CHPRE Newsletter

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Published Work

Journal of General Internal Medicine
The CareFirst Patient-Centered Medical Home Program: Cost and Utilization Effects in Its First Three Years

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ABSTRACT

Background - Enhanced primary care models have diffused slowly and shown uneven results. Because their structural features are costly and challenging for small practices to implement, they offer modest rewards for improved performance, and improvement takes time.

Objective - To test whether a patient-centered medical home (PCMH) model that significantly rewarded cost savings and accommodated small primary care practices was associated with lower spending, fewer hospital admissions, and fewer emergency room visits.

Design - We compared medical care expenditures and utilization among adults who participated in the PCMH program to adults who did not participate. We computed difference-in-difference estimates using two-part multivariate generalized linear models for expenditures and negative binomial models for utilization. Control variables included patient demographics, county, chronic condition indicators, and illness severity.

Participants - A total of 1,433,297 adults aged 18–64 years, residing in Maryland, Virginia, and the District of Columbia, and insured by CareFirst for at least 3 consecutive months between 2010 and 2013.

Intervention - CareFirst implemented enhanced fee-for-service payments to the practices, offered a large retrospective bonus if annual cost and quality targets were exceeded, and provided information and care coordination support.

Measures - Outcomes were quarterly claims expenditures per member for all covered services, inpatient care, emergency care, and prescription drugs, and quarterly inpatient admissions and emergency room visits.

Results - By the third intervention year, annual adjusted total claims payments were $109 per participating member (95 % CI: −$192, −$27), or 2.8 % lower than before the program and compared to those who did not participate. Forty-two percent of the overall decline in spending was explained by lower inpatient care, emergency care, and prescription drug spending. Much of the reduction in inpatient and emergency spending was explained by lower utilization of services.

Conclusions - A PCMH model that does not require practices to make infrastructure investments and that rewards cost savings can reduce spending and utilization.

KEY WORDS - patient-centered careprimary care redesignprogram evaluation

Electronic supplementary material - The online version of this article (doi:10.1007/s11606-016-3814-z) contains supplementary material, which is available to authorized users.

INTRODUCTION

Numerous models have been proposed for enhancing primary care and improving care coordination, while pursuing the triple aim of greater access, lower costs, and improved quality. These models range from patient-centered medical homes (PCMH) to accountable care organizations (ACOs).1 Many small physician practices, which provide most of the primary care services delivered in the United States, struggle to meet the requirements of even a standard PCMH model, citing large investments in infrastructure such as electronic medical records, retraining, workflow redesign, ongoing certification, and additional care coordination personnel, which can cost up to $100,000 per physician by some estimates.2–4 Some observers have argued that policy initiatives aimed at promoting these models could unintentionally lead to greater consolidation of physician practices and spell the end of small-scale practices.5

This issue:

'The CareFirst Patient-Centered Medical Home Program: Cost and Utilization Effects in Its First Three Years' article will appear in the November 2016 issue of the Journal of General Internal Medicine.

For more about CHPRE go to **chpre.org**

GMU's CareFirst Evaluation Team Celebrates Successes at the 2016 Team Retreat

August 2016

This year we gathered at Top of the Town in Rossyln, VA. Here are some of our favorite memories from the retreat!

GMU-CareFirst Evaluation Team photo on terrace.

The team completes team building activities to improve teamwork, develop trust, and enhance group problem solving skills.

Alison Cuellar, PhD giving a progress update for the Quantitative Analysis.

Visit to the White House

August 2016

CHPRE staff and research assistants tour the West Wing with former CHPRE graduate research assistant, Stephen Petzinger, who currently serves as a Program Examiner in the Health Division for the Office of Management and Budget.

Fall Health Policy Seminar Series

The seminars will take place from 12:00pm-1:30pm - Merten Hall (Room 1204)

Health Care Spending Trends
Wednesday, September 21
Abe Dunn PhD
Senior Economist
U.S. Department of Commerce

Nurse Practitioner's Quality of Care
Monday, October 17
Ellen Kurtzman PhD, RN
Associate Professor
George Washington University

Online Physician Ratings & Quality Transparency
Thursday, November 17
Gordon Gao PhD
Associate Professor
University of Maryland Business School

Donald Trump's Proposed Healthcare Plan - Taking a closer look from various perspectives.

