What Do We Know about the Effects of Medical Homes on Health Care Costs?

Meredith Rosenthal, PhD
Harvard School of Public Health

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Knowledge of the Peer-Reviewed Variety

• Foundational literature on the impact of primary care (measured a variety of ways) on costs and outcomes (e.g., Starfield et al., 2005, Friedberg et al., 2010)

• Analysis of the impact of the Chronic Care Model (e.g., Coleman et al., 2009)

• Geisinger (Gilfillan et al., 2010, Maeng et al., 2012)

• Group Health of Puget Sound (Reid et al., 2009, Reid et al., 2010)

• A generally negative (null) and very blurry picture in the rest of the literature from 2 recent reviews
Lessons From Multi-Payer PCMH Pilots (not yet peer-reviewed)

- Evaluation of multi-payer pilots in RI, CO, OH, Rochester NY, and PA
- Qualitative and quantitative analyses
- Pilots vary in terms of technical and financial support, breadth and depth
Lessons From Multi-Payer PCMH Pilots (not yet peer-reviewed)

- Small practices can become medical homes in the NCQA sense with money and technical assistance.
- Getting broad participation of payers and getting them to chip in for all their patients (including ASO) is a major morale issue for practices in PCMH pilots.
- Technical assistance seems to be most helpful (according to practices) if it is local and on the ground – not webinars from an undisclosed location.
- Building a medical home from the ground up requires a sequence – 1. teams, systems to measure and track care; 2. quality improvement; 3. engage medical neighborhood and coordinate care.
- Cost drivers most likely to be impacted are ED visits, hospitalization for exacerbation of chronic illness: the first is much easier to influence and measure.
- Total cost of care savings at two years is unlikely and unrealistic.
Observation of recent PCMH pilots suggests that with adequate financial and technical support small practices can make significant strides in adoption of medical home structures and processes.

Logical sequence of transformation and the fact that complex change takes time means cost savings won’t be instant.

Aspirations for cost savings reside in better care coordination/care transitions. Cost savings more likely if PCMHs:

- Have strong information linkages with hospitals and specialists
- Are working within a context where hospital and specialist incentives are aligned
- Capitalizing on medical homes may require ACOs, payment reforms that bring specialists and hospitals to the table.
Knowledge of the Commercial Variety

June 2012:

- The U.S.’ largest private payers, including Humana, United HealthCare, Aetna, and a number of the Blue plans commit to support CMS’ Comprehensive Primary Care Initiative
- CareFirst BlueCross BlueShield, the District’s largest private insurer, reports better care and savings of almost $40 million

April 2012:

- Horizon BlueCross BlueShield (NJ) announces improvements in quality measures and utilization indicators, as well as decreased costs of 10% PMPM

January 2012:

- Citing early results from Colorado, New Hampshire, and New York, Wellpoint plans to increase its investment in all primary care markets by 2014 (increasing base fee schedule by 10%, paying for e-visits, and engaging in shared savings)
- Ohio’s Office of Health Transformation plans to spend $1 million to help transition 50 facilities into PCMHs and train 1,000 – 1,500 clinicians to practice under the model