



**ACHIEVING PERSON-CENTERED PRIMARY CARE:
THE PATIENT-CENTERED MEDICAL HOME**

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Invited Testimony
Special Senate Committee on Aging
Hearing on
“Person-Centered Care: Reforming Services and Bringing Older Citizens
Back to the Heart of Society”

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ACHIEVING PERSON-CENTERED PRIMARY CARE: THE PATIENT-CENTERED MEDICAL HOME

Melinda K. Abrams, M.S.

Executive Summary

Thank you, Mr. Chairman, for this invitation to testify on person-centered care for older adults in ambulatory care settings. I am Melinda Abrams, assistant vice president at The Commonwealth Fund, where I direct the Patient-Centered Primary Care Initiative.

The patient-centered medical home is an approach to providing person-centered care in primary care settings. This model organizes care around the relationship between the patient and the personal clinician. In February 2007, four primary care specialty societies representing more than 300,000 physicians released joint principles outlining and defining key characteristics of a medical home.

In practical terms, a medical home offers each patient a personal clinician with a practice that provides better access and effective care coordination within the context of an ongoing relationship.

- In a medical home, a patient can expect to obtain care from the physician practice on holidays, evenings and weekends without going to the emergency room. He or she may also expect to have medical questions answered by telephone or e-mail on the same day they were asked.
- In a patient-centered medical home, the primary care clinician helps the patient select a specialist and, with support from designated staff, follows up with both the providers and the patient about test or examination results, reviews treatment options, and helps to resolve conflicting advice received from multiple providers.
- To carry out these enhanced functions, medical homes require improved infrastructure—such as electronic health records, patient registries to organize clinical information, the ability to review test results remotely, and the capacity to collect and analyze data about quality of care provided.

I want to emphasize the importance of the medical home for older Americans. Since 86 percent of Medicare beneficiaries have one or more chronic conditions, investing and improving coordination of care in primary care is critical to reduce

unnecessary and redundant services, gaps in service, problems with care transitions, and medical errors.

Patient-centered medical homes also require fundamental payment reform. Many medical home services are reimbursed either inadequately or not at all by the current fee-for-service system. Primary care practices would submit to a voluntary and objective qualification process to be recognized as a medical home and in exchange, the practice would be supported with an enhanced or additional payment to cover the improved care management, infrastructure, and care coordination.

There is substantial evidence showing that a strong foundation of primary care can reduce costs and improve quality.

The Commonwealth Fund's 2007 International Health Policy Survey found that only half of all adults in the United States have a medical home. Patients with a medical home were more likely than those without to report better access to care, more time with their doctors, and fewer duplicate tests. Among adults with chronic illnesses, patients with a medical home were less likely to report medical errors and more likely to have a written care plan to manage their illness at home.

The Commonwealth Fund is supporting evaluations of several medical home demonstrations to determine if the model can slow the growth of health care expenditures. There are data to suggest this approach can reduce health system costs.

For example, a medical home pilot project at The Geisinger Health System, an integrated delivery system in northeast and central Pennsylvania, showed a 20 percent reduction in hospital admissions and 12 percent decrease in hospital readmissions at their Lewistown Hospital. Although they do not serve a large proportion of elderly patients, a few state Medicaid programs, such as the one in North Carolina, have demonstrated cost savings of \$225 million in 2004 when beneficiaries are enrolled in networks of medical homes. In both these examples, primary care clinicians were paid an additional per-member, per-month fee to manage and coordinate patient care beyond the standard care covered by traditional fee-for-service payments.

Congress has recognized the potential value of stronger, patient-centered primary care. The Tax Relief and Health Care Act of 2006 instructs the Centers for Medicare and Medicaid Services to develop an eight-state demonstration of the medical home model. The recently passed Medicare Improvements for Patients and Providers Act of 2008

provides an additional \$100 million dollars to augment that demonstration. I commend Congress for its willingness to test this promising approach in Medicare.

As the committee considers legislative and regulatory strategies to encourage person-centered care for older citizens in ambulatory care settings, there are a number of steps Congress could take. They are:

Ensure transparency of the Medicare medical home demonstration.

In light of the keen interest from numerous stakeholders (large employers, labor unions, state and commercial payers, consumer groups) to reform and improve primary care, regular reporting to Congress and the public about the progress of and early lessons from the Medicare demonstration can inform policy and practice around the country, as well as ensure timely release of evaluation results.

Direct the Centers for Medicare and Medicaid Services to join commercial and state payers in the Medicare medical home demonstrations. With explicit encouragement from Congress, Medicare could collaborate with the several commercial payers and state Medicaid programs that are willing to change payment rates to primary care practices to test the patient-centered medical home.

Pursue intermediate and incremental financing changes to promote medical home components.

- One option is to authorize a separate payment for discrete services associated with key care coordination functions, such as hospital discharge planning, which could help reduce unnecessary hospital readmissions.
- Implement the recent recommendation of the Medicare Payment Advisory Commission to increase payment levels for evaluation and management services provided by primary care clinicians to help support care management and care coordination.

Implementation of scholarships or educational loan forgiveness programs to encourage medical students to choose careers in primary care. This strategy would address the shortage of primary care physicians to staff medical homes.

Thank you for this opportunity to participate in today's hearing. I look forward to addressing your questions.

ACHIEVING PERSON-CENTERED CARE: THE PATIENT-CENTERED MEDICAL HOME

Melinda K. Abrams, M.S.

Thank you Chairman Kohl, Senator Smith, Senator Casey, and members of the Committee for this invitation to testify about medical homes in your hearing about care for older Americans. I am Melinda Abrams, assistant vice president at The Commonwealth Fund, and responsible for the Patient-Centered Primary Care Initiative. The Commonwealth Fund is a private, grantmaking foundation that aims to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable populations, including elderly adults.

The principle driving patient-centered care is relatively simple: the health care system should be designed around the person—not administrators, physicians, or financial factors. The Commonwealth Fund 2007 International Health Policy survey showed that an overwhelming majority of Americans want care that is accessible, well-coordinated and family-centered.¹ And yet, today's health care system has difficulty focusing on the patient. Care is generally reimbursed with little or no regard for medical outcomes, physician offices rarely schedule patient appointments in the evenings or weekends to be convenient to patients, and there is little coordination between primary and specialty care providers.

In this testimony, I am going to discuss how medical homes, by providing patient-centered primary care, can improve health outcomes. I will define the concept, present evidence showing its value, and review policy options for future congressional action.

Defining the Patient-Centered Medical Home

A patient-centered medical home is an approach to primary care that organizes care around the relationship between the patient and the clinician. The concept was first introduced by pediatricians, but their definition of such care is relevant to other populations, especially older adults with multiple chronic conditions. A medical home is a practice that provides primary care and is “accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective.”²

¹ C. Schoen, R. Osborn, M. M. Doty, M. Bishop, J. Peugh, and N. Murukutla, “[Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007.](#)” *Health Affairs* Web Exclusive (Oct. 31, 2007):w717–w734.

² American Academy of Pediatrics, “The Medical Home: Medical Home Initiatives for Children with Special Needs Project Advisory Committee,” *Pediatrics*, July 1, 2002 110(1):184–86.