By Valerie Neff Newitt, April 2016

Political criticism is rarely kind. After last month's unveiling of GOP presidential frontrunner Donald Trump's "Healthcare Reform to Make America Great Again," (www.donaldjtrump.com/positions/healthcare-reform), vitriolic commentary was in no short supply.

"Donald Trump's healthcare plan shows his complete disregard for expertise," wrote Peter Suderman at Reason.com. "It is a bunch of words somewhat related to health policy that his campaign is calling a 'plan.' Those words demonstrate not only that Trump does not understand healthcare policy, but that he cannot be bothered to hire anyone who does to work with him."

Politico's Paul Demko wrote that the plan was actually "Trump's healthcare surrender. While the billionaire businessman has repeatedly said that poor people shouldn't be 'dying in the street,' for instance, now he wants to turn the country's biggest health program for the poor into a block grant and give tax breaks to people who buy their own insurance."

Putting politics aside, how does the plan resonate with others who consider health policies from multiple perspectives? ADVANCE offers the following points of view for readers' consideration.

An Academic Perspective

Len M. Nichols, PhD, professor, and director of the Center for Health Policy Research and Ethics, College of Health and Human Services at George Mason University, was quick to weigh in with the following point-by-point insights on Trumps seven-point plan (shown in italics):

Point 1 - "Completely repeal Obamacare. Our elected representatives must eliminate the individual mandate. No person should be required to buy insurance unless he or she wants to." Nichols noted, "Over 20 million people would lose coverage the day that repeal becomes effective, causing tremendous disruption in every state. Complete repeal of cost-saving provisions means all the Medicare payment reforms which have held cost growth below historical norms since 2010 will go away. This means less coverage, and higher cost from the outset."

Point 2 - "Modify existing law that inhibits the sale of health insurance across state lines. As long as the plan purchased complies with state requirements, any vendor ought to be able to offer insurance in any state. By allowing full competition in this market, insurance costs will go down and consumer satisfaction will go up."

"'Across state lines' sounds great, but no serious actuary or economist ever supported this, unless there are federal minimum standards like those in the ACA for guaranteed issue (GI) and modified community rating (MCR)," explained Nichols. "But Trump's Point 1 repeals ACA in toto, so we're back to the historical version of this proposal. I admit it sounds great, and it appeals to the ideological wing of the Republican Party. But in reality, it is not designed to improve consumer options in the insurance market, but rather to enable insurers to select their preferred set of regulations. In a world of ACA repeal - one with no GI or MCR in all states - insurers will find states that have no rules about selling to all or restrictions on how much they can charge those who have health conditions. They will officially domicile there, and use the rules of that state to cherry-pick the healthy in states that try to have rules. This is what proponents of this policy have always wanted (this long pre-dates Trump and I doubt he is aware). They want no restrictions on medical underwriting, which would lead to lower premiums for the healthy, and much higher premiums - and lack of insurance - for those with pre-existing conditions. They would be left in the cold."

Point 3 - "Allow individuals to fully deduct health insurance premium payments from their tax returns under the current tax system. Businesses are allowed to take these deductions so why wouldn't Congress allow individuals the same exemptions? As we allow the free market to provide insurance coverage opportunities to companies and individuals, we must also make sure that no one slips through the cracks simply because they cannot afford insurance. We must review basic options for Medicaid and work with states to ensure that those who want healthcare coverage can have it."

"This is a simple matter of tax fairness, and it would help encourage more people who do not have group coverage at work to buy coverage. So this is a good 'fairness' idea," said Nichols.

Point 4 - "Allow individuals to use Health Savings Accounts (HSAs). Contributions into HSAs should be tax-free and should be allowed to accumulate. These accounts would become part of the estate of the individual and could be passed on to heirs without fear of any death penalty. These plans should be particularly attractive to young people who are healthy and can afford high-deductible insurance plans. These funds can be used by any member of a family without penalty. The flexibility and security provided by HSAs will be of great benefit to all who participate."

Nichols clarified, "This is a liberalization of current rules on HSAs, which are somewhat restrictive at the moment. HSAs are seen as ways to make high-deductible plans more palatable to people who generally prefer more generous plans. But note, high deductibles are touted because they force consumers to bear cost, put 'skin in the game,' etc. HSAs defer the pinch of that skin, i.e., they negate the avowed purpose of the high deductible in the first place. This point basically enables high-income healthy individuals to avoid out-of-pocket payments for care, which will not help hold down healthcare costs."

