ISSUE Brief

A *National Business Group on Health*® Publication

March 2016

National Business Group on Health®

Patient-Centered Primary Care COLLABORATIVE

The Primary Care Imperative: New Evidence Shows Importance of Investment in Patient-Centered Medical Homes

Executive Summary

Primary care accounts for about 5% of health care spending, but decisions made in the primary care setting influence up to 90% of overall cost and quality through referrals, testing, invasive procedures, and hospitalizations. The fee-for-service (FFS) payment system does not adequately reward high-quality primary care care nor address patient health holistically to reduce overall costs.

The PCMH model offers an alternative paradigm designed to increase access to care, improve quality, and better care for the patient overall. The model is growing, but up until recently, data on whether the PCMH has delivered on improving health and reducing costs has been limited. This is why the Patient-Centered Primary Care Collaborative's (PCPCC) 2016 PCMH Evidence Report is so exciting. Last year, over 90% of PCMHs that evaluated cost of care or utilization of acute care services found improvements, greatly improving the case for employer investment in the model.

What Employers Can Do to Promote PCMHs:

Many employers, several of whom already pay care coordination fees to support PCMHs, have been reluctant to further engage with this delivery system reform. Given robust results from the PCMH Evidence Report, the Business Group recommends employers take the following actions:

- Ask your health plan(s) to identify opportunities for a PCMH strategy (i.e., which of your markets have a PCMH presence, how many of your employees see PCMH providers, what fees you pay) and to provide educational materials that highlight which practices provide PCMH care.
- Contract with health plans that identify PCMHs that are improving outcomes and reducing costs.
- Ask for regular health plan reports on PCMH performance in your markets.
- Reduce or eliminate cost-sharing for care delivered in a PCMH, as allowed under the plan, and communicate the benefits of selecting a PCP participating in a high-performing PCMH.
- Consider direct-contracting with PCMH providers in markets with large employee bases and providers with high quality track records, if partnering with your health plan is not possible.
- Study and consider joining multi-payer PCMH collaboratives in your markets.

This issue brief addresses common employer concerns and lays out convincing evidence that investing in PCMHs is a valid strategy for improving employee health, and reducing costs.

This *Issue Brief* was developed by the *National Business Group on Health*® and the *Patient-Centered Primary Care Collaborative*, which should be cited accordingly. 2016 *National Business Group on Health*®

Introduction

Employers have traditionally focused on aspects of health care they believe are within their purview and that they have the ability to meaningfully influence. This includes setting benefit plan design and providing incentives for certain positive health behaviors. But as more employers offer consumer-directed health plans with tools to help employees make smart health care decisions, they must shift toward engagement with the health care delivery system to continue driving outcomes improvement and cost reduction.

Primary care generally serves as the entry-point into the health care system. Thus, comprehensive reform and transformation begin with primary care. What's more, delivery models like patient-centered medical homes (PCMHs) are showing clear and convincing evidence that employer-purchaser investment in primary care can improve quality and eliminate wasteful health care spending.

Nevertheless, employers have legitimate questions and concerns regarding deeper participation in health care delivery transformation. *For example: Are care coordination payments improving the system, or just adding costs? Are PCMHs and accountable care organizations (ACOs) simply retreads of the failed HMO movement of the 1990s?* The PCMH Evidence Report, authored by the Patient-Centered Primary Care Collaborative (PCPCC), shows how dozens of PCMH programs are addressing these concerns, coordinating payers and achieving results. This issue brief, a collaborative effort between PCPCC and the National Business Group on Health, reviews the capabilities of the PCMH model, addresses common employer concerns, and provides recommendations for benefit managers.

A Patient's Perspective on Comprehensive Primary Care

Shonda works in the accounts receivable department of a large company that relies on her to accurately and efficiently update payments in customer accounts. Shonda has been up all night with the flu and has decided it's time to see a doctor, but at 2 a.m., all doctors' offices are closed. If she goes to the emergency room (ER), she knows she will wait for hours and likely receive a bill for hundreds of dollars or more, if she hasn't reached her deductible. But if she waits until morning to call a doctor, she probably won't get an appointment for days, maybe even weeks. Not sure whether immediate treatment is necessary, Shonda errs on the side of caution by heading to the ER. Six long hours later she leaves with a prescription and anxiety about a big bill. She takes two sick days, and then returns to work tired and worried about the ER bill.