In February 2007, four primary care specialty societies—representing more than 300,000 internists, family physicians, pediatricians and osteopaths—released joint principles defining the patient-centered medical home with the following characteristics:³

- ***Personal physician.*** Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous, and comprehensive care.
- ***Team care.*** The physician directs team of professionals and staff who collectively take responsibility for the ongoing care of patients.
- ***Whole person orientation.*** The personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life, acute care, chronic care, preventive services, and end-of-life care.
- ***Integrated, coordinated care.*** Care is integrated and coordinated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services).
- ***Quality and safety.*** Practices use evidence-based medicine and clinical decision-support tools to guide decision-making. Physicians advocate for their patients by partnering and planning care with them. Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement. Patients actively participate in decision-making and feedback is sought to ensure patients’ expectations are being met. Patients and families participate in quality improvement activities at the practice level.
- ***Enhanced access.*** Care is available through availability of same-day appointments; expanded hours of operation; and new options for communication among patients, their personal physicians, and practice staff.
- ***Payment.*** Payment systems recognize the enhanced value derived from care coordination, health information technology, and team-based care.

So what does this mean in practical terms? In a medical home, a patient could expect to obtain care from the physician practice on holidays, evenings, and weekends, without going to the emergency room. The patient could have medical questions

³ American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and American Osteopathic Association, “Joint Principles of the Patient-Centered Medical Home,” Mar. 2007.

answered by telephone or e-mail on the same day that he or she contacts the office. Non-urgent care appointments could be scheduled one or two days ahead of time, instead of weeks or months. In a medical home, care coordination is vastly improved. The primary care clinician helps the patient select a specialist and (with support from staff) follows up with both the providers and the patient about test or examination results. In a medical home, the personal physician reviews treatment options with the patient and his or her family to help understand or resolve conflicting advice received from multiple providers.

Patient-centered medical homes require improved infrastructure—such as electronic health records, patient registries, the ability to review test results remotely, and electronic prescribing or referrals—to deliver primary care effectively. Patients at medical homes could expect to receive e-mail or telephone reminders from the practice about overdue appointments as well as telephone notification about test results and have the option to view their record online. Patients could also expect to routinely complete surveys or participate in focus groups to report on the care experience. The medical home practice would use that information, along with data about clinical quality, to improve how the practice is structured or managed. Patients must perceive that the medical home serves their needs to be truly patient-centered.

The patient-centered medical home also requires fundamental payment reform that is intended to strengthen and reward primary care. For successful implementation, primary care practices would submit to a voluntary and objective qualification process to be recognized as a patient-centered medical home. In exchange, the medical home would be supported with an enhanced or additional payment to support the improved care management, infrastructure, and care coordination.

I want to emphasize the importance of the revised approach to payment and practice in helping older Americans. Approximately 125 million Americans are living with chronic illness.⁴ Among the Medicare population, 86 percent of the nearly 40 million beneficiaries have one or more chronic conditions and 23 percent have five or more chronic conditions.⁵ In a medical home, patients would receive individual care that is integrated and coordinated across all providers, which would reduce duplication of service and ensure consistency of a care plan for patients with multiple conditions.

⁴ G. Anderson and J. Knickman, “Changing the Chronic Care System to Meet People’s Needs,” *Health Affairs*, Nov./Dec. 2001 20(6):146–60.

⁵ M. Maxfield et al., “Design of the CMS Medical Home Demonstration,” submitted to the Office of Research Development and Information at the Centers for Medicare & Medicaid Services, June 19, 2008.

Evidence Demonstrating the Value of the Patient-Centered Medical Home

Evidence on Medical Homes Improving Quality of Care

Health care systems with a strong foundation of primary care can reduce costs and improve quality. People with primary care clinicians are more likely than those without to receive preventive services, to have better management of chronic illness, and to report better experiences with their care.⁶ States with more primary care providers have lower total mortality rates, lower heart disease and cancer mortality rates, and higher life expectancy at birth compared with states that have few primary care providers.⁷ In contrast, increases in specialist supply are associated with increased cost, but not improved quality.⁸

Edward H. Wagner, M.D., M.P.H., director of the MacColl Institute for Healthcare Innovation, developed the chronic care model, which has shown that an effective way to help people with chronic conditions is to structure care around productive interactions between “an informed, activated patient” and a “prepared, proactive practice team”. Achieving this effective relationship requires organization and support of individual practices in ways that are equivalent to a patient’s having a medical home. Self-management support and appropriate health information systems are necessary components of the practice infrastructure. The literature shows that implementation of these elements improves quality of care for patients with diabetes, asthma, and depression.^{9,10,11,12}

Two recent Commonwealth Fund surveys show the benefits of having a medical home.^{13,14} In both studies, a presence of medical home was determined by specific patient

⁶ Dartmouth Atlas Project. *The Care of Patients with Severe Chronic Illness: An Online Report on the Medicare Program* (Hanover, N.H.: Dartmouth Medical School, Center for the Evaluative Clinical Sciences, 2006).

⁷ B. Starfield, L. Shi and J. Macinko, “Contribution of Primary Care to Health Systems and Health,” *Milbank Quarterly*, Sept./Oct. 2005 83(3):457–502.

⁸ B. Starfield, L. Shi, and J. Macinko, “The Effects of Specialist Supply on Populations’ Health: Assessing the Evidence,” *Health Affairs* Web Exclusive (Mar. 15, 2005):w97–w107.

⁹ M. W. Batersby, “Health Reform Through Coordinated Care: SA HealthPlus,” *BMJ*, Mar. 19, 2005 330(7492):662–65.

¹⁰ P. Lozano, J. A. Finkelstein, V. Carey et al., “A Multisite Randomized Trial of the Effects of Physician Education and Organizational Change in Chronic-Asthma Care,” *Archives of Pediatrics & Adolescent Medicine*, Sept. 2004 158(9):875–83.

¹¹ G. A. Piatt, T. J. Orchard, S. J. Emerson et al., “Translating the Chronic Care Model into the Community,” *Diabetes Care*, Apr. 2006 29(4):811–17.

¹² M. Dwight-Johnson, K. Ell, and P. J. Lee, “Can Collaborative Care Address the Needs of Low-Income Latinas with Comorbid Depression and Cancer? Results from a Randomized Pilot Study,” *Psychosomatics*, May-June 2005 46(3):224–32.

¹³ A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, [*Closing the Divide: How Medical Homes Promote Equity in Health Care: Results from the Commonwealth Fund 2006 Health Care Quality Survey*](#) (New York: The Commonwealth Fund, June 2007).

¹⁴ Schoen et al., “Toward Higher-Performance Health Systems,” 2007.

experience reports. The Commonwealth Fund's 2007 International Health Policy Survey deemed patients had medical homes, if they reported:

- a regular doctor or source of primary care,
- a provider who had information about their medical history,
- the provider could be contacted by phone during office hours, and
- the provider coordinated their care.

