National Briefing Webinar
Marci Nielsen, PhD, MPH
February 11, 2016
AGENDA

• PCPCC:
  – Who we are & what we do

• 2015 Annual Evidence Report:
  – What we studied & what we learned

• Paying for Value
  – Where delivery reform meets payment reform
  – What’s Next?

• Q & A
Patient-Centered Primary Care (PCPCC)
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
Capitol Hill Briefing hosted by:
The Primary Care Caucus

Co-Chairs
Honorable Joe Courtney (D-CT)
Honorable David Rouzer (R-NC)
Section One:
A CHANGING POLICY LANDSCAPE

#PCMHEvidence
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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

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.
PAYING NOW... OR... PAYING LATER

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

PAYMENT REFORM AND MEDICARE

Health & Human Services

- Shift 30% of Medicare FFS payments to value through APMs by 2016, 50% by 2018
- Created of Health Care Payment Learning & Action Network
- Investment in Multi-payer Efforts

Congress

- Passage of Medicare Access and CHIP Reauthorization Act (MACRA)
  - Merit-based Incentive Payment System (MIPS)
  - Alternative Payment Models (APMs)

HCP LAN
Health Care Payment Learning & Action Network

https://hcp-lan.org/

http://doctorwhostories.wikia.com/wiki/The_Macra_Terror_(TS)
PAYMENT REFORM & PCMH

• Fee-for service fails to compensate for PCMH scope of services – esp for small and independent practices
  • Numerous Alternative Payment Models (APMs) can support PCMH
  • Evidence does not point to single payment model that best supports PCMH

Payment Innovation Models

<table>
<thead>
<tr>
<th>Payment model</th>
<th>Description</th>
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<tbody>
<tr>
<td>Enhanced Fee-for-Service (FFS)</td>
<td>Increased FFS payments to practices that are recognized and/or functioning as PCMHs</td>
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<tr>
<td>FFS with PCMH-specific billing codes</td>
<td>Practices can bill for new PCMH-related activities (i.e. care coordination)</td>
</tr>
<tr>
<td>Pay-for-Performance</td>
<td>Practices are paid more for meeting process measures (HEDIS), utilization targets (ED use, generic prescribing), and/or improving patient experience</td>
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<tr>
<td>Per-Member-Per-Month (PMPM) Payments</td>
<td>Practices are paid a capitated monthly fee in addition to typical FFS billing, often adjusted for PCMH recognition level, or degree of care coordination expected</td>
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<td>Shared Savings</td>
<td>Practices are rewarded with a portion of savings if the total cost of care for their patient panel increases more slowly than a preset target and quality thresholds are met</td>
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<tr>
<td>Comprehensive or Population-based Payment</td>
<td>Partial or complete risk for total cost of care (risk adjusted), to include new models of &quot;direct primary care&quot;</td>
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Section Two:
NEW EVIDENCE FOR PCMH AND INNOVATIONS IN PRIMARY CARE

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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
LIMITATIONS

• Several reports published this year fall outside the scope of our inclusion criteria
  – We track these studies on our PCMH Map
• Does not include studies focused on disease-specific, non-primary care medical homes
• Generally include only the measures that reach statistical significance
• Studies included vary significantly
• DEFINING & MEASURING PCMH REMAINS A CHALLENGE
RESULTS: TRENDS

($n^1 = $Improvement in measure/$n^2 = $Measure assessed by study$)

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<th>Aggregated Outcomes from the 30 Studies</th>
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<table>
<thead>
<tr>
<th>23 of 25</th>
<th>studies that reported on utilization measures</th>
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<tr>
<td>23 of 25</td>
<td>found reductions in one or more measures</td>
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DETAILS: Utilization

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

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.
Section Three: DISCUSSION OF FINDINGS AND IMPLICATIONS

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KEY FINDING

• 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)

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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.).

**NATURE VS. NURTURE: Factors Driving PCMH Practice Success in 2 Regions of Pennsylvania**

<table>
<thead>
<tr>
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<th>Southeast Region</th>
<th>Northeast Region</th>
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<tbody>
<tr>
<td><strong>Nature</strong> Practices</td>
<td>• Mostly small, independent practices • A few very large academic medical centers and FQHCs</td>
<td>• Several “right-size” (medium-sized) practices • Solo practices often belonged to larger medical group • Strong relationship with hospitals</td>
</tr>
<tr>
<td>Patient population</td>
<td>• Many had significant economic hardship</td>
<td>• Less diverse, fewer with economic challenges</td>
</tr>
<tr>
<td><strong>Nurture</strong> Quality improvement focus</td>
<td>• QI focused almost exclusively on diabetes care</td>
<td>• Focused on multiple chronic conditions</td>
</tr>
<tr>
<td>Implementation</td>
<td>• Fairly rushed implementation, 1st region in the initiative to launch • Only 1/3 of practices had EHRs at the beginning of implementation</td>
<td>• Had opportunity to learn from other regions • All practices had EHRs at beginning of implementation</td>
</tr>
<tr>
<td>Payment model</td>
<td>• Practices received PMPM after earning NCQA recognition • Payments not contingent upon hiring care manager</td>
<td>• Practices were not required to have NCQA recognition until 18 months into implementation 2 streams of payment: • 1 for care management and • 1 for practice transformation</td>
</tr>
<tr>
<td></td>
<td>No opportunity for shared savings until year 4 (after initial JAMA study was published)</td>
<td>Opportunity for shared savings tied to quality improvement</td>
</tr>
<tr>
<td>Payer support</td>
<td>In many practices, no data and no technical support provided</td>
<td>Provided practices with ED and inpatient notification and reports from the beginning of implementation</td>
</tr>
</tbody>
</table>
KEY FINDING