If Shonda had been in a PCMH, her care, safety, and costs could have been much improved. She could have called the 24/7 nurse phone line at 2 a.m. to find out if she needed care. The nurse would have triaged her based on a description of her symptoms. This likely would have set up a next-day appointment made possible by team-based care that embraces same-day access. Patients with less intensive conditions, like the flu, can be seen by the right provider, right away. The nurse could have reassured Shonda that only severe cases of the flu are treated with prescription medications, and advised her to rest and take a fever-reducing medication. The next day, Shonda's doctor or a nurse practitioner would have had more time to spend with her, addressing immediate symptoms, but also using the PCMH integrated information technology system to identify and address gaps in care, like overdue flu vaccinations. Shonda's experience would have been better, her bill much lower, and her health addressed as a whole, rather than in a fragmented system that is incentivized to treat quickly and move on. Shonda would have returned to work healthy and with less worry knowing she got the right care at the right time.

What Are Employers Paying For? An Overview of the PCMH Model

Primary care accounts for over half of physician visits, but only 4%-7% of U.S. health care spending.[1,2,3,4] The dominant fee-for-service (FFS) payment system does not reward high-quality care, but instead encourages a high volume of quick visits and little or no ongoing care coordination for patients. The PCMH model offers an alternative paradigm.

The PCMH embraces team-based care, including physicians, nurses, nurse practitioners, pharmacists, dieticians, care coordinators and behavioral health specialists working together. Many care teams include community health workers and medical assistants, and others. A comprehensive team enables patients to receive timely, coordinated care supported by actionable data and technology. The PCMH model can improve health outcomes and reduce costs in the following ways:[5]

Why Focus on Primary Care When It Is A Fraction of The Overall Health Care Spend?

"Although primary care today accounts for only 5% of [health care] spending, the decisions made in the primary care setting have important implications for downstream medical care, such as subspecialty referrals, imaging and other medical testing, invasive procedures, and hospitalizations. A group of 100 adult primary care physicians could potentially influence almost $1 billion in… spending."
- Mostashari, Sanghavi, and McClellan (2014) in *Journal of the American Medical Association*

- Improving Access and Continuity: PCMH primary care practices provide access to care (telephonic or otherwise) available 24/7 and same-day or next-day appointment scheduling, giving patients enhanced access to primary care at all times. Combined with an ability to coordinate with retail clinics and telehealth providers, PCMHs help patients avoid unnecessary ER visits and streamline care.
- Identifying Gaps in Care for Chronic Conditions and Offering Preventive Services: PCMH primary care practices, often in conjunction with health plans' data analytics staff, proactively assess patients' needs in order to identify opportunities for providing necessary and appropriate care for chronic conditions, such as medication management and review, and also to provide preventive services to patients who need them.
- Integrating Risk-Stratified Care Management: PCMH primary care practices, also in conjunction with health plan partners, assess their attributed populations (actively elected or assigned based on past utilization) and implement high-touch care management for at-risk patients. This helps patients manage conditions and avoid costly hospital visits.
- Supporting Patients and Caregivers in Shared Decision-Making: PCMH primary care practices integrate culturally competent self-management support for patients and the use of decision aids to help patients make decisions about elective and patient-sensitive care. Studies suggest informed patients are more likely to choose less intensive procedures that align with their values and are often less costly both to them and to their employers.[6]

- Coordinating Care Across Health Care Settings: PCMH primary care practices operate in teams, triaging patients to the appropriate clinical team members. This allows for more time to work with patients and patients' other health providers, coordinating and managing care transitions, making referrals to specialists based on quality and cost data, and exchanging information between patients and providers (e.g., using health information technologies and electronic health records).

PCMH transformation can be especially challenging for small practices that lack the resources and capacity to implement advanced features of the PCMH without support from larger clinical networks.[7] However, many smaller practices have excelled at reducing unnecessary utilization, given their close connection to their communities.[8] Small practices can benefit from initiatives that maximize community resources, such as sharing nurse coordinators for chronically ill patients.

Advanced Primary Care and ACOs

Accountable care organizations (ACOs) rely on primary care practices for population health management, directing the flow of information between ACO providers, and linking attributed patients to nonclinical partners like community centers, faith-based organizations, public health agencies and employee assistance programs for social supports that will help keep patients healthy and out of intensive care. ACOs need a strong primary care coordination foundation to deliver on outcomes improvement and cost reduction. But many ACOs still reimburse primary care providers through fee-for-service with some gain sharing after year's end, which hampers their ability to implement PCMH improvements.

