MEMORANDUM

TO: **Senate and House Medicaid Committees**

FROM: **Illinois Academy of Family Physicians**

RE: **Illinois' Medicaid Medical Home – the Nation's Largest**

DATE: **December 1, 2010**

In an effort to assist the state of Illinois reach sound fiscal and policy decisions that impact our patients, the Illinois Academy of Family Physicians offers the following written testimony to the newly created House and Senate Committees on Medicaid.

A patient-centered medical home does not equal mandatory managed care. Here's why:

Medical Home means…	***Managed Care means…***
Physician-patient relationship	Systematic "gatekeeper" relationship
Patient-centered, personalized care	Contractually-dictated care
Preventive services, fewer ER visits	Patients get "partialist" care with services that are "carved out"
Less hospitalization, better tracking	Physicians handcuffed by "one size fits all" rules.
Physician support and feedback	More rules and unhappy patients
Healthier, engaged patients	Fiscal savings by limiting access to services
Fiscal savings through comprehensive, coordinated care	

Reverting to managed care for Medicaid would be a step back for Illinois. **The solution to our state's health care problems, both physician and fiscal, lies in the primary care medical home. And Illinois should be proud to have the nation's largest medical home project working and saving money in the Medicaid program.** Yes, Illinois Health Connect and Your Healthcare Plus were featured programs at the national meeting of the Patient-Centered Primary Care Collaborative in Washington, DC this October. In fact, the organization's President, IBM Executive Paul Grundy, M.D. addressed the Illinois Chamber's Healthcare Council several years ago about the medical home concept. And here we are in December 2010, reviewing their successes and savings! With strong emphases on disease management, community and medical home partnerships and redesigned payment schemes for providers that reward care coordination, case management and quality overhigh volume, these programs have delivered initial success in terms of improved quality metrics, patient/provider satisfaction, and early cost savings to the state.

Here are some of the the highlights:

- IHC -- 1.8 million in 5700 medical homes; 200,000 in managed care, 1.8 million in IHC; Capacity for 5.4 million
- YHP – 280,000 patients
- Saved $180 million in FY '08 (IHC and YHP in full force for last six months)
- Saved $320 million in FY '09 (first full year of operations)

Much of the savings have been attributed to the deployment ofnumerous provider and community based resources that focus on chronic disease management, addressing mental health disparities, partnering with community stakeholders and regulatory agencies and increasing carecoordination. These elements are perceived to be critical to improving quality in vulnerable populations andcontrolling state costs. The Agency for Healthcare Research and Quality (AHRQ) supports these elements asfundamentally important to curbing unnecessary, redundant or costlier care.Family medicine has long advocated for a medical home system built on a primarycare foundation. With Illinois Health Connect and Your Healthcare Plus, this type of team-based approach provides the necessary information and support enablingprimary care physicians to ensure appropriate, coordinated and cost-effective careto Medicaid patients. Both these programs are built on a primary care foundationand succeed in the medical home model.

Similarly, both programs receive input from a variety of work groups and committees comprised of stakeholderorganizations and primary care providers who work collaboratively, with the best interests and healthoutcomes of the patients they serve as a common priority, bringing measureable results forpatients and higher satisfaction for the providers.

Advanced primary care models, like medical homes, can provide the coordination mechanisms and decision support to improve quality, cost, and satisfaction. Abundant research comparing nations, statesand regions within the U.S., and specificsystems of care has shown that healthsystems built on a solid foundation of primarycare deliver more effective, efficient, and equitable carethan systems that fail to invest adequately in primarycare. However, some policy analysts have questionedwhether these largely cross-sectional, observationalstudies are adequate for making inferences aboutwhether implementing major policy interventions tostrengthen primary care as part of health reform wouldin the relatively short term "bend the cost curve" atthe same time as improving quality of care andpatient outcomes.

Is there research using prospective, controlled studydesigns which shows what happens to quality, access andcosts as a result of investments to enhance and improveprimary care? **Have recent evaluations documented theoutcomes of interventions in the U.S. promoting primary care patient-centered medical homes (PCMHs)?**

The answer to these questions is, *Yes*.