Point 5 - "Require price transparency from all healthcare providers, especially doctors and healthcare organizations like clinics and hospitals. Individuals should be able to shop to find the best prices for procedures, exams or any other medical-related procedure."

"Transparency is generally good, but be careful what you wish for," cautioned Nichols. "There are 9000 CPT codes. medical prices are complicated, and the rates vary by payer. The biggest problems consumers have are: (1) the same set of doctor/hospital charges will cost consumers different amounts, depending on which insurer they have, and (2) it's pretty hard to anticipate all services you will need in a hospitalization before you are admitted. Without insurer-specific transparent tools, this plank will not help consumers much."

Point 6 - "Block-grant Medicaid to the states. Nearly every state already offers benefits be-

yond what is required in the current Medicaid structure. The state governments know their people best and can manage the administration of Medicaid far better without federal overhead. States will have the incentives to seek out and eliminate fraud, waste and abuse to preserve our precious resources."

"Both God and the devil live in these details," said Nichols. "If the block-grant approach is reasonable (risk adjusted per capita caps), this could be humane and wise. But if the block-grant proposal is a fixed pie/global budget mostly designed just to shift costs to the states, then this is actually a bait-and-switch attempt to reduce our society's commitment to the most vulnerable among us. It's hard to determine the true objective from the language released so far."

Point 7 - "Remove barriers to entry into free markets for drug providers that offer safe, reliable and cheaper products. Congress will need the courage to step away from the special interests and do what is right for America. Though the pharmaceutical industry is in the private sector, drug companies provide a public service. Allowing consumers access to imported, safe and dependable drugs from overseas will bring more options to consumers."

"Re-importation sounds good, but would in fact be counterproductive in the extreme," said Nichols. "The U.S. does pay the highest prices for drugs, because our government is prohibited by Congress (which is apparently sufficiently controlled by pharma) from negotiating with drug companies. That can be fixed without re-importation. But if we were allowed re-importation from Canada, there simply would not be enough drugs sold to Canada to flood back in to satisfy our much larger demand. Furthermore, drug companies would likely raise prices overseas and not lower them here, so U.S. consumers would not gain much and consumers overseas would lose. Ultimately, everyone would lose, because less revenue means less research and development, and less future innovation."

See entire article at http://chpre.org/latest-news/

Oncologists Blast New Medicare Part B Drug Plan Proposed payment model called 'misguided,' 'dangerous'

by Joyce Frieden - News Editor, MedPage Today

The reviews are in from the oncology community for the Centers for Medicare & Medicaid Services (CMS) proposal to restructure payment for drugs under Part B of the Medicare program and they're overwhelmingly negative.

"On both policy and process, CMS missed the mark with this proposal," the Association of Community Cancer Centers said in a statement Wednesday. "The agency sought no stakeholder input and is providing little turnaround time before implementation of such a sweeping, misguided change in Medicare reimbursement."

The proposed payment model "is an inappropriate, dangerous, and perverse mandatory experiment on the cancer care of seniors who are covered by Medicare," wrote Bruce Gould, MD, president of the Community Oncology Alliance, in a letter to CMS acting administrator Andy Slavitt and Health and Human Services Secretary Sylvia Burwell. "This experiment is a misguided government intrusion on the treatment of seniors with cancer and a very dangerous precedent in severing the sacred physicianpatient bond."

The model, which CMS announced Tuesday, would replace the current Medicare reimbursement the average sales price of the drug plus a 6% addon fee to cover costs with a rate of the average sales price plus 2.5%, plus a flat fee of $16.80 per drug per day. The flat fee would be adjusted at the beginning of each year.

Since Medicare Part B pays for drugs that are administered in a physician's office or hospital outpatient department, oncologists who administer many cancer drugs in their offices would be greatly affected by the new payment scheme, which CMS officials hope will encourage physicians to chose more costeffective drugs rather than more expensive drugs, which provide higher reimbursements under the current system.

It wasn't just the oncology community that was unhappy. "Yesterday's announcement marks another troubling example of unelected bureaucrats making decisions behind closed doors that impact the American people and their healthcare," said representatives Fred Upton (RMich.), Kevin Brady (RTexas), and Sen. Orrin Hatch (RUtah) in a statement issued Wednesday.

