Primary Care Home Perspective SB231, SB609

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History

Early 2000s

- **Regence investment in primary care through direct grants to provider systems**

2007

- **Regence launches Intensive Outpatient Care Program (IOCP) model in Washington (with Boeing)**

2010

- **Through Oregon Health Leadership Council, multi-payer High Value Patient Centered Care (HVPCC) is launched for two-year study**
  - **IOCP model, multi-payer approach – all payers following same program design to enable study level data analysis**

2011

- **Center for Medicare & Medicaid Innovation (CMMI) releases RFP for Comprehensive Primary Care Initiative (CPCi)**

2012-2016

- **CMMI Selects Oregon as CPCi region**
  - **Moda, PacificSource, Regence, Providence, CareOregon, OHA, Tuality Health Alliance all at table**
  - **Regence, Providence, CareOregon, OHA, THA remain participating payers**

High-Value Patient Centered Care (HVPCC)

- **14 Medical groups, 2 year pilot study (10/2010 – 2/2013)**
  - **NP in each practice, focus on most intensive patients**

- **As a collaborative of payers, deficit observed (claims savings minus care management fees) - $2.65M**
  - **8 of 14 medical groups had claims savings before care management fees**
  - **5 of 14 medical groups had net savings after care management fees**

- **HVPCC payers met to discuss next steps and each payer indicated individual or other multi-stakeholder initiatives were in place**
  - **CCOs, CPCi, other pilots**

Comprehensive Primary Care Initiative (CPCi)

67 primary care practice locations, 499 Medicare providers

- Six payers (Regence, Medicaid, Medicare, Providence, CareOregon, Tuality Health Alliance)
- 49,000 Medicare FFS beneficiaries
- 146,000 total members attributed through all payers
- Regence + Medicare FFS >46% of all attributed members in CPCi

Launched November 2012, pilot program ends December 2016

- Collaborate with other payers to align strategies to support comprehensive primary care services
- Test whether comprehensive primary care, coupled with payment reform, data, and health information technology can achieve Triple Aim (quality, cost, experience)

What Should Come Next?

- Encourage further experimentation.
  - OHA should participate in, not mandate, collaboratives.
- Avoid adding cost layers for patients who would not benefit from PCMH approaches, or turning into compliance activity.
- Encourage upfront payer investment by participating in development of a sustainable PCMH model, and reduce risk of waste on models that do not work well.
- Use data from CPCi after its conclusion to refine PCMH methods: Evaluate, Adjust, Next Generation.