Patient-Centered
Primary Care
COLLABORATIVE

The Honorable Max Baucus, Chairman
The Honorable Orrin Hatch, Ranking Member
Senate Committee on Finance
215 Dirksen Senate Office Building
Washington, DC 20510

July 18, 2013

Dear Senators Baucus and Hatch:

As a large and diverse stakeholder group, we thank you for this opportunity to comment on U.S. health system payment reforms that will transition us from an inefficient volume-based system, to one that rewards value and improvements in health outcomes and quality. Founded in 2006, the Patient-Centered Primary Care Collaborative (PCPCC) is dedicated to advancing an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home. Today, PCPCC's membership represents more than 1,000 organizations throughout the U.S., working in partnership to advance public policy that supports care delivery and payment innovations across a broad range of stakeholders.

The Medical Home Model

In an independent analysis, the Lewin Group estimated that widespread adoption of the medical home model in Medicare and Medicaid could reduce national health spending relative to currently projected levels, by an estimated $175 billion through 2020. They emphasized that the model should be tied to strong positive incentives for patients to participate, and embedded in supportive care systems.

The medical home is best described as a model or philosophy of primary care that is:

- **Patient-centered:** Practitioners, patients, and their families are partners in care and work together to ensure that health decisions respect patient wants, needs, and preferences. Patients are also provided the education and support they need to make decisions and participate in their own care.
- **Comprehensive:** A team of care providers is wholly accountable for a patient's physical and mental health care needs, including prevention and wellness, acute care, social supports, and chronic care.
- **Coordinated:** Care is organized across all elements of the broader health care system, including specialty care, hospitals, home health care, community services, and other supports.
- **Accessible:** Patients are able to access services with shorter waiting times, "after hours" care, 24/7 electronic or telephone access, and strong communication through health IT innovations.
- **Committed to quality and safety:** Clinicians and staff enhance use health IT and other tools to monitor population health, care management, and patient outcomes to ensure that providers, patients, and families make informed decisions about their health.

The Primary Care Consensus

Based on current rates of health care spending that are driven by the unsustainable fee-for-service payment system, clear support continues to align across the public and private sector that patient-centered, coordinated, team-based primary care is critical to achieving health system transformation. The PCPCC recently analyzed proposals demonstrating this consensus across five leading policy organizations, including: the Partnership for Sustainable Health Care, The Brookings Institution, the Bipartisan Policy Center, The Commonwealth Fund, and the Center for American Progress. The analysis is included in the attached crosswalk "The Primary Care

Consensus: A Comparison of Health System Transformation Proposals." As the consensus to support primary care builds, the PCPCC urges Congress to support public policies that shift the current fee-for-service system to a fee-for value system built on a strong foundation of patient-centered primary care. Specifically we support current proposals before Congress that recommend a phased-in approach to payment reforms that allow for additional research on the best methodologies to support the medical home, such as reforming Medicare over a multi-year period, and applying new payment models that move away from fee-for-service (FFS) as we learn which models are best suited for which types of care and in which environments. Once proven, these models should be scaled appropriately to allow for greater participation by providers throughout the entire health care system.

Our specific recommendations include:

Adopt payment reform incentives such as shared savings and reimbursement increases across providers, consumers, employers, and states that reward shifts toward high value delivery systems such as patient-centered medical homes, Accountable Care Organizations (ACOs), and integrated health systems. We also call for incentives that reward advanced primary care strategies that have demonstrated tangible impact on cost, quality, and outcomes, including:

- **Care coordinators, patient navigators, and/or health coaches** are embedded as critical members of care teams to support patients and families as they navigate the health system and enhance care delivery.
- **Proactive processes are in place** to manage the health care needs of all patients (patient outreach, clinical decision support, appointment reminders) and special attention is paid to complex populations (eg, chronic disease, behavioral health, substance abuse, and the elderly).
- **Care is documented and shared electronically** across providers and institutions, including patients, primary care, specialists, hospitals, home health, and others.
- **24/7 access and alternatives to traditional face-to-face visits** are offered, including access to electronic health records and patient portals.
- **Quality improvement goals and data** are used to monitor populations, including their risk levels, use of care plans, appropriate medication use, and self-management.

Reward new delivery models that maximize innovations in care, particularly for high-need, high-risk populations, and further expand medical homes and ACOs. We acknowledge that the integration of behavioral health, social supports, and other ancillary health services in the medical neighborhood are critical to these delivery models.

Educate and reward patients and consumers for making healthier, high-quality choices (i.e. choosing medical home or ACO providers); allow for greater transparency and free access to health care pricing and patient data; and provide free, online access to tools and resources to help inform these choices.

Evidence for Primary Care and the Patient Centered Medical Home

A number of studies have found evidence of cost savings and quality improvements resulting from the implementation of medical home programs. However we acknowledge that the magnitude of savings depends on a range of factors, including program design, enrollment, payer, target population, and implementation phase. Most often, the medical home's effect on lowering costs is attributed to reducing expensive, unnecessary hospital and emergency department utilization. Currently, more than 90 health plans, dozens of employers, 42 state Medicaid programs, numerous federal agencies, hundreds of safety net clinics, and thousands of small and large clinical practices nationwide have adopted this innovative model.

Successful examples of medical home programs include the following:

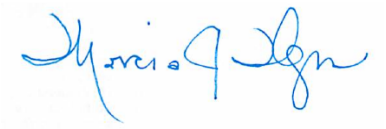
- **Geisinger's Proven-Health Navigator Model**, which serves Medicare patients in rural northeastern and central Pennsylvania, found 71 percent savings over expected costs.
- Evidence from the **Genesee Health Plan** in Flint, Michigan, indicates that increasing access to primary care services and using health navigators to help patients adopt healthy behaviors and manage chronic diseases reduced enrollee use of emergency department services by 51 percent between 2004 and 2007 and reduced hospital admissions by 15 percent between 2006 and 2007.
- One study found that that **WellPoint's** medical home model in New York yielded risk-adjusted total PMPM costs that were 14.5 percent lower for adults and 8.6 percent lower for children enrolled in a medical home.
- Preliminary results from **CareFirst Blue Cross Blue Shield's** medical home program showed an estimated 15 percent savings in its first year of operation, before accounting for provider bonuses. Results from the formal evaluation reveal $98 million in total savings over two years.
- Similar levels of savings have been found in medical home models that include a mix of public and private payers For example, **UPMC's** multi-state medical home pilot, which includes a mix of commercial, Medicaid, Medicare, and dually eligible patients, showed a net savings of $9.75 PMPM for individuals enrolled in the medical home pilot.

The PCPCC: A Source of Evidence and Results

In addition to the successes described above, the PCPCC continues to compile and codify results from medical home initiatives that illustrate effects on the Triple Aim goals. In Appendix A, we provide an update to the PCPCC's September 2012 review of 46 medical home initiatives: *Benefits of Implementing the Primary Care Patient-Centered Medical Home*. The initiatives come from peer-reviewed journals and industry generated studies. Although research methods continue to evolve, we strongly encourage Congress to look to the growing body of evidence, which finds that medical homes supported by payment incentives are oftentimes the best positioned for success and impact.

As Congress considers various payment reform proposals to improve our fragmented health system, we appreciate the opportunity to underscore the need for increased and enhanced support for primary care and the medical home. Further, we appreciate your strong commitment to a thoughtful, bipartisan solution to address health system inefficiencies. Thank you for the opportunity to share with you our ideas and we look forward to working with you. Should you have any questions, please contact me at mnielsen@pcpcc.net or (202) 417-2074.

Sincerely,



Marci Nielsen, PhD, MPH
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Encl.

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