"This decision was made with a complete lack of transparency and clear disregard for the people and stakeholders who will be impacted the most. [CMS's] proposed experiment on seniors stands to limit access to the critical care the sickest Medicare beneficiaries rely on, as well as disrupt how health care providers serve patients in the future. The model could ultimately result in seniors' receiving different standards of care based solely on where they live in the country."

But others had a different view. "I applaud the idea," Len Nichols, PhD, director of the Center for Health Policy Research and Ethics at George Mason University, in Fairfax, Va., said in an interview with MedPage Today. "It won't solve all our problems because it presumes that there's a choice [of medications] and in many of the most recent cancer [drugs] there's no choice. But at the same time it is a move in the right direction."

The Department of Health and Human Services (HHS) also released positive outside comments about the CMS proposal. "Part B drug payments are generally not based on value, or on the competitive approaches that have helped bring a value focus to Part D drug payments," said Mark McClellan, MD, PhD, former CMS administrator under President George W. Bush. "While not all of these ideas will work out, testing new Part B drug payment models and finding more effective ways to encourage drug innovation while avoiding unnecessary costs is very important for Medicare beneficiaries and the Medicare program."

"The new models proposed ... by CMS are an important step in our goal to deliver the best, valuebased care to patients," said Vincent Rajkumar, MD, of the Mayo Clinic in Rochester, Minn., in another statement released by HHS. "It is critical that these models are tested if we are to provide access to the most effective treatments to our patients in a manner that is affordable and valuedriven."

Contributing Writer Shannon Firth contributed to this story.

Insurers, Academics Protest High Cost Drugs, Propose Solutions
Allowing Medicare to negotiate drug prices seen as useful step

by Shannon Firth

Insurers and academics berated pharmaceutical companies for jacking up drug prices and suggested ways to alleviate the problem at the America's Health Insurance Plans National Health Policy Conference on Wednesday.

The U.S. spent $457 billion on prescription drugs in 2015, according to the Centers for Medicare & Medicaid Services. Many experts say it's not so much the absolute amount but the rate of increase, 12% from 2013 to 2014, that worries them.

Much of the growth is due to a shift in prescribing higher cost drugs and price increases on existing drugs.

Diane Holder, president of UPMC Insurance Services Division in Pittsburgh, spoke of a friend and colleague who has hepatitis C but is not covered for expensive new curative treatments such as Sovaldi or Viekira Pak. The friend told Holder she was considering mortgaging her house to pay for drugs outofpocket.

Holder said she thought to herself, "It's just wrong ... there's a cure" for the disease.

Another insurance executive, John Bennett, MD, president and CEO of Capital District Physicians' Health Plan in Albany, N.Y., said the problem with healthcare today isn't overutilization but the unit cost of needed medications, particularly specialty drugs.

"If we told you now that in your town there was one supplier of electricity and gas and water and that supplier was allowed to charge you whatever they want, would there not be mass chaos, riots in the streets?

He continued, "Why aren't we angry that our grandparents can't get their arthritis drugs without spending their life savings?"

Len Nichols, PhD, a professor of health policy at George Mason University, in Fairfax, Va., said the root of the problem is that the drug market is out of balance, because of America's resistance to regulation. But he said, "We don't have a free market in drugs."

He continued, "By construction, we made monopolies for the purpose of encouraging innovation," alluding to patents on innovator drugs. "Maybe you want to think about changing the rules, so that the rules serve market forces better."

Nichols critiqued strategies presented by Democratic candidates Hillary Clinton and Bernie Sanders.

These have included requiring manufacturers to:

- Meet a set spending ratio between research and development versus marketing
- Explain how they set their prices and the U.S. tax credits they receive
- Make public their transaction prices and profits from overseas

Nichols argued that trying to calculate what drugmakers spend on research is a "fool's errand" that would be unfair and accomplish little besides employing lawyers and accountants. He also noted that pharma companies need profits on current drugs to fund future innovation.

"You do not want to kill all cash flow," he said. "What matters is how are they setting a price today based upon today's market conditions and anticipating conditions in the future and what kind of cash flow does that generate today," he told MedPage Today.

Nichols also dismissed as unworkable such proposals as capping outofpocket costs, setting price controls, and allowing drug imports from other countries.