Based on these criteria, only half of all adults in the United States have medical homes. Across all seven countries that participated in the survey, patients with medical homes, compared with those who did not have medical homes, were more likely to report positive care experiences. Specifically, patients with medical homes were more likely to experience better access to care on holidays, evenings, and weekends; greater involvement in care decisions; more time with their doctors; fewer duplicate tests; and greater assistance in selecting specialists. Among adults with chronic illness, patients with medical homes were less likely to report medical errors (e.g., mistakes or wrong medications) and more likely to have a written care plan to manage their illness at home and receive reminders for preventive or follow-up care. The 2006 Health Care Quality Survey showed similar benefits of medical homes for adults, with the added advantage of demonstrating substantial reduction of racial and ethnic disparities.¹⁵

Evidence on Medical Homes Reducing Health Care Costs

The Commonwealth Fund is supporting rigorous evaluations of several medical home demonstrations to determine if they slow the growth of health care expenditures. Preliminary data from one medical home pilot and results from a few studies suggest that widespread adoption of patient-centered medical homes can reduce health system costs and achieve better quality and health outcomes.

The Geisinger Health System, an integrated delivery system in northeast and central Pennsylvania, shows positive, early results from its medical home pilot. The health system encompasses 40 community practice sites, several specialty hospitals, and multiple tertiary medical centers. All clinicians and practice sites are connected through fully integrated electronic health records. As part of the patient-centered medical home pilot, Geisinger expanded patient care to include ongoing telephone monitoring and case management, telephone follow-up post-hospital discharge and post-emergency department visits, easy access to clinicians by telephone, group visits, educational

¹⁵ Beal et al., *Closing the Divide*, 2007.

services, and personalized tools such as chronic disease report cards. Participating providers were paid an additional fee for the improved access and care coordination. After one year, preliminary findings show a decrease in hospital admission rates, ranging from a 14 percent reduction in Lewisburg Community Hospital to a 20 percent drop in Lewistown. Hospital readmission rates also declined dramatically. The Lewistown hospital demonstrated a 12 percent decrease in hospital readmissions while Lewistown declined by 48 percent.¹⁶

Although they do not serve a large proportion of elderly patients, a few state Medicaid programs have demonstrated that medical homes can reduce health care costs across a system of care. The North Carolina Medicaid program, called Community Care of North Carolina, enrolls beneficiaries in local, primary care networks of medical homes. An analysis by Mercer Consulting found that a \$10.2 million investment resulted in savings of \$225 million when compared to traditional, Medicaid fee-for-service.¹⁷ In Iowa, Medicaid beneficiaries were enrolled in a primary care case management program, which slowed Medicaid spending by 3.8 percent (saving \$66 million) over an eight-year period, with the effects strengthening over time.¹⁸ Under this model, primary care clinicians are paid an additional per-member-per-month fee to manage and coordinate patient care beyond the standard care covered by traditional fee-for-service payments.

Recently, The Commonwealth Fund issued a report, *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, which includes 15 options for slowing the growth in health care outlays while improving access and quality of care. One option estimated the savings accrued if all Medicare beneficiaries in traditional fee-for-service were required to enroll in a medical home for primary care. In recognition of the enhanced services (care management, care coordination, patient education, and same-day access to appointments), physicians would receive a per-member, per-month fee in addition to the regular fee-for-service payments. Under the policy option, the projected net cumulative savings to national health expenditures is \$60 billion over five years and \$193.5 billion over 10 years. Most of the savings were derived from a decrease in hospital and physician expenses as a result of higher-quality and more-efficient care delivered by medical homes.

¹⁶ G. Steele, "AHRQ: Who Should Pay for Health IT? Institutional Commitment to Health IT," Presentation at AcademyHealth Annual Research Meeting, June 9, 2008.

¹⁷ M. Lodh et al., "ACCESS Cost Savings—State Fiscal Year 2004 Analysis," Mercer Governmental Human Services Consulting letter to Jeffrey Simms, State of North Carolina, Office of Managed Care (Mar. 24, 2005), <https://www.communitycarenc.com/PDFDocs/Mercer%20SFY04.pdf> (accessed July 21, 2008).

¹⁸ E. T. Momany, S. D. Flach, F. D. Nelson et al., "A Cost Analysis of the Iowa Medicaid Primary Care Case Management Program," *Health Services Research*, Aug. 2006 41(4 Pt 1):1357–71.

Challenges Facing Implementation of the Patient-Centered Medical Home

Successful implementation of the patient-centered medical home must overcome many challenges, but two in particular require immediate attention —our current reimbursement system and the capacity of our clinical workforce to staff medical homes.

Many medical home services (such as care coordination or care management) and infrastructure (health information technology or registries) are reimbursed either inadequately or not at all in the current fee-for-service system. Current reimbursement is biased in favor of procedures (such as surgical operations or imaging) and does not adequately pay for time spent with patients to take their medical history, conduct an examination, or provide follow-up before or after an appointment. In its June 2008 report, the Medicare Payment Advisory Commission summarized the problem: “In consideration of the devaluation of primary care services, the Commission is concerned that these services risk being underprovided, as physicians view them as less valued and less profitable. Yet, primary care services and—perhaps more importantly—primary care clinicians, are critical to delivering more coordinated, high-quality care to the Medicare population.”¹⁹ Further, many technical procedures become more efficient with improvements in technology. If reimbursement levels stay constant, then payment effectively increases. However, similar efficiencies are rarely realized in primary care, since less time with patients might mean compromising patient-centered care.

Another challenge is a shortage of primary care physicians to staff medical homes. Due to lower reimbursement levels for primary care, the average medical or surgical sub-specialist makes almost twice the annual salary of the average primary care physician and this income gap is growing over time.²⁰ This income disparity has led declining numbers of medical students to select residencies in primary care. There are other factors that may also exacerbate the declining number of primary care physicians. For example, sub-specialty physicians are perceived to enjoy a better lifestyle with more regular hours and less on-call responsibilities than their primary care colleagues. For the Medicare population, a dwindling workforce could threaten access to primary care services for elderly Americans.

Intense National Interest in the Patient-Centered Medical Home

The patient-centered medical home is not just a pipe dream derived from survey results or econometric models. The evidence showing the quality and cost gains from stronger

¹⁹ Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Reforming the Delivery System* (Washington, D.C.: MedPAC, June 2008), p. 27.

²⁰ T. Bodenheimer, R. Berenson, and P. Rudolf, “The Primary Care-Specialty Income Gap: Why It Matters,” *Annals of Internal Medicine*, Feb. 20, 2007 146(4):301–06.

primary care through medical homes has galvanized a broad array of stakeholders. In addition to the four primary care specialty societies, medical homes have been endorsed by large employers, including IBM and WalMart and labor and consumer organizations, like the AFL-CIO and AARP. The model is being tested in several demonstrations by major private health plans, including Blue Cross Blue Shield and Aetna.

Public payers have also recognized the potential value of stronger, well-coordinated primary care and authorized new payment models to promote the patient-centered medical home. As you know, the Tax Relief and Health Care Act of 2006 instructs the Centers for Medicare and Medicaid Services (CMS) to develop an eight-state demonstration of the medical home under Medicare.²¹ The recently passed Medicare Improvements for Patients and Providers Act of 2008 provides an additional \$100 million dollars to augment that demonstration.²² I commend Congress for its willingness to test this promising approach.

