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I am Dr. Lowell Keppel, President of the Wisconsin Academy of Family Physicians (WAFP). I would like to thank the legislative council for allowing us to testify in favor of a Patient-Centered Medical Home (PCMH) pilot program for Wisconsin's Medical Assistance recipients in the final recommendations of the Special Committee.

The PCMH model is an innovative – and proven – health care delivery model based on a physician-guided medical practice, chosen by the patient, which integrates health care services for patients who confront a complex and confusing health care system.

Under the PCMH model, primary care physicians oversee all aspects of a patient's care and coordinate a team of specialty practitioners to meet the patient's medical needs at each stage of life. The PCMH places an emphasis on prevention and wellness to significantly reduce overall care costs by improving outcomes, reducing complications, eliminating unnecessary care and unnecessary emergency room visits

A definition of a PCMH and how it should function was developed by the four national primary care specialty societies in March 2007. The PCMH practice is structured to focus on the patient using tools and procedures that are much more than what has traditionally been called a primary care practitioner's office.

These patient-centered tools and procedures apply directly to Performance-Based Disease Management Programs for Large Populations. They include tools such as these:

- chronic disease registries for tracking the care that patients receive, assuring increased adherence to the best possible evidence-based medical care guidelines,

- patient-specific care coordination that provides practical support and valuable information to chronically ill patients so that they and their family can be empowered to take better care of themselves,

- better tracking of lab and imaging test results and sub-specialty referrals by the care team, resulting in reduced duplication of tests, better access by all treating physicians to the patient's results, and overall improved quality of care.

- electronic prescribing that provides real-time access for a treating practitioner to a complete up-to-date medication status for each patient, significantly reducing the potential for medical errors.

- an improved appointment schedule process that significantly increases same-day access for patients to be seen by a practitioner on their health care team. This results in significantly reduced emergency room utilization and increased patient satisfaction.

These and other tools that are part of the PCMH restructured care process have the potential to save Wisconsin's Medical Assistance program (and virtually all Wisconsin payors) millions of dollars as has been demonstrated in other states.

But it is costly for physicians to restructure their offices in this way, both in terms of building the infrastructure to support the tools as well as re-training their staff, building the healthcare team, and potentially hiring additional staff. Current payment models that only reward face-to-face care and that disproportionately pay for procedures over cognitive care and non face-to-face care coordination do not adequately create payment incentives for physicians to provide the required changes to their practices.

This is why the WAFP agrees with the four major primary care specialty societies' proposal that payment reform that adequately recognizes the added value that a PCMH brings to the healthcare system must occur simultaneously with the practice changes, in order to provide a payment environment that will support the needed changes and make them financially sustainable.

To that end, the WAFP has developed the proposal that is before you. It uses a blended payment model that preserves and slightly enhances the current fee for service (FFS) payment system for a practice that has been recognized as a PCMH, and, in addition, provides a fixed care coordination fee in the form of a Per Member Per Month (PMPM) payment to a practice for each patient that has voluntarily chosen that practice as his/her Medical Home.

Let's look at the proposal together:

First, the proposal does not result in any up-front costs for the state or provide increased payments for practices until the required changes in practice structure and function have been put in place. Because we believe that the value and benefits to patients in the form of improved outcomes have been adequately demonstrated, we believe that many physicians will voluntarily make the changes to their practices, if they can be convinced that some of the savings generated by their changes will go into helping them be financially sustainable.

Second, in order to work, there needs to be a standardized way to identify when a practice is functioning as a PCMH. Our proposal relies upon the National Committee for Quality Assurance (NCQA) to be the independent 3rd -party organization that assesses physician practices and recognizes those that meet the standards as a PCMH.

By going through this single assessment process, a practice can demonstrate and be recognized as a PCMH and qualify for the program at one of 3 levels, based upon NCQA's existing 3-level recognition program. The WAFP proposal uses this recognition process as the basis for a practice in order to qualify for participation in the payment proposal.

Third, once a practice has demonstrated compliance at one of 3 levels, the payment proposal would begin, with an enhanced FFS payment for the face-to-face office visits PLUS the fixed care coordination fee in the form of a PMPM payment to a practice for each patient that has voluntarily chosen that practice as his/her Medical Home. You can see from the table at the bottom of page 1 that the magnitude of these increased payments is graduated, based upon the level of recognition achieved, thus creating incentives for

practices to continue to make process improvements that will result in increases both in quality and in cost-savings generated.

Lastly, we show the potential magnitude of savings expected, based upon the experience in the North Carolina Medicaid population over the past 5 years. You'll see that in our proposal over half of the projected savings remains with the State.

But our proposed payment figures are not based solely on the NC experience. They are also consistent with those proposed by many other payor groups. For instance, a coalition of over 200 large employer groups who are all self-insured, known as the Patient Centered Primary Care Coalition uses a model that pays physicians in PCMH practices a care coordination fee of $125 per patient per year ($10.40 PMPM) for its population that is non-Medicare aged. This is right in line with the amounts we are proposing.

Also, CMS has proposed in its Medical Home Demonstration Project to pay a care coordination fee, on average, between $40 and $50 PMPM to PCMHs caring for Medicare-aged patients.

These plus many other efforts around the country are utilizing the blended PCMH payment model to create positive change in how primary care is delivered. Many of them are summarized in a document available at www.pcpcc.net that we can provide for you on request.

In summary, we believe that physicians will voluntarily make the changes to their practices, because the evidence shows that the PCMH model of care provides better outcomes for patients. But without payment reform, the changes will be slow and the savings generated from the improved care model will be delayed. This is why we recommend that the State take the lead and including a blended payment model in its final recommendation for the Medicaid population.

We believe that our proposal would be both attractive enough to speed up the needed changes in physician practices and affordable enough to be paid out of the savings to the system, plus leave significant additional dollars in savings for the state to use as they see fit.

I would be happy to address any questions now, or, for further information, you can contact the WAFP offices (Larry Pheifer, executive director) at 262-512-0606 or via email at academy@wafp.org.

Respectfully submitted,

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Wisconsin Academy of Family Physicians