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

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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Lessons From Multi-Payer PCMH Pilots (not yet peer-reviewed)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Lessons From Multi-Payer PCMH Pilots (not yet peer-reviewed)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

What I See As a Researcher

- 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