The states have been equally active on the topic of medical homes. In Pennsylvania, Governor Rendell and the legislature have begun a statewide “roll-out” (i.e., not a demonstration) of the patient-centered medical home model.²³ In Massachusetts, a bill was introduced last week that would permanently restructure financing of Medicaid plans to provide a supplemental fee to primary care practitioners working in qualified medical homes.²⁴ Under a Commonwealth Fund grant to the National Academy for State Health Policy, a survey of Medicaid and State Children’s Health Insurance Program directors revealed that 23 states have efforts under way to test the patient-centered medical home in state Medicaid programs.²⁵

The Commonwealth Fund is actively engaged and closely monitoring many of the national and state medical home activities around the country. We are supporting a demonstration with safety-net clinics, further development of measures to qualify a primary care practice as a medical home, evaluations of several medical home demonstrations, and the development of policy and payment options. Of course, the patient-centered medical home cannot fix all the quality and cost problems of our health system. Through our evaluations, we will learn the impact of medical homes on clinical

²¹ Tax Relief and Health Care Act of 2006 (Dec. 20, 2006), Division B, Section 204.

²² Medicare Improvements for Patients and Providers Act of 2008 (July 15, 2008), Part 1, Section 133.

²³ Chronic Care Management, Reimbursement and Cost Reduction Commission, “Prescription for Pennsylvania, Strategic Plan,” Feb. 2008; <http://www.rxfopa.com/assets/pdfs/ChronicCareCommissionReport.pdf> (accessed July 21, 2008).

²⁴ Commonwealth of Massachusetts Senate, Bill No. 2526, Section 44 (proposed).

²⁵ N. Kaye and M. Takach, Preliminary State Scan Summary Results, Unpublished data (Jan. 25, 2008).

quality, patient experience, and health care costs. It will be years before we have any answers, as it takes time to achieve both practice transformation and a positive return on investment. However, The Commonwealth Fund's substantial investment in medical homes demonstrates our commitment to the approach as central to establishing a strong foundation for primary care that can help the United States' health care system achieve higher performance.

Policy Options for Congressional Consideration

As the committee considers legislative and regulatory strategies to encourage person-centered care for older citizens, there are a number of steps Congress could take.

They are:

Ensure transparency of the Medicare medical home demonstration.

Demonstrations take several years to get under way, be completed, and publish results. Congress' interest in careful implementation of the CMS Medicare medical home demonstration is evidenced by the recent passage of the Medicare Improvements for Patients and Providers Act of 2008 in which you allocated \$100 million dollars to allow the Secretary to expand the demonstration. In light of the keen interest from numerous state and commercial payers to test and expand the model, regular reporting to Congress and the public about the progress and early lessons from the Medicare medical home demonstration can inform similar initiatives around the country. Routine updates could also encourage timely release of evaluation results, which will shape future program implementation. I am not suggesting interference with Medicare's operation of the demonstration, but rather recommending a mechanism for public review and discussion of the Medicare medical home experience to help shape policy and practice.

Direct the Centers for Medicare and Medicaid Services to join commercial and state public payers in the Medicare medical home demonstration.

Several commercial payers are willing to change payment rates to primary care practices to test patient-centered medical homes. Although there are examples of partnerships between state Medicaid and commercial payers on current medical home demonstrations (e.g., Rhode Island, Colorado), there is no active collaboration between commercial payers and Medicare. With explicit encouragement from Congress, there is an opportunity to facilitate such a partnership.

Pursue intermediate and incremental financing changes to promote medical home components, such as care coordination.

Two options include:

- Authorize a separate payment for discrete services associated with key care coordination functions, such as discharge planning, which could help reduce unnecessary hospital readmissions. The physician’s or clinical care team’s role could be clearly defined—preparation of discharge summary, medication reconciliation, a post-discharge status update with patient and patient’s family—and verified with documentation.
- Increase payment levels for evaluation and management services provided by primary care clinicians to help support care management and care coordination. The Medicare Payment Advisory Commission made a similar recommendation in its June 2008 report. It suggested that “the Congress establish a budget-neutral payment adjustment for primary care services billed under the physician fee schedule and furnished by primary care-focused practitioners.”²⁶

Implement scholarships or educational loan forgiveness programs to encourage medical students to choose careers in primary care.

Increasing tuition expenses and lower salary projections contribute to fewer medical students choosing careers in primary care. Tuition assistance—in the form of debt forgiveness or medical school scholarships—could reduce the financial burden and enable more students to enter the field of primary care.

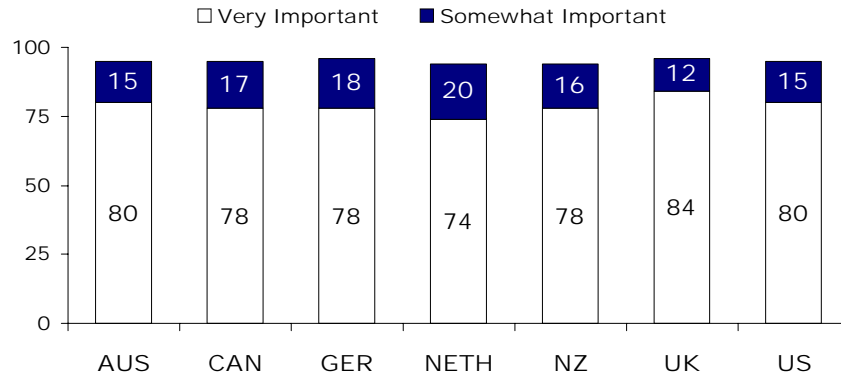
Thank you for this opportunity to participate in today’s hearing and to address questions of the Committee.

²⁶ MedPAC, *Reforming the Delivery System*, 2008.

Figure 1. Strong Public Support for “Medical Home”:
Accessible, Personal, Coordinated Care

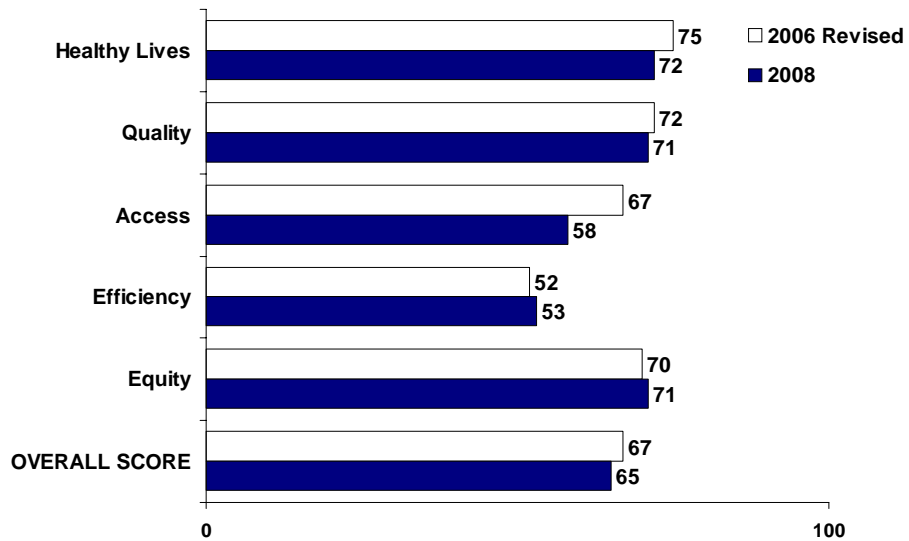
When you need care, how important is it that you have one practice/clinic where doctors and nurses know you, provide and coordinate the care that you need?

