Patient-Centered
Primary Care
COLLABORATIVE

# The PCPCC's Annual PCMH Evidence Report

## Frequently Asked Questions (FAQ)

**1. Why do we gather the evidence every year? What are we trying to learn?**

Because the patient-centered medical home (PCMH) is an evolving innovation, we publish an annual summary of the cost and utilization evidence to provide policymakers and the public with a yearly snapshot of what we've learned – and where we believe we still have work to do. Although this report includes a year's worth of PCMH studies examining cost and utilization, it should not be considered a formal "meta-analysis" of the data. Instead, we aggregate cost and utilization measures from individual studies and examine the trends (both within the year and over time). We describe our findings in detail in each of the tables, separated by study type, and an analysis of the findings in the discussion section of the report.

**2. Why do we include separate studies by type of publication (peer-reviewed, industry, government)?**

Given the size and budget for this report, we are unable to analyze the quality of each individual study's design. Instead, we catalog the studies based on the type of publication in order to acknowledge differences across type. For example, a review of the peer-reviewed evidence gives us an externally validated view of the data, but often long after there are lessons to be learned and disseminated. Early peer-reviewed evidence from less mature PCMHs found mixed results (in terms of cost and quality outcomes), but this year's report demonstrates that that is changing as practices further implement the model. Industry reports give us a faster view of the data, but without independent validation, the results must be viewed accordingly. Finally, including state and federal evaluations – which are typically published by independent evaluators – gives us rich data on multiple measures but can be difficult to digest, accordingly we include summary data.

**3. What did we learn from the latest 2014-2015 report?**

The 30 publications analyzed in our 2014-2015 report 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 in the report show potential.Those with the most impressive cost and utilization outcomes were generally those that 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.

- **Cost Savings**: 21 out of 23 studies that reported on cost measures found reductions in one or more measures.
- **Utilization Reductions**: 23 out of 25 studies that reported on utilization measures found reductions in one or more measures.

**4. Why is payment highlighted in the 2014-2015 PCMH evidence report?**

A major barrier in reforming our fragmented care delivery system is in how we pay for care: the predominant fee-for-service payment system is piecemeal, inflationary, administratively burdensome and technically complex. Because fee-for-service does not reimburse for key PCMH features — such as facilitating information sharing and care coordination with sub-specialists and hospitals, managing web-portals and personal health records, email communication and telephone visits, developing connections to community-based organizations, and integrating behavioral health — it often fails to compensate for the complete scope of services offered by a PCMH. Smaller practices with little reserve capacity are especially challenged in offering PCMH-level care without adequate financial support.

In addition, the cost of sustaining the PCMH model can be financially challenging and administratively cumbersome for some practices. Although more research is needed to understand the costs of transformation, the evidence suggests that advanced primary care practices require time, expert coaching to acquire new quality improvement and data management skills, and sufficient resources to assume greater accountability for both quality and cost.

Various payment innovations have been testing ways to support primary care innovation and PCMH. Depending on the region and the provider arrangement (e.g., a solo or small practice, an Independent Practice Association or Accountable Care Organization (ACO), or an employed provider as part of a health system), some practices that were once paid fee-for-service only, are now receiving additional per member per month payments (PMPM). Others are receiving payment incentives tied to performance metrics that measure quality, cost, or patient engagement. Medicare has been piloting various types of payment reform — ranging from pay-for-reporting to bundled payment — but the scale and spread of delivery models that tie payment to quality for all Medicare beneficiaries is more recent.

**5. What is the Patient-Centered Primary Care Collaborative (PCPCC)/Patient-Centered Primary Care Foundation (PCPCF)?**

For nearly a decade, the Patient-Centered Primary Care Collaborative (PCPCC) – a not-for-profit membership organization – has advocated a vision of an effective and efficient U.S. health system built on a strong foundation of primary care and the PCMH. 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 PCPCC achieves its mission through the work of its executive members, Stakeholder Centers, experts, and thought leaders focused on key issues of delivery reform, payment reform, patient and family/caregiver engagement, and benefit redesign to drive health system transformation.