• 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
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):** Supporting ACOs, PCMH, & other value based arrangements

Source: THINC - Taconic Health Information Network and Community
APM FRAMEWORK WORK GROUP

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Category 4</th>
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<tbody>
<tr>
<td>Fee for Service – No Link to Quality &amp; Value</td>
<td>Fee for Service – Link to Quality &amp; Value</td>
<td>APMs Built on Fee-for-Service Architecture</td>
<td>Population-Based Payment</td>
</tr>
</tbody>
</table>

- **A**: Foundational Payments for Infrastructure & Operations
- **B**: Pay for Reporting
- **C**: Rewards for Performance
- **D**: Rewards and Penalties for Performance
- **A**: APMs with Upside Gainsharing
- **B**: APMs with Upside Gainsharing/Downside Risk
- **A**: Condition-Specific Population-Based Payment
- **B**: Comprehensive Population-Based Payment

- The LAN’s Alternative Payment Model Framework and Progress Tracking (APM FPT) Work Group was successful in developing a Framework for categorizing APMs.

- Within the APM framework, population-based-payment models fall into categories some of 3 and 4.
MACRA – MIPS & APMS

Providers Must Choose FFS + PFP\(^1\) or Accountable Care

**Merit-Based Incentive Payment System (MIPS)**

- **2015:H2 – 2019:** 0.5% annual update
- **2018:** Last year of separate MU, PQRS, and VBPM\(^2\) penalties
- **2020 – 2025:** Frozen payment rates
- **2022 and on:** -9% to +27\(^2\) at risk
- **2026 and on:** 0.25% annual update

**Advanced Alternative Payment Models\(^3\)**

- **2015:H2 – 2019:** 0.5% annual update
- **2019 - 2024:** 5% participation bonus
- **2019 - 2020:** 25% Medicare revenue requirement
- **2021 and on:** Ramped up Medicare or all-payer revenue requirements

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1. Pay for performance.
2. Value-based payment modifier.
3. Positive adjustments for professionals with scores above the benchmark may be scaled by a factor of up to 3 times the negative adjustment limit to ensure budget neutrality. In addition, top performers may earn additional adjustments of up to 10 percent.
4. APM participants who are close to but fall short of APM bonus requirements will not qualify for bonus but can report MIPS measures and receive incentives or can decline to participate in MIPS.

Source: Medicare Access and CHIP Reauthorization Act of 2015; Advisory Board research and analysis. PATEL, KAVITA, APA Presentation, November 2015
### MULTI-PAYER COLLABORATIVES: Beyond early evaluations

<table>
<thead>
<tr>
<th>COMPREHENSIVE PRIMARY CARE INITIATIVE (CPC)</th>
<th>MULTI-PAYER ADVANCED PRIMARY CARE DEMONSTRATION (MAPCP)</th>
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<tbody>
<tr>
<td>• 5 out of 7 regions reported cost and/or utilization improvements</td>
<td>6 out of 8 MAPCP states found cost and/or utilization improvements</td>
</tr>
<tr>
<td>• Arkansas</td>
<td>• Michigan</td>
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<tr>
<td>• Colorado</td>
<td>• Pennsylvania</td>
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<tr>
<td>• Hudson Valley New York</td>
<td>• New York</td>
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<td>• New Jersey</td>
<td>• North Caroline</td>
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<td>• Oregon</td>
<td>• Rhode Island</td>
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<td>• Vermont</td>
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KEY FINDING

ASSESSING AND PROMOTING VALUE

– BETTER MEASURES & DEFINITIONS:

• Variation across study measures -- and PCMH initiatives – make for challenging evaluations and expectations (patients, providers, payers)

Payment Reform to Define PCMH

The Centers for Medicare and Medicaid Services (CMS) will define PCMH certification for the purpose of payment incentives as part of the Medicare Access and CHIP Reauthorization Act (MACRA). This provides an important opportunity to unify around a clear PCMH definition and recognition process that offers measurable value and impact to patients, providers, and payers, as well as to researchers evaluating the model.
1. Support more than 140,000 clinicians in their practice transformation work
2. Improve health outcomes for millions of Medicare, Medicaid and CHIP beneficiaries and other patients
3. Reduce unnecessary hospitalizations for 5 million patients
4. Generate $1 to $4 billion in savings to the federal government and commercial payers
5. Sustain efficient care delivery by reducing unnecessary testing and procedures
6. Build the evidence base on practice transformation so that effective solutions can be scaled
SELECT PCPCC TCPI GOALS

– Define and support patient-practice partnerships
– Promote clinic-to-community linkages
SAVE THE DATES

– Safety Net Medical Home Grantee Symposium *(CareFirst BlueCross BlueShield of Maryland, co-hosted by PCPCC)*
  • March 15, 2016; 9:00am – 3:00pm
  • The Newseum, 555 Pennsylvania Ave NW, Washington, DC 20001

– PCPCC’s March National Briefing webinar
  • Thursday, March 31st at 1:00pm ET
  • “The Primary Care Imperative: New Evidence Shows Importance of Investment in Patient-Centered Medical Homes” *(Authored by National Business Group Health and the PCPCC)*

– National Medical Home Summit *(Co-hosted by the PCPCC)*
  • June 6 & 7th
  • Grand Hyatt, Washington DC

– Celebrate the PCPCC’S 10 year Anniversary – Annual Meeting & Awards Dinner
  • November 9th and 10th, Grand Hyatt, Washington DC
Please download the report, sign up for our free monthly newsletter and alerts, or support our efforts as by becoming executive member at:

www.pcpcc.org