# The Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration: Year Two Evaluation Findings

Susan G. Haber, ScD
RTI International

Presented at:
Eighth National Medical Home Summit
Washington, DC
June 6, 2016

# Presentation Overview

1. Brief overview of the MAPCP Demonstration
2. Overview of evaluation methodology
3. Overview of Year Two findings
4. Conclusions

# MAPCP Demonstration Overview

- CMS (Medicare) joined ongoing state-sponsored initiatives in 8 states
  - NY, RI, VT, NC, MN, ME, MI, PA
- Initiatives had to include Medicaid and commercial payers
- Participating practices received PMPM payments and other supports to facilitate transformation to PCMHs

# MAPCP State Initiatives

- MAPCP Demonstrations began in 2011 through 2012
- Initially a 3 year demonstration
  - Extended until the end of 2016 in some states: NY, RI, VT, ME, and MI
  - Evaluation goes through December 2014

| State | Initiative Name | Initiative Start |
|---|---|---|
| **Cohort 1: MAPCP Demonstration Start = July 2011** | | |
| New York | Adirondack Medical Home Demonstration | January 2010 |
| Rhode Island | Chronic Care Sustainability Initiative | October 2008 |
| Vermont | Blueprint for Health | July 2008 |
| **Cohort 2: MAPCP Demonstration Start = October 2011** | | |
| Minnesota | Health Care Homes | July 2009 |
| North Carolina | Community Care of North Carolina | April 2003 |
| **Cohort 3: MAPCP Demonstration Start = January 2012** | | |
| Maine | Maine PCMH Pilot | January 2010 |
| Michigan | Michigan Primary Care Transformation Project | July 2010 |
| Pennsylvania | Chronic Care Initiative | October 2009 |

# MAPCP Demonstration Scope at End of Year Two

| State | Geographic Scope | All-Payer Participants | Medicare Participants | Participating Practices | Participating Providers | Payers (includes Medicare) |
|---|---|---|---|---|---|---|
| NY | 4 counties | 100,809 | 24,771 | 37 | 189 | 9 |
| RI | Statewide | 53,946 | 10,658 | 18 | 99 | 5 |
| VT | Statewide | 262,107 | 65,896 | 112 | 585 | 5 |
| MN | Statewide | 904,169 | 106,635 | 136 | 1,704 | — |
| NC | 7 counties | 83,301 | 30,842 | 42 | 150 | 4 |
| ME | Statewide | 125,232 | 52,485 | 71 | 482 | 5 |
| MI | Statewide | 1,151,518 | 267,568 | 314 | 1,618 | 5 |
| PA | 2 regions | 166,082 | 36,360 | 55 | 386 | 7 |
| Total | — | 2,847,164 | 595,215 | 785 | 5,213 | — |

# Medicare Practice Payment Structures, Year Two

| State | Base Payment Per Member Per Month | + Bonus | * |
|---|---|---|---|
| NY | $5.90 | + P4P bonus<br>(Payers contribute $0.50 PBPM) | ✓ |
| RI | $4.00/$5.50<br>(higher for in-house care coordinator) | + $0 - $0.50 P4P bonus PBPM | |
| VT | $1.20 - $2.39<br>(depending on NCQA score) | | ✓ |
| MN | $0 - $58.50<br>(depending on # of chronic conditions, mental illness, non-English speaking) | | |
| NC | $2.50/$3.00/$3.50<br>(depending on NCQA score) | | ✓ |
| ME | $6.95 | | ✓ |
| MI | $2.00/$6.50<br>(higher for in-house care coordinator) | + P4P bonus<br>(Payers contribute $3.00 PBPM) | ✓ |
| PA | $1.08 - $7.00<br>(depending on demo year, patient age) | + 40%-50% of shared savings<br>(compared to non-demo PCMHs) | |

* Payers in these states also paid supporting organizations (e.g., Community Health Teams)