The Best Laid Plans... Are PCMHs *Actually Working?*

Coordinated, team-based care sounds great, but ultimately, employers want to know if PCMH transformation is reducing costs and improving outcomes. PCPCC's 2016 PCMH Evidence Report and Primary Care Innovations Map show that the answer is "yes." The majority of providers adopting the PCMH model are improving quality, reducing waste and stemming costs. [9]

The Patient-Centered Primary Care Collaborative's 2016 analysis of 30 PCMH evaluation studies points to a clear trend for the majority of PCMH practices. The analysis shows clear and convincing evidence that PCMHs are driving reductions in health care costs and/or unnecessary utilization, such as emergency department (ED) use, hospital utilization and hospital readmission.[10] A 2015 PCPCC report also showed that the majority of PCMHs are improving quality, access to care, and patient satisfaction.

Do all PCMH initiatives look alike? How will I know what to look for in a successful PCMH?
PCMH is not a "one size fits all" model, and the context in which an initiative is implemented matters. Research is beginning to identify factors driving success in PCMH programs that achieve positive outcomes (see text box on page 6). Notably, effective PCMHs need adequate resources. Some receive per-member per-month (PMPM) fees to fund upfront investments in practice improvement and in clinical interventions that address patient health outside of the office visit. Successful PCMH arrangements also frequently incorporate shared savings incentives or other payment models, like pay-for-performance with quality or other performance benchmarks, to reward cost-effective care that meets or exceeds evidence-based quality metrics.[11]

Each study measured cost and utilization differently in the PCPCC evidence report, but several examples highlight strong cost savings from PCMHs.

- Adult patients in Blue Cross Blue Shield of Michigan's Physician Incentive Program had per-member per-month costs (PMPM) $16.73 lower than patients seeing non-PCMH providers, a 4.4% difference.[20]
- PCMH practices in the Vermont Blueprint for Health program reduced patient expenditures by $40 PMPM over a 5 years, reducing costs by $104.4 million per year. Increases in primary care spending were more than offset by large reductions in hospital, emergency department, and imaging services.[21]
- UCLA Health System PCMH practices reduced emergency department utilization by 12% and net spending by $450,000 over one year for 10,500 patients.[22]
- The University of Utah "Care By Design" PCMH program cut patients' 30-day hospital readmission rate in half by coordinating care between hospitals and PCPs before and after discharges.[23]

We do know that the longer a PCMH practice has operated under the model, giving practices time to transform and respond to these new incentives, the better the results.[12] So, while time is necessary for practices to fundamentally change the way they deliver care, affect quality in a positive way and reduce costs, the upfront investment is critical in supporting the non-billable costs associated with care delivery transformation. One way that practices see a return on primary care investment quicker is by maximizing the use of claims data, biometrics and health risk assessment results, and ensuring patients with multiple chronic illness get extra support. By leveraging the results from this information, the health plan and the PCMH can identify and support employees who will benefit most from coordinated care through a PCMH.

Practice Size and Location Affect Outcomes

Medium-sized practices may find it to easier to be more successful in achieving positive outcomes through the PCMH model, because they usually have the capacity to implement infrastructure improvements (when supported by payers) and they do not have the organizational inertia that slows change in some large health care organizations. That being said, smaller practices (one or two physicians) have demonstrated lower hospital readmission rates, because their patients may have increased access to their physicians.[13] Predictably, practices in higher cost regions, like New York City, have been found to reduce costs faster compared to those operating in already lower cost markets.[14]

Achieving Cost Reductions Can Take A Few Years, But Quality Can Improve Much Faster

Evidence suggests it takes 2-3 years to achieve significant cost savings, though quality improvements are often seen in the first year of implementation. Many studies show faster PCMH improvement on quality metrics focused on higher risk chronic disease (e.g., diabetes and asthma) management.

Key Elements to Look for in Successful PCMHs

- Strong health information technology (HIT) infrastructure
- Previous experience working on quality improvement initiatives
- Committed physician-provider leadership
- Coordinated, proactive care management
- Continuous access to data on quality of care and utilization patterns for primary care providers

Contextual Factors Improving PCMH Success

- Medium-sized practices large enough to fund transformation, but small enough to be nimble
- Practices with two to three years of experience implementing the PCMH model
- Multi-payer coordination in support of PCMH
- Faster cost reductions for PCMHs located in high cost regions

Source: Friedberg, Sixta, Bailit. June 2015. Health Affairs Blog.