Percent saying very or somewhat important



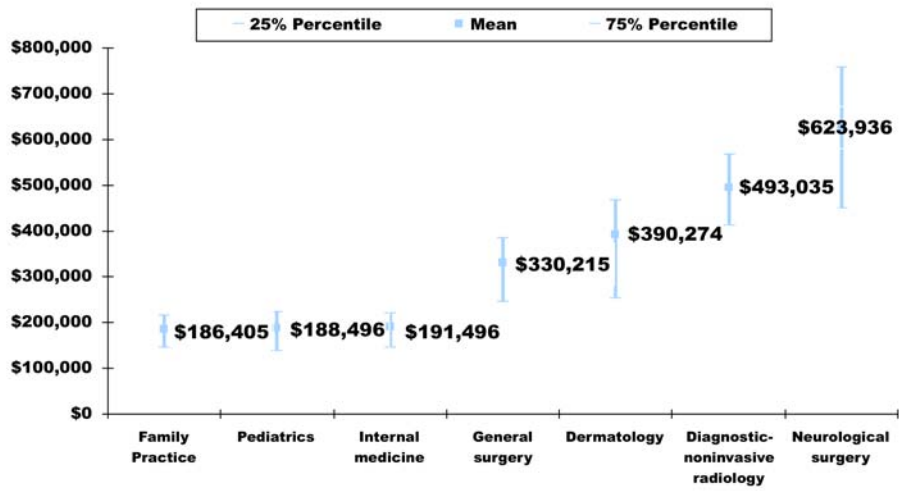
Source: 2007 Commonwealth Fund International Health Policy Survey.

Figure 2. Scores: Dimensions of a
High Performance Health System



Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.

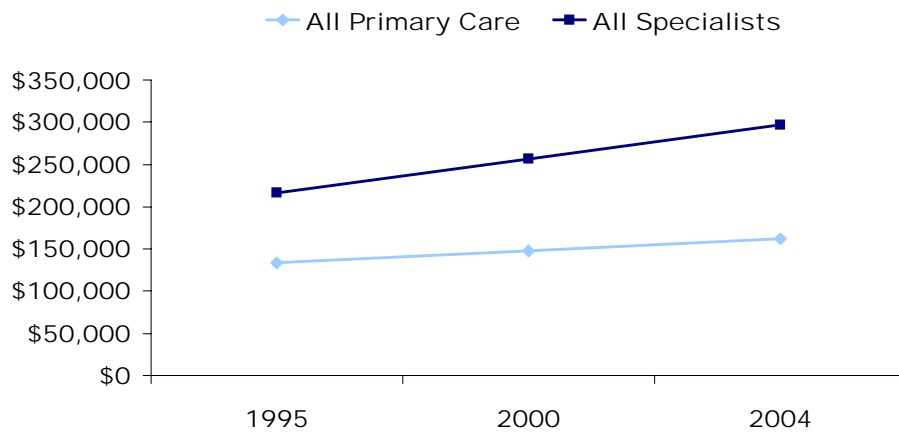
Figure 3. Average Medical Specialty Salaries



Source: Reprinted with permission from the Medical Group Management Association, 104 Inverness Terrace East, Englewood, CO 80112-5306; (303) 799-1111. www.mgma.com. Copyright 2006.

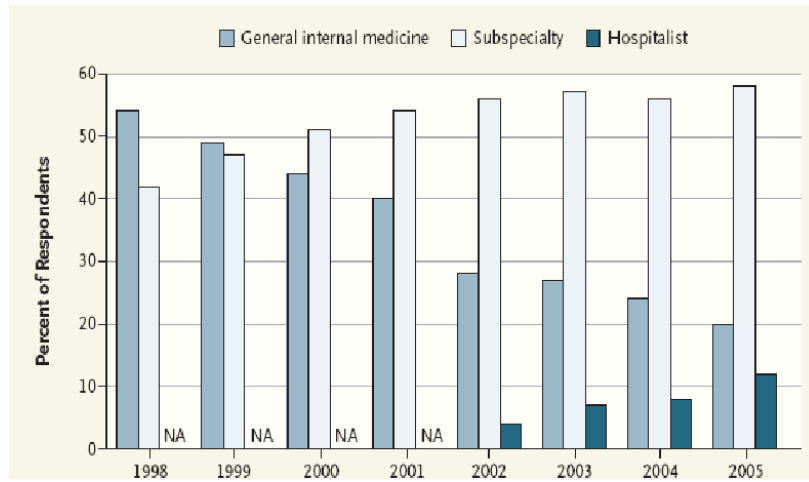
Figure 4. The Primary Care-Specialty Income Gap Is Widening

Median pretax compensation of physicians, 1995-2004



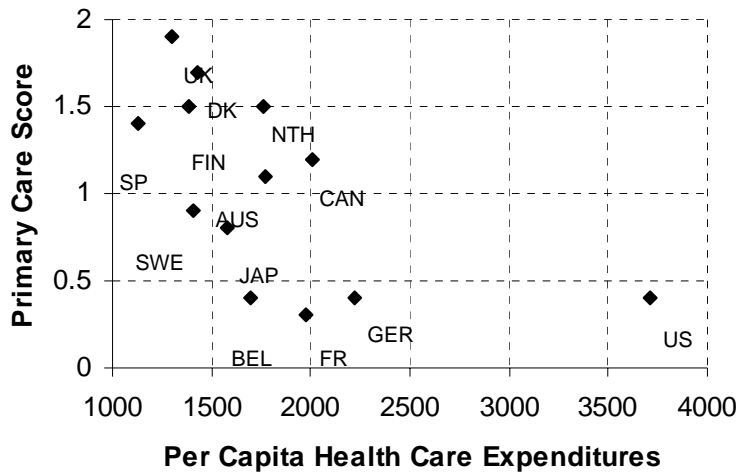
Source: T. Bodenheimer, R. A. Berenson and P. Rudolf, "The Primary Care-Specialty Income Gap: Why It Matters," *Annals of Internal Medicine*, Feb. 2007 146(4):301-06.

Figure 5. Proportions of Third-Year Internal Medical Residents Choosing Careers as Generalists, Subspecialists, and Hospitalists



Source: T. Bodenheimer, "Primary Care—Will it Survive?" *New England Journal of Medicine*, Aug. 2006 355(9):861–64.

