care delivery designed to advance and achieve the Triple Aim of improved patient experience, improved population health, and reduced cost of care.[1] Simply put, a medical home provides enhanced primary care services of value to patients, their families, and the care teams who work with them. The evolving model promises improved access to high-quality, patient-centered primary care through trusted relationships with patients, families, and caregivers; incorporates team-based care with clinicians and staff working at the top of their skill set; and provides cost-effective care coordination and population health management connecting patients to the "medical neighborhood" and to their community. By investing in enhanced primary care and ensuring that PCMHs are foundational to Accountable Care Organizations (ACOs) and/or other integrated health systems, the PCMH model is demonstrating that a cost-effective, accessible, more equitable, higher-quality health care system is possible.

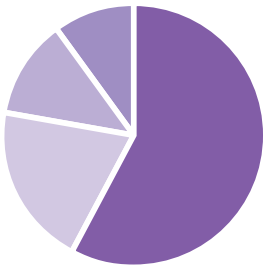
As in previous editions, this year's *Annual Review of the Evidence* provides a summary of PCMH cost and utilization results from peer-reviewed studies, state government evaluations, industry reports, and new this year, independent federal program evaluations published between October 2014 and November 2015. It reviews the recent evidence for PCMH and advanced primary care in light of new and long-awaited developments in health system payment reform including Medicare's transition to value-based payments and passage of the Medicare Access and CHIP Reauthorization Act (MACRA). In addition, significant multi-payer and state-level reforms are happening across the United States in conjunction with increasing commercial interest and investment in advanced primary care.

Key points from this year's evidence review include:

Controlling Costs by Right Sizing Care: *Advanced primary care is foundational to delivery system transformation — medical home initiatives continue to reduce health care costs and unnecessary utilization of services*

This year's 30 publications point to a clear trend showing that the medical home drives reductions in health care costs and/or unnecessary utilization, such as emergency department (ED) visits, inpatient hospitalizations and hospital readmissions. Various approaches to PCMH payment that are highlighted show potential. Those with the most impressive cost and utilization outcomes were generally those who participated in multi-payer collaboratives with specific incentives or performance measures linked to quality, utilization, patient engagement or cost savings. The more mature medical home programs demonstrated stronger improvements.

30 total studies



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

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

Aligning Payment and Performance: *Payment reform is necessary to sustain delivery system changes, but alignment across payers is critical for health care provider buy-in*

As payment for primary care practices is fundamentally restructured to support value-based care, advanced primary care and medical homes must be recognized as foundational to ACOs and other integrated delivery reforms. This means explicitly rewarding primary care clinicians and their teams for meeting performance targets within ACOs, and ensuring that incentives are directly shared with practices and providers — and not just limited to the organization or health system.

Given increasing provider "measurement fatigue," alignment of both payment and performance measurement across public and private payers is key to garnering support from primary care practices transitioning to these value-based payment models. Multi-payer initiatives like the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration and the Comprehensive Primary Care (CPC) Initiative are learning how to best align local, regional, and national payer and provider interests in order to scale and spread best practices to optimize both delivery and payment reform. Although this report describes several alternative payment models that can support the PCMH, many different payment strategies are being tested. The evidence does not yet clearly point to a single payment strategy that is most successful in delivering advanced primary care.

Assessing and Promoting Value: *Measurement for PCMHs must be aligned and focused on value for patients, providers, and payers*

As part of Medicare payment reform implementation, the Centers for Medicare and Medicaid Services (CMS) will define and reward "certified" PCMH practices. Because of the variability in PCMH definition and certification in the public and private sectors, existing PCMH measures should be aligned to enhance our ability to evaluate PCMHs and understand which components of the model are most impactful. Although our inclusion criteria for this publication is limited to medical home studies assessing cost and utilization changes, several of the studies note statistically significant improvements in quality of care metrics, access to primary care services, and patient or clinician satisfaction. All are important. The PCMH definition, as well as measures to implement, recognize, and evaluate it — should be aligned and demonstrate clear value to patients, providers, and payers.

REFERENCE

[1] Institute for Healthcare Improvement *Triple Aim Measures*. (2014). Retrieved from http://www.ihi.org/Engage/Initiatives/ TripleAim/Pages/MeasuresResults.aspx

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