Although some major evaluations of the PCMH are only now getting off the ground, including the evaluation of the Medicare Medical Home Demonstrations, evaluations of other primary care initiatives are much farther along. And the findings of some of these evaluations are startingto emerge in peer-reviewed journals and otherpublications. A briefing document titled, "**The Outcomes of Implementing Patient-Centered MedicalHome Interventions:** A Review of the Evidence on Quality, Accessand

Costs from Recent Prospective Evaluation Studies" was published in August 2009 and prepared by Kevin Grumbach, MD, Thomas Bodenheimer, MD MPH and Paul Grundy MD, MPH. This document summarizes key findings fromrecent PCMH evaluation studies. These studies haveinvestigated a variety of PCMH models, in a varietyof settings ranging from integrated delivery systems tocommunity-based office practices. Some evaluationsexamine interventions focused on general primary carepatient populations, and others on high risk subsets. Theevaluations span privately insured patients, Medicaid,SCHIP and Medicare beneficiaries, and the uninsured.Across these diverse settings and patient populations,evaluation findings consistently indicate that investmentsto redesign the delivery of care around a primarycare PCMH yield an excellent return on investment:

- Quality of care, patient experiences, care coordination,and access are demonstrably better.

- Investments to strengthen primary care result withina relatively short time in reductions in emergencydepartment visits and inpatient hospitalizations thatproduce savings in total costs. These savings at aminimum offset the new investments in primary care in a cost-neutral manner, and in many cases appear to produce a reduction in total costs per patient.

We have seen these very resultswith Illinois Health Connect and Your Healthcare Plus.

In late 2009, the Illinois Academy of Family Physicianscommissioned a case study of these two programs which was funded by severalsources including grants from the Community Memorial Foundation (Hinsdale, Ill.), Michael Reese Health Trust(Chicago), and the Family Health Foundation of Illinois (Lisle, Ill.), with a federal Medicaid match of those grants. This case study now forms the basis of a qualitative evaluation being funded by the Commonwealth Fund and researched by the Robert Graham Center.

Change takes time. In order for Illinois' medical home model to continue its successes, we must support the efforts of providers, hospitals, community health centers, and others involved in keeping the primary care case management model intact.For 2011, Illinois Health Connect plans to continue to expand quality bonuses and promote "medical homeness" factors to move practices along medical home continuum

What more can a Patient-Centered Medical Home offer?

- A high-quality, coordinated medical home can help patients avoid hospitalizations and emergency department visits, thereby reducing costs.
- In a medical home, the practice is organized around the patient – communication is based on trust, respect and shared decision-making. Patients want access to personalized, coordinated and comprehensive primary care when they need it, when it's convenient for them.
- Lack of a personal physician is associated withlower rates of use of preventive services and higher ratesof preventable illness and complications. Across allchronic diseases, long-term adherence to a medical treatmentplan is complex and often inconsistent.Manyexperts believe that patients who develop a treatment planin collaboration with their physician or other providerwill be more adherent and have better outcomes.

A PCMH is a physician practice that has gone through a voluntary qualification process to demonstrate that it has the following characteristics and capabilities needed to effectively partner with patients to provide patient-centered care:

- **a personal physician** who is accountable for taking care of all of a patient's health care needs;

- **collaboration with multi-disciplinary teams of physicians, nurses, caregivers, and other health professionals,** both within a practice and through coordination of care with health professionals in the community, to assure that all of the patient's needs are met;
    - **health information technologies** to facilitate access to services and coordination and sharing of information among health professionals, care givers and sites of service;
    - **transparency and accountability** for achieving better results through reporting on evidence-based measures of care.

A **better payment model** designed to support care provided through a PCMH would:

- **Pay physicians for the time spent to coordinate care** with family caregivers and other health professionals that is separate from--and in addition to--the work included in a face-to-face encounter..
- **Create financial incentives for physicians to acquire and use health information technologies**—such as patient registry systems, secure email, evidence-based clinical decision support, and electronic health records--to achieve better outcomes.
- **Result in higher payments to primary care physicians for achieving better outcomes and reducing total health care spending** through a PCMH**. Such payments should:** recognize **the time and expenses incurred** in delivering patient-centered care through a medical home, **be sufficient to address long-standing payment inequities that undervalue primary care,recognize the potential savings** (such as preventing avoidable hospital admissions/ emergency room visits by patients with chronic illnesses) that can be achieved through effective care coordination by physicians, and **include rewards based on performance**.
- **Provide accountability and transparency** for achieving better results by linking a portion of payments to reporting on evidence-based measures of care.

<u>How can we ensure enough medical homes for Illinois citizens</u>?