Other ideas may be more practical, he suggested. Using reference prices and relative efficacy information to determine a price something European governments do could be a solution.

He also noted that Clinton, Sanders, and Republican frontrunner Donald Trump have favored requiring Medicare to negotiate drug prices to a degree in Part B, Part D, or both.

Nichols said, "Allowing Medicare to negotiate gives you some power and that would give you [insurers] power to negotiate on the backend ... Medicare can't say 'no,' now. That's a problem when they can charge you a hundred thousand bucks an episode to extend a life for two weeks."

Another solution could be to tie marketing exclusivity to the launch price level of a drug. He outlined his solution in a recent policy brief.

"You pick a price that's too high, you don't get the exclusivity. You only get the exclusivity protection that extends past the patent if you price it reasonably."

The key, he said, is picking a price that is reasonable enough to allow capital to continue to feed the market and spur innovation.

Len Nichols on CNBC's Nightly Business Report Discussing the Growing Costs of Prescription Drugs

http://nbr.com/2016/04/14/nightly-business-report-april-14-2016/

CHPRE | In the News

Catching Up with Len Nichols, Ph.D.

Accountable Care News - August 2016

ACN: *What kind of imprint will MACRA have on accountable care organizations (ACOs)?*

Len Nichols: MACRA will push more ACO's to bearing downside risk. That is the fundamental thrust, gain (and possible pain) for performance risk.

ACN: *What do you see as the main challenges of developing alternative payment models (APMs)?*

Len Nichols: ACO-like organizations, with years of experience, should be mostly ready. The biggest challenges are for small practices without information system sophistication. Many electronic health records (EHRs) cannot yield custom reports to support decisions about which measures to choose for evaluation. Thus, many small practices, due to EHR limitations, are flying blind in a world in which, according to the proposed MACRA rule, they are competing in a zero sum game against large sophisticated practices. Not fair, not wise. Hopefully CMS will revise rules and timing to give these practices a fighting chance.

ACN:*What are the key components of a reformed healthcare delivery system?*

Len Nichols: The key is to align the interests of providers, whether in an ACO or not, to lower costs for society. This requires management of total cost of care, patient experience and patient outcomes. If hospitals, physicians or plans do not see how they can gain from a new system, it will fail. Therefore, both structure and communication about the structure of a new incentive system really matter.

ACN: *From your vantage point as an economist, how can the healthcare industry become fiscally responsible?*

Len Nichols: Number one, all creatures respond to incentives so health providers are no better or worse than others. Our incentives have been slanted to favor more care as opposed to better care. And some of our patients have also been convinced that more is always better, when it is manifestly not. So the main thing our industry has to do is to accept that we must lower cost growth per capita and not hope to be exempt from new incentive structures. Twenty percent PhRMA margins, for example, will end, and pretending otherwise will be increasingly unacceptable and likely to provoke policy backlash.

ACN: *What more do ACOs need to do to achieve a value-based healthcare system?*

Len Nichols: Some ACOs have been successful, seemingly by paying attention to what patient-centered primary care can do, and to low cost/high touch ways to reduce unnecessary emergency use and admissions. The next frontier will be enlisting specialists with proper incentives to help reduce costs and to engage in secondary prevention—-stopping pre-diabetics and pre-heart condition patients from developing full blown diseases that need to be managed and contained as opposed to merely prevented. Then and only then can we reduce costs by one-third, which the Institute of Medicine said was possible in 2009.

Presentations | Len Nichols, Ph.D.

Upcoming Talks:

September 26 • Brookings - Health Care Markets Summit : Health Policy Suggestions for a New Administration

September 30 • CAPC Panel on Health Policy Post-Election

October 7 • Arkansas Hospital Assoc. - Health Policy Post-Election

October 11 • Catholic Conference on Health - The Role of Government in Health Care

October 24 • PhRMA State Policy Convention: Health Policy Post-Election

Past Presentations:

May 18 • Medicaid Managed Care Congress 2016

June 14 • RWJF Conference on Culture of Health

June 17 • NHRI Pay Reform Summit

July 12 • Commonwealth Fund July Board Retreat : Prescription Drug Pricing Policy Options

July 13 • Newseum : Health Policy Post Election

September 22 • Kansas Association for the Medically Underserved - Len Nichols speaking "This Election WILL End: How Will Medicaid, the ACA and Health Policy Change?"