Background

What is Patient-Centered Medical Home

...A vision of health care as it should be
...A framework for organizing systems of care
...Part of health care reform agenda
UPMC Health Plan Medical Home

- Team Based
- Technology
- System Design
- Communication Link
- Self-Management
- Evidence-based

- Cost
- Access
- Patient Experience
- Quality

UPMC Health Plan Medical Home System Design
Principles

Patient-centered

Physician guided

Adapted: Defining Primary Care an Interim Report, Institute of Medicine 1994
UPMC Health Plan Medical Home in Brief

- Program started in 2008
  - Independent and employed physician practices with >1,000 health plan members
- Program Growth as of February 2013
  - All product lines
  - 143,826 members
  - 163 active sites
  - 602 physicians

Supported By Plan Resources

- Case/Disease Managers, Lifestyle Coaches, Behavioral Health
- Plan Pharmacists
- Health Planet Disease Registries Care Plans
- Case Review Committees

Practice Based Care Manager

- Goal: Increase practice health care team collaboration.
- Focus: Assisting practices in meeting target goals for Shared Savings Program

Supports: Physicians Health Care Team and Members

- Educates patients on conditions
- Devises member self-management plans
- Prepares patients for visits, reviews meds, etc.
- Informs physician of care gaps, orders needed, important updates
UPMC Health Plan

• History of Medical Home
  – Started in 2008 with six practices

![Number of PCMH Practices and Total Members](chart.png)
Patient Centered Medical Home Demographics

Gender of Members
- PCMH
- RON

Age of Members
- PCMH
- RON

Charlson Comorbidity Index of Members
- PCMH
- RON

Line of Business of Members
- PCMH
- RON
Key Findings

- **Total (Medical + Pharmacy) Cost PMPM Trend**
  - All LOB
  - *The difference in trend is not statistically significant (p=0.63)*

- **Medical Cost PMPM Trend**
  - All LOB
  - *The difference in trend is not statistically significant (p=0.22)*

- **Pharmacy Cost PMPM Trend**
  - All LOB
  - *The difference in trend is weakly statistically significant (p=0.065)*
**Cost**

<table>
<thead>
<tr>
<th>Change in Inpatient Medical Surgical PMPM from July 2008 to June 2012 - All LOB</th>
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<tr>
<td>$16.16 (-)</td>
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<tr>
<td>-$5.60</td>
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*The difference between PCMH and RON is **not** statistically significant (p=0.65)*

**Characteristics**

- UPMC employed sites
- Having >5% of members high risk*

Statistical better cost trends

*5 providers + 5 Rxs + annual $25,000 or 9 providers + 9 Rxs + average $1000 PMPM*
Utilization Trend

30-Day Readmission Rate any DRG Trend
All LOB

*The difference in trend is weakly statistically significant (p=0.087)*

[Graph showing trend lines with labels: PCMH, RON, Linear Trend (PCMH), Linear Trend (RON)]

Generic Fill Rate Trend
All LOB

*The difference in trend is not statistically significant (p=0.48)*

[Graph showing trend lines with labels: PCMH, RON, Linear Trend (PCMH), Linear Trend (RON)]
Results by Line of Business

Total (Medical + Pharmacy) Cost PMPM Trend

Commercial LOB

*The difference in trend is not statistically significant (p=0.56)

Total (Medical + Pharmacy) Cost PMPM Trend

Medicaid LOB

*The difference in trend is not statistically significant (p=0.11)

Total (Medical + Pharmacy) Cost PMPM Trend

Medicare LOB

*The difference in trend is not statistically significant (p=0.35)

Total (Medical + Pharmacy) Cost PMPM Trend

SNP LOB

*The difference in trend is not statistically significant (p=0.39)
Current Healthcare Delivery/Payment Models

Initial Hypothesis on Prioritization of Provider Engagement and Payment Models

- **Degree of Impact**: Potential effect on bending the cost curve in 3-5
- **Degree of Difficulty**: Ability to implement based on provider environment, historical relationships, and existing capabilities

### Rationale – Preliminary Hypothesis

- **Medical Homes**: Strong support and emerging evidence around impact; potential to leverage existing pilots and scale up rapidly
- **Centers of Excellence**: Superior outcome and cost profile for selected high-cost Diseases and procedures; opportunity to explore providers outside market
- **Disease/Procedure-Based “Products”**: Increasing adoption and evidence of potential impact on cost curve; may be selectively implemented with handful of providers
- **Accountable Care Organizations**: Increased popularity and visibility in reform proposals; potential to facilitate coordination
- **Admin Integration**: Potential to reduce back-office complexity; will require technology and infrastructure to facilitate integration
- **Mature P4P**: Various P4P programs implemented with limited impact; opportunity to optimize existing programs to generate more incremental savings and avoid excess administration
- **Pay for Outcomes**: Greater potential for cost savings than P4P however, difficulty in developing outcomes-based measurement
- **Bundled Case Rates**: Some pilots being implemented with varying levels of impact; requires EBM, case rates and episodes of care, and underlying infrastructure/systems
- **Global Payments**: Potential to deliver significant savings; raises concerns on capitation; relatively challenging given fragmented nature of NH provider environment
- **eBay for Healthcare**: Market sets the price for highly elective procedures; however, limited enabling infrastructure at present; may lead to reduced health plan role in the future
- **Uniform Hospital Pricing**: May significantly cut delivery costs; however, potential policy issues from previous implementation; may also minimize provider discount advantage

Adopted - FTI Consulting
Shared Savings Overview

Current State

- First gain share July 2011
- Six groups in Share Savings (93,635 members)

Strategy

- Redefine payment methods based on increase quality, decreasing overall cost of care, increase member satisfaction
- Strong physician leadership, engagement and focus on MER (total cost of care) quality and revenue
Case Example

- Family practice group; original adopter PCMH (2008)
- ~1400 Medicare Advantage members
- Shared Savings April 2012
Case Study: Shared Savings

Shared Savings Expense Comparison
April - December

Based on claims incurred April - December and paid through January 31, 2013.
“Moving into the next century, the most important breakthroughs will be in the form of clinical \textit{process} innovation rather than clinical \textit{product} improvement...the next big advances in health care will be the development of protocols for delivering patient care across health care settings over time.”

J.D. Kleinke, \textit{The Bleeding Edge}