Figure 6. Primary Care Score vs. Health Care Expenditures, 1997



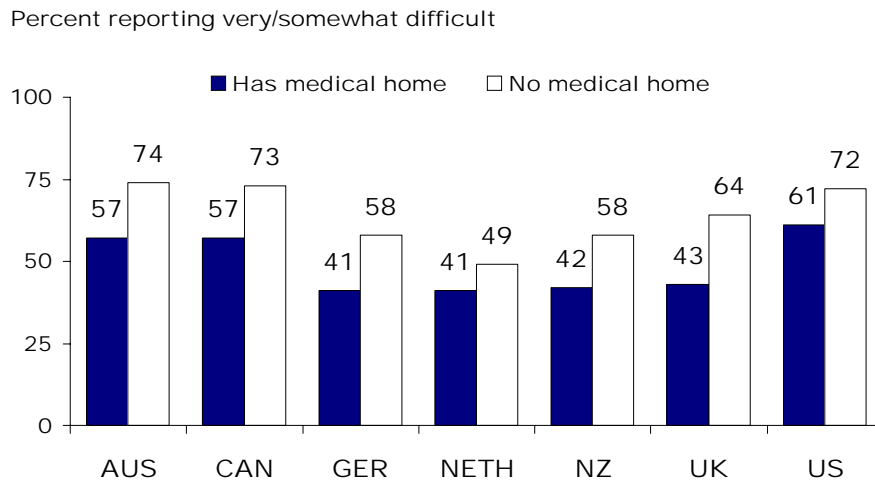
Source: B. Starfield, *Why More Primary Care: Better Outcomes, Lower Costs, Greater Equity*, presentation given at the Primary Care Roundtable: Strengthening Adult Primary Care: Models and Policy Options, Oct. 2006. Starfield 10/00 IC 1731

Figure 7. 2007 International Survey
Indicators of a Medical Home: U.S.

Indicator	Percent
Patient has regular doctor or place of care	90
Doctor/staff know important information about patient's history	74
Place is easy to contact by phone during regular office hours	57
Doctor/staff help coordinate care received from other doctors/sources of care	50
All four indicators of Medical Home	50

Source: 2007 Commonwealth Fund International Health Policy Survey.

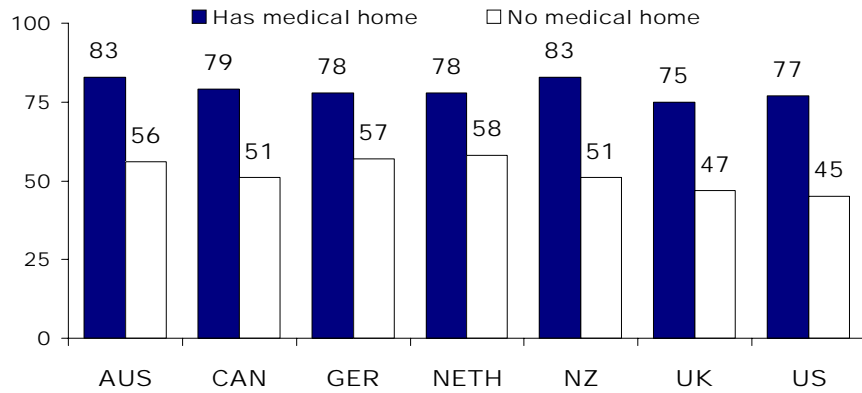
Figure 8. Access: Patients with a Medical Home Less Likely to Report Difficulty Getting Care on Nights, Weekends, and Holidays Without Going to the ER



Note: Medical home includes having a regular provider that knows you, is easy to contact, and coordinates your care.
Source: 2007 Commonwealth Fund International Health Policy Survey.
Data collection: Harris Interactive, Inc.

Figure 9. Communication/Decision Making: Doctor Always Explains Things, Spends Enough Time with You, and Involves You in Decisions, by Medical Home

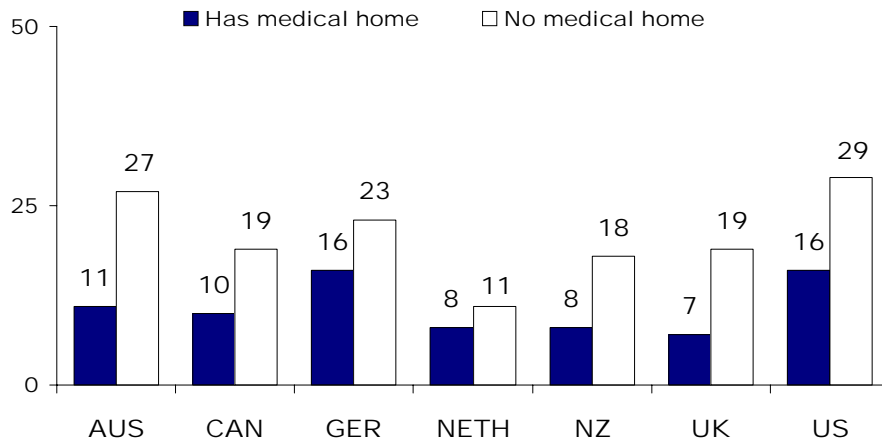
Average percent of adults with a regular doctor or place of care reporting "always" across three indicators of doctor-patient communication



Note: Medical home includes having a regular provider that knows you, is easy to contact, and coordinates your care.
 Source: 2007 Commonwealth Fund International Health Policy Survey.
 Data collection: Harris Interactive, Inc.

Figure 10. Coordination: Medical Records Not Available During Visit or Duplicative Tests, by Medical Home

Percent of adults reporting

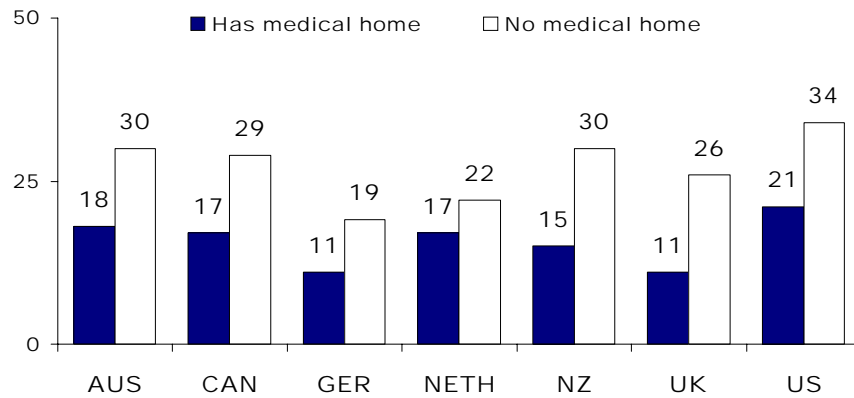


Note: Medical home includes having a regular provider that knows you, is easy to contact, and coordinates your care.
 Source: 2007 Commonwealth Fund International Health Policy Survey.
 Data collection: Harris Interactive, Inc.

Figure 11. Safety: Any Patient-Reported Error

Base: Adults with chronic condition

Percent any medical, medication, or lab error

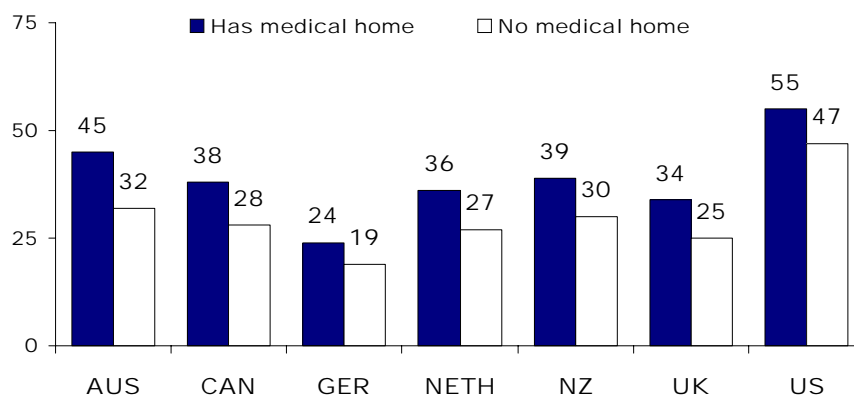


Note: Errors include medical mistake, wrong medication/dose, or lab/diagnostic errors. Medical home includes having a regular provider that knows you, is easy to contact, and coordinates your care.
 Source: 2007 Commonwealth Fund International Health Policy Survey.
 Data collection: Harris Interactive, Inc.