# Evaluation Design

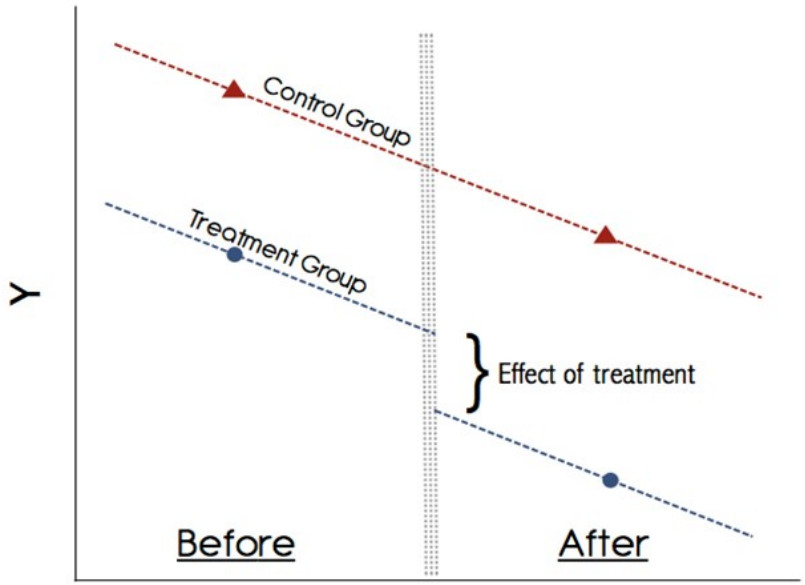
- Mixed methods evaluation
- Qualitative data sources
  - **Annual site visits**
  - Medicare and Medicaid beneficiary focus groups (late 2014)
- Quantitative data sources
  - **Medicare fee-for-service (FFS) beneficiary enrollment and claims data**
  - Medicaid enrollment and claims/encounter data
  - Medicare beneficiary survey (mid 2014)
  - Practice transformation survey (early 2015)

# Approach to Quantitative Analyses: Difference-in-Differences

- Selected comparison group (CG) practices
  - PCMH and non-PCMH CGs
  - Separate analyses for the two CGs
- Identified patients attributed to MAPCP and CG practices

- Compared change in outcomes among MAPCP attributed beneficiaries to change among CG attributed beneficiaries
  - Control for beneficiary, practice, and country characteristics

| | CG | MAPCP | Difference |
|---|---|---|---|
| Before | a | b | b-a |
| After | c | d | d-c |
| Change | c-a | d-b | (d-c)-(b-a) |



# Expectations for Outcomes

- Beneficiaries served by these transformed practices expected to have:
  - Better access to more coordinated, safer, and higher quality care
  - Better patient experience with care
  - More efficient utilization, including reductions in inpatient admissions, readmissions, ER visits and increases in primary care visits
  - Improved health outcomes
  - Reductions in total per capita expenditures, resulting in budget neutrality for Medicare

# Practice Transformation

- Practices required to obtain and maintain PCMH certification
  - Either NCQA or state-specific
- Practices required to meet additional state-specific requirements
  - e.g., health IT, expanded access, use of disease registries, participation in learning activities
- Care coordinators viewed as the MVP of the PCMH model
  - Focused on high risk patients, patients recently hospitalized or seen in ER, patients due for preventive services
- Practices experienced growing pains in implementing EHRs
  - Lack of interoperability across vendors posed barrier to data exchange
- Most practices felt payments were not adequate to support transformation

# Expenditures: Medicare FFS, First 2 Years ($ PBPM)

| State | Total | | Acute Care | | Post-acute Care | |
|---|---|---|---|---|---|---|
| | PCMH | Non-PCMH | PCMH | Non-PCMH | PCMH | Non-PCMH |
| NY | −26.82* | −17.36 | −27.94* | −10.19 | −1.98 | −3.32 |
| RI | −32.08 | −1.53 | −30.23 | −3.41 | −7.78 | 0.12 |
| VT | −31.17 | −65.35* | −0.22 | −21.08* | −19.06* | −20.16* |
| MN | — | 15.25 | — | 10.03 | — | 4.56 |
| NC | −14.54 | −13.74 | −4.67 | −15.78 | −3.69 | 3.51 |
| ME | 43.78 | 26.49 | 15.50 | 13.39 | 19.36 | 5.00 |
| MI | −83.43* | −17.09 | −38.70* | −7.59 | −18.66* | −10.33* |
| PA | −7.50 | −28.66 | −7.08 | −14.60 | 5.23 | −1.79 |