We need more primary care physicians.Primary care is at the heart of the patient centered medical home. Yet in our nation, primary care is rapidly losing ground as the preferred field of practice. The Association of American Medical Colleges (AAMC) projects a physician shortfall of more than 130,000 physicians nationwide by 2025. Our national organization, the American Academy of Family Physicians projects that Illinois will need an additional 1,000 family physicians more than our current level to meet demands for services that we will see by the year 2020. **Basically we need to ramp up family physician production by 30 percent.**

The numbers in Illinois are not even close. Illinois has eight allopathic medical schools throughout the state. This year, only 89 out of 1,184 - only 8 percent - of Illinois allopathic medical graduates chose family medicine… continuing a poor trend dating back to the mid 1990s. In 2011, a first-year medical

student could be a practicing family physician by 2017. So if we hope to shore up our supply of family physicians in 2020, we need to start moving those numbers up **now**.

Payment mechanisms that devalue time spent with patients and the attraction of better-paying specialty or subspecialty practice in our nation combine to reduce the ranks of primary care providers. Primary care physicians earn half to one-third of the income of many of their specialist counterparts. Between 1995 and 2003, they experienced a relative income drop of more than 10 percent. As a result, medical school graduates abandoned primary care at an alarming rate. Correcting the income disparity between primary care and subspecialty physicians by boosting primary care incomes to at least **60 percent** of the equivalent subspecialty income would turn the tide back toward primary care.

Concluding Remarks

The Illinois Academy of Family Physicians (IAFP) appreciates the opportunity to share our enthusiasm for patient-centered medical homes. We believe Illinois has made great strides in providing medical homes to the Medicaid population. There are numerous resources available that expand on the areas covered in this testimony: IAFP welcomes the opportunity to share in depth any of these findings. We also look forward to continuing our collaboration with those interested in improving patient care through the medical home.

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About the Illinois Academy of Family Physicians: The Illinois Academy of Family Physicians (www.iafp.com) is a professional membership society dedicated to maintaining high standards of primary care and representing 3,500 family physicians, family medicine residents and medical students. Family physicians are trained to care for patients of all ages and both sexes, providing preventive, acute and chronic care services, making them ideal providers to anchor the medical home.

About the Robert Graham Center: Established in 1999, the Graham Center (http://www.graham-center.org) is responsible for research and analysis to inform deliberations of the American Academy of Family Physicians (AAFP) in its public policy work and to provide a family medicine perspective to policy deliberations in Washington, D.C. The Center also established formal academic and research relationships in Washington, D.C. With Georgetown University, this meant faculty appointments and research support for the family medicine department. There are also sustaining relationships with the George Washington University School of Public Health, the U.S. Agency for Healthcare Research and Quality, the National Center for Primary Care at Morehouse University, practice-based research networks in Washington, D.C., and Virginia, and with community health center networks in Washington, D.C., and Baltimore.

About Illinois Health Connect: Illinois Health Connect (IHC) (www.illinoishealthconnect.com) connects over 1.9 million Illinois citizens with a primary care provider (PCP) at a medical home. Providers enrolled in IHC receive a per member per month care management fee. Providers who meet or exceed annual benchmarks on developmental screening, diabetes management, asthma management, mammograms and vaccinations also qualify to receive bonus payments. IHC also provides patient outreach and assistance to help in selecting or changing a PCP for their medical home and provides IHC practices monthly reports on their patient panel in addition to access to quality tools to assist providers in managing and coordinating the care of their enrolled patients. HFS contracted with Automated Health Systems to administer the day-to-day operations of the IHC program and family physician Margaret A. Kirkegaard, MD, MPH is the program's medical director.

About Your Healthcare Plus: Your Healthcare Plus (YHP) (www.yhplus.com) covers 280,000 Medicaid-only patients with chronic or complex conditions often associated with frequent emergency room visits and hospitalizations. Patients receive additional phone or face-to-face support from Your Healthcare Plus to improve use of their medical home, adherence to treatment plans and better self-management of chronic illness. This support occurs through interactions with YHP staff that includes nurses, social workers, behavioral health specialists and lay community educators. The program offers providers online continuing medical education (CME) for providers. YHP also provides decision support for complex medication regimens and quarterly clinical metric reports on six chronic conditions, diabetes, asthma, coronary artery disease, COPD, congestive heart failure and depression. YHP is administered by McKesson Health Solutions and family physician Carrie E. Nelson, MD, MS, FAAFP is the program's medical director.