Figure 12. Chronically Ill: Doctor Gives You Written Plan for Managing Care at Home, by Medical Home

Base: Adults with chronic condition

Percent with care plan

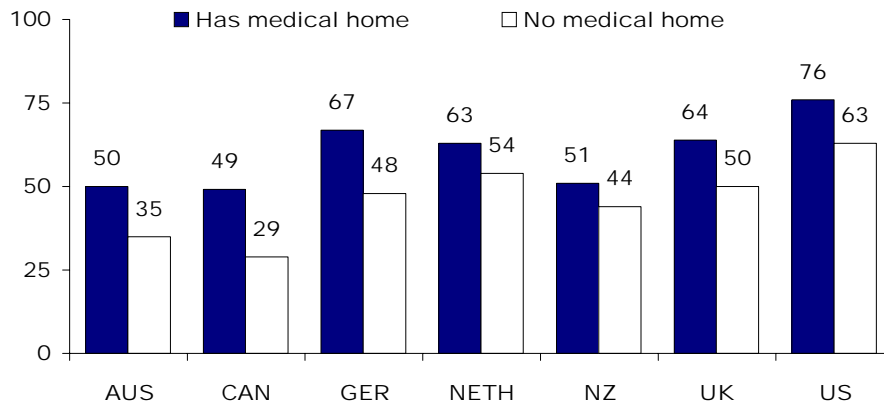


Note: Medical home includes having a regular provider that knows you, is easy to contact, and coordinates your care.
 Source: 2007 Commonwealth Fund International Health Policy Survey.
 Data collection: Harris Interactive, Inc.

Figure 13. Receive Reminder for Preventive/Follow-Up Care, by Medical Home

Base: Adults with a chronic condition

Percent with reminder



Note: Medical home includes having a regular provider that knows you, is easy to contact, and coordinates your care.
 Source: 2007 Commonwealth Fund International Health Policy Survey.
 Data collection: Harris Interactive, Inc.

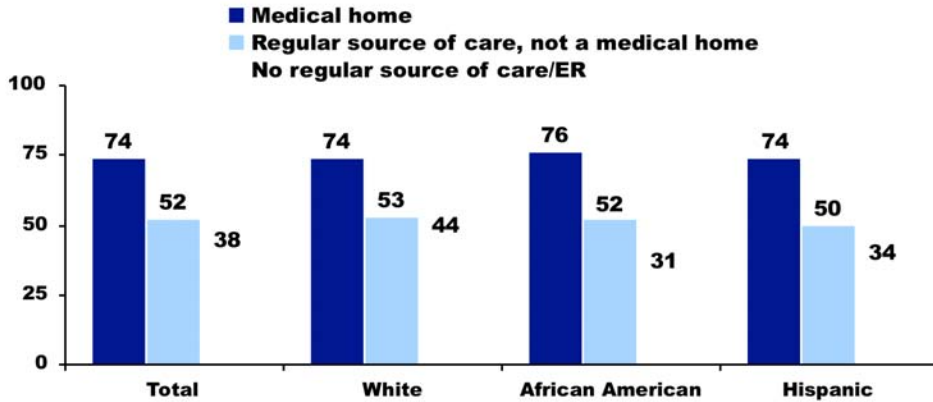
Figure 14. 2006 Fund Quality of Care Survey Indicators of a Medical Home (adults 18-64)

Indicator	Total		Percent by Race			
	Estimated millions	Percent	White	African American	Hispanic	Asian American
Regular doctor or source of care	142	80	85	79	57	84
<i>Among those with a regular doctor or source of care . . .</i>						
Not difficult to contact provider over telephone	121	85	88	82	76	84
Not difficult to get care or medical advice after hours	92	65	65	69	60	66
Doctors' office visits are always or often well organized and running on time	93	66	68	65	60	62
All four indicators of medical home	47	27	28	34	15	26

Source: Commonwealth Fund 2006 Health Care Quality Survey.

Figure 15. Racial and Ethnic Differences in Getting Needed Medical Care Are Eliminated When Adults Have Medical Homes

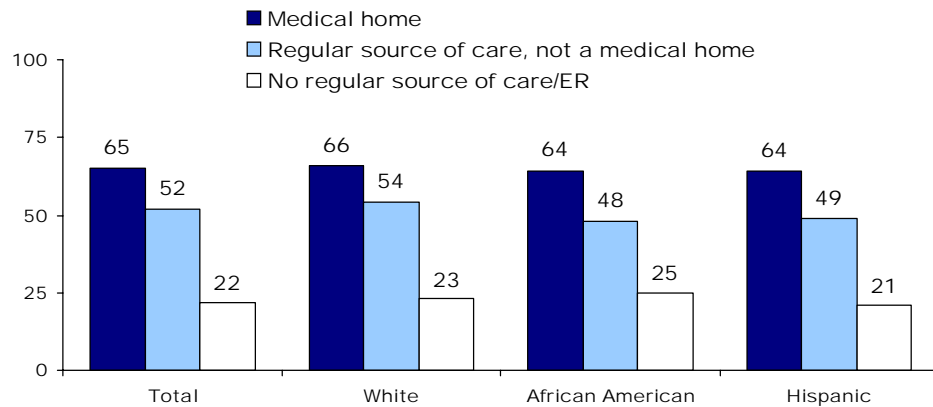
Percent of adults 18–64 reporting always getting care they need when they need it



Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

Figure 16. When African Americans and Hispanics Have Medical Homes They Are Just as Likely as Whites to Receive Reminders for Preventive Care Visits

Percent of adults 18–64 receiving a reminder to schedule a preventive visit by doctors' office



Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

Figure 17. Adults with a Medical Home Are More Likely to Report Checking Their Blood Pressure Regularly and Keeping It in Control