* = significant at p<0.10

•Medicare Part A and Part B expenditures, not including MAPCP fees paid to practices

# Utilization: Medicare FFS, First 2 Years (rate per 1,000 beneficiary quarters)

| State | All-Cause Admissions | | ER Visits Not Leading to Hospitalization | |
|---|---|---|---|---|
| | PCMH | Non-PCMH | PCMH | Non-PCMH |
| NY | −8.8* | −4.0* | −0.6 | −3.9 |
| RI | −3.4 | 2.8 | −5.6 | 0.2 |
| VT | 0.5 | 0.8 | 15.7* | 10.4* |
| MN | — | −0.1 | — | 5.1 |
| NC | −0.1 | 0.7 | 5.3 | −2.0 |
| ME | 1.2 | 3.7 | −12.5* | −10.1 |
| MI | −8.0* | −1.2 | 2.6 | 2.5 |
| PA | −2.0 | 1.8 | −3.7 | −1.7 |

* = significant at p<0.10

# Processes of Care: Medicare FFS, First 2 Years (percentage of beneficiaries receiving)

| State | HbA1C Testing | | Retinal Eye Examination | | Total Lipid Panel | |
|---|---|---|---|---|---|---|
| | PCMH | Non-PCMH | PCMH | Non-PCMH | PCMH | Non-PCMH |
| NY | 2.0 | 1.4 | 2.0* | 3.0* | 2.0 | 1.9 |
| RI | 7.9* | 7.9 | 2.7 | −0.0 | −1.8 | −0.3 |
| VT | −3.3 | −0.9 | −1.7 | −1.2 | −2.5 | −2.5 |
| MN | — | 1.0 | — | 2.4 | — | −1.1 |
| NC | 1.4* | 1.5* | −1.1 | −0.5 | 2.6 | 1.9 |
| ME | 1.5 | 1.7 | −2.0* | 2.1 | 2.6 | −1.1 |
| MI | −0.4 | 1.1* | −0.9 | −0.2 | −1.5 | −1.7 |
| PA | −0.0 | 0.9 | 0.5 | −0.5 | 2.3 | 0.8 |

* = significant at p<0.10

# Patient Safety and Health Outcomes: Medicare FFS, First 2 Years (rate per 1,000 beneficiary quarters)

| State | PQI Admissions—Overall | | PQI Admissions—Acute | | PQI Admissions—Chronic | |
|---|---|---|---|---|---|---|
| | PCMH | Non-PCMH | PCMH | Non-PCMH | PCMH | Non-PCMH |
| NY | −1.7 | −1.7 | −0.6 | −1.3 | −1.2 | −0.4 |
| RI | −1.5 | 1.2 | −0.7 | 0.4 | −0.7 | 0.8 |
| VT | 1.3 | 1.3* | 0.5 | 0.5 | 0.9 | 0.8* |
| MN | — | −0.4 | — | −0.2 | — | −0.1 |
| NC | 0.4 | 0.5 | 0.3 | 0.9* | 0.1 | −0.3 |
| ME | 0.5 | 0.3 | −0.1 | −0.5 | 0.7 | 0.8 |
| MI | −1.0 | −0.4 | −0.0 | −0.7 | −0.9 | 0.2 |
| PA | −0.1 | −0.1 | 0.5 | −0.2 | −0.6 | 0.0 |

