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

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WELCOME & OPENING REMARKS

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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:
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PCMH MODEL/FRAMEWORK

Person-Centered
Supports patients and families in managing decisions and care plans

Comprehensive
Whole-person care provided by a team

Coordinated
Care is organized across the ‘medical neighborhood’

Committed to Quality and Safety
Maximizes use of health IT, decision support and other tools

Accessible
Care is delivered with short waiting times, 24/7 access and extended in-person hours

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

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.

Source: www.pcpcc.org/initiatives
PAYING NOW ... OR PAYING LATER

- Hospital outpatient visits/other: 28%
- Professional procedures (non-hospital): 30%
- Hospital inpatient: 21%
- Drugs: 17%
- Primary Care: 4%


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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
(n¹ = Improvement in measure/n² = Measure assessed by study)

Aggregated Outcomes from the 30 Studies

$\cdots$ 21 of 23 studies that reported on cost measures found reductions in one or more measures

$\cdots$ 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

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**

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<thead>
<tr>
<th>Location/Initiative</th>
<th>Cost &amp; Utilization</th>
<th>Additional Outcomes</th>
<th>Payment Model Description</th>
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| **Colorado Multi-payer PCMH pilot**<sup>46</sup>  
**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* < .001) and $11.54 PMPM for patients with 2 or more comorbidities (25.2%; *p* < .001)  
• 7.9% reduction in ED use (*p* = .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* = .001) and $6.61 PMPM for patients with 2 or more comorbidities (14.5%; *p* = .003)  
• 9.3% reduction in ED visits (*p* = .001)  
• 1.8% reduction in primary care visits (*p* = .06) for patients with 2 or more comorbidities  
• 10.3% reduction in ACSC inpatient admissions (*p* = .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 |

**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)
WHY DO SOME MEDICAL HOMES WORK WHILE OTHERS DON’T?

‘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.).

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<th>Nature vs. Nurture: Factors Driving PCMH Practice Success in 2 Regions of Pennsylvania</th>
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TRAJECTORY TO VALUE-BASED PURCHASING
PCMH part of a larger framework

HIT Infrastructure:
EHRs and population health management tools

Primary Care Capacity:
PCMH or advanced primary care

Care Coordination:
Coordination of care across medical neighborhood & community supports for patient, families, & caregivers

Value/Outcome Measurement:
Reporting of quality, utilization and patient engagement & population health measures

Value-Based Purchasing:
Reimbursement tied to performance on value

Alternative Payment Models (APMs): ACOs, PCMH, & other value based arrangements

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

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