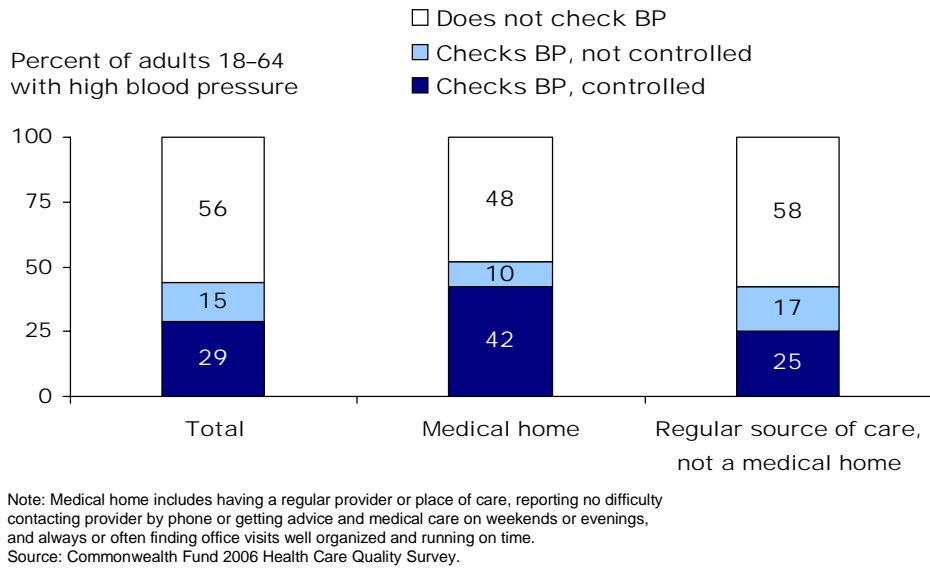
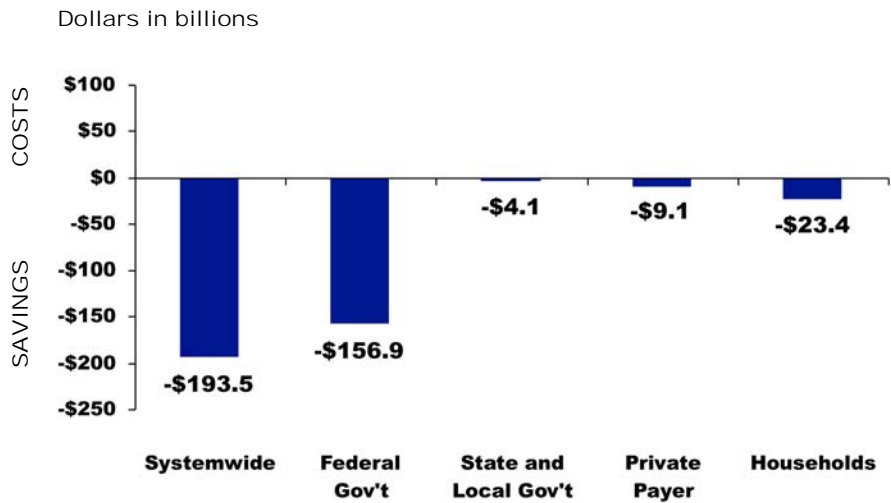


Figure 18. Estimated Distribution of 10-Year Impact on Spending from Strengthening Primary Care and Care Coordination



Source: Based on estimates by The Lewin Group for The Commonwealth Fund, 2007.

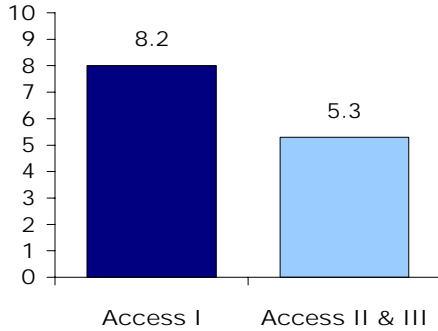
Figure 19. Community Care of North Carolina: Medical Homes Can Save Health Care Costs



Asthma Initiative:
Pediatric Asthma
Hospitalization Rates

(April 2000–December 2002)

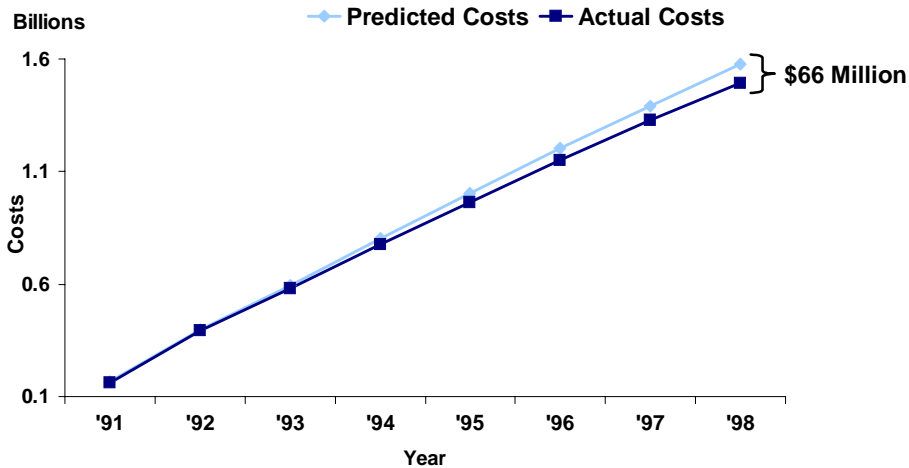
In patient admission rate
per 1,000 member months



- 14 networks, 3,200 MDs, >800,000 patients
- \$3 PMPM to each network
- Hire care managers/medical management staff
- \$2.50 PMPM to each PCP to serve as medical home and participate in disease management
- Care improvement: asthma, diabetes, screening/referral of young children for developmental problems, and more!
- Case management: identify and facilitate management of costly patients
- Cost (FY2004) - \$10.2 Million investment; Savings: \$124M compared to FY2003 and \$225M compared to Medicaid FFS (Mercer Consulting)

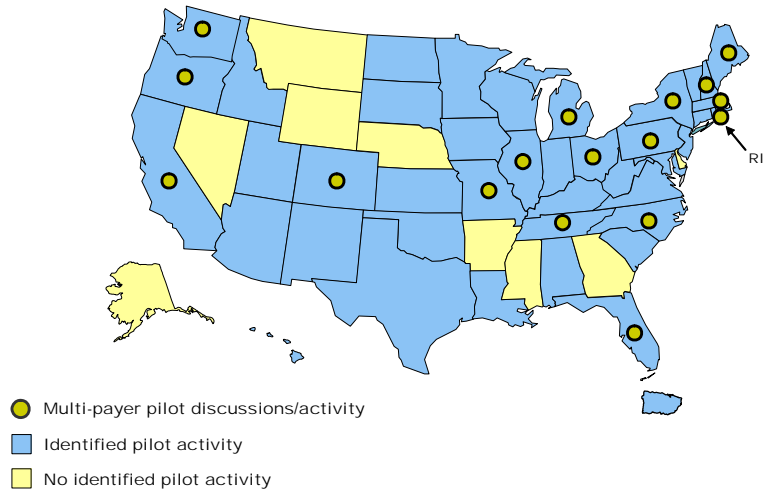
Source: L. A. Dobson, Presentation to ERISA Industry Committee, Washington, D.C., Mar. 12, 2007 (Updated June '08).

Figure 20. Iowa Medicaid Saved \$66 million (1991–1998)



Source: E. T. Momany, S. D. Flach, F. D. Nelson et al., "A Cost Analysis of the Iowa Medicaid Primary Care Case Management Program," *Health Services Research*, Aug. 2006 41(4 Pt 1):1357–71.

Figure 21. Overview of Current Pilot Activity and Planning Discussions of the PCMH (as of July 2008)



Source: Patient-Centered Primary Care Collaborative, July 16, 2008.