* = significant at p<0.10

# Access to Care and Coordination of Care: Medicare FFS, First 2 Years

| State | Primary Care Visits (rate per 1,000 beneficiary quarters) | | 14-Day Follow-Up (rate per 1,000 beneficiaries with live discharge) | | 30-Day Readmissions (rate per 1,000 beneficiaries with live discharge) | |
|---|---|---|---|---|---|---|
| | PCMH | Non-PCMH | PCMH | Non-PCMH | PCMH | Non-PCMH |
| NY | −16.3 | 19.3 | −0.1 | 19.1 | −15.6 | 1.3 |
| RI | 64.4 | 19.6 | 7.2 | 10.9 | −30.0 | 23.5 |
| VT | −56.4 | −20.5 | 35.3 | −7.4 | −13.7 | −1.9 |
| MN | — | 10.6 | — | −6.2 | — | −22.7* |
| NC | −25.1 | −4.3 | −12.6 | 6.4 | 3.3 | 8.1 |
| ME | 20.7 | 56.9* | 70.3 | 2.6 | −14.7 | 6.7 |
| MI | −4.3 | 3.2 | 17.1 | 27.2* | −29.6* | −4.4 |
| PA | 61.3* | 56.1* | 43.9 | 44.8* | −6.5 | −8.6 |

* = significant at p<0.10

# Special Populations Total Expenditures: Medicare FFS, First 2 Years ($ PBPM)

| State | Multiple Chronic Conditions | | Behavioral Health Conditions | | Dually Eligible for Medicaid | |
|---|---|---|---|---|---|---|
| | PCMH | Non-PCMH | PCMH | Non-PCMH | PCMH | Non-PCMH |
| NY | −67.27 | −63.29 | −56.25 | −52.70 | −9.32 | 5.94 |
| RI | −99.82 | 15.28 | −28.73 | 2.75 | −53.56 | 17.41 |
| VT | −63.44 | −108.94* | −76.37 | −60.86* | 21.57 | −46.79* |
| MN | — | 71.44 | — | 35.68 | — | 14.00 |
| NC | −55.61 | −53.74 | −50.82 | −20.76 | 9.36 | 22.11 |
| ME | 137.07 | 66.44 | 26.94 | 24.94 | 58.61 | 10.74 |
| MI | −266.33* | −104.65* | −80.91 | −70.84* | −96.88* | −36.90 |
| PA | −25.14 | −70.69 | −68.98* | −104.21 | −8.92 | 1.38 |

* = significant at p<0.10

•Medicare Part A and Part B expenditures, not including MAPCP fees paid to practices

# Conclusions

- Although most impact estimates are not statistically significant, positive impacts beginning to emerge
  - Findings cover relatively early period of implementation – takes time to observe results of practice change
  - Changing utilization patterns and health outcomes is difficult – practice doesn't have full control
  - Use of patient portals and other alternatives to face-to-face visits may explain absence of increase in primary care visits in most states
- Reduction in acute-care expenditures necessary for reduction in total expenditures
- Lack of integration between primary care and behavioral health services identified as a limitation and focus for Year Three in several states
- Health IT viewed as critical to PCMHs, but widely cited challenges
- Role of care managers continued to evolve

# Next Steps

- Third Annual Report posted at: https://downloads.cms.gov/files/cmmi/mapcp-thirdevalrpt.pdf
  - Implementation updates based on site visits only
- Final Report underway
  - Medicare analyses through December 2014
  - Medicaid analyses through December 2014
  - Focus groups with Medicare and Medicaid beneficiaries and caregivers
  - CAHPS PCMH survey of Medicare fee-for-service beneficiaries
  - Practice transformation survey
  - Cross-state analyses to identify initiative features associated with success

# Further Information

Donald Nichols, Project Director: dnichols@rti.org

Susan Haber, Deputy Project Director: shaber@rti.org

MAPCP Web site: https://innovation.cms.gov/initiatives/Multi-payer-Advanced-Primary-Care-Practice/

Second Annual Report posted at: https://downloads.cms.gov/files/cmmi/mapcp-secondevalrpt.pdf

This research was funded by the Centers for Medicare & Medicaid Services under contract number HHSM-500-2010-00021I. The contents of this presentation are those of the authors and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services.