Multi-Payer PCMH Programs Increase Opportunities for Transformation

PCMH initiatives that coordinate payer alignment of financial incentives and quality measurement create stronger incentives for providers to transform and reduce duplicative reporting processes.[15] Employers can support multi-payer PCMH programs by partnering with participating health plans. Sometimes employers participate directly in multi-payer initiatives.

The Center for Medicare & Medicaid Innovation (CMMI) leads two of the largest multi-payer PCMH programs in the country, both of which incorporate public and private payers:

- Over five years, the *Multi-Payer Advanced Primary Care Practice Demonstration* achieved a return on investment of $1.35 for every dollar spent across practices in five states, even accounting for PMPM fees to pay for practice transformation and non-visit based clinical care. The *Comprehensive Primary Care (CPC) initiative,* launched in 2012 in seven regions across the U.S., brings together 38 payers, 476 practices and over 2,800 providers, impacting nearly 2.7 million patients. Practices receive a $20 PMPM fee and are expected to achieve several quality benchmarks. After just one year, avoidable ER use and hospitalizations were reduced nearly enough to offset care management fees, and program evaluators anticipate further cost reductions once practices have had more time to transform.[16]

Addressing Common Employer Concerns

Concern: Are care coordination fees just adding more costs to the health care system?
Answer: The PCPCC PCMH Evidence Report shows how PCMHs use per-member per-month (PMPM) fees or other funds to support care coordination activities that aren't traditionally reimbursed, expand their care teams, and improve practice infrastructure, such as health information technology (HIT) for population health management, while still controlling overall health care costs. It is often the case that, the reduction of unnecessary or inappropriate care more than accounts for the up-front investments. Because of the high prevalence of waste in the system, these investments in primary care can quickly reduce unnecessary utilization of downstream, expensive care. Large health plans also generally use this strategy for their fully-insured book of business, for which they are wholly at risk; and often they are able to negotiate reduced rate increases for certain specialists to offset the implementation of PMPM coordination fees.

Employers & Health Plans Lead the Way on Primary Care

Cerner Corporation opened its first on-site health clinic in 2006, and assumed most employees would use it for same-day or urgent care. But demand for primary care services quickly outstripped capacity, and Cerner flipped it to a team-based, integrated primary care clinic. Now, with three clinics employing physicians, nurse practitioners, chiropractors, pharmacists, dieticians, health coaches and counselors, Cerner covers nearly 30,000 visits per year and fills two-thirds of all prescriptions taken by its Kansas City headquarters population. For this Kansas City population, per member per year spending is approximately $360 less for people who used the clinics than for those who did not.

In 2012, *MGM Resorts* contracted directly with individual PCPs to provide primary care in a PCMH model. Currently, there are 26 PCPs on the plan that operate under 18 different business entities. The providers guarantee same or next business-day appointments for urgent treatment and wait times of less than 30 minutes for scheduled appointments; and they are reimbursed based on quality. MGM incentivized employees to select a health care plan associated with this physician network by reducing out-of-pocket costs, compared to other plan options, and eliminating the deductible. Enrollment has quadrupled to 21,000 members out of the 44,000 eligible members in southern Nevada. The rate of annual health screenings in this population rose to 95%, leading to a rise in identified gaps in care and driving increases in appropriate preventive care.

At *Perdue Farms,* 87% of associates receive care at one of 15 on-site primary care clinics that focus on prevention and disease management. Due to the convenience of having services on-site, team-based medical providers can monitor employee and dependent health status regularly, as well as connect associates with community supports and specialty services. The program has improved adherence to appropriate medical procedures and saved money. Perdue is experimenting with telehealth and eliminating copays for targeted chronic conditions.

CareFirst Blue Cross Blue Shield covers 45% of the commercially insured population in its Virginia, DC and Maryland market. Its 4-year-old PCMH program is one of the largest and most successful in the United States. An April 2015 analysis showed that, of its 1.1 million members, those patients attributed to PCMH providers had yearly spending 9.5% below non-attributed members in 2014. The program has saved $609 million over four years.

Decades of using the predominant fee-for-service (FFS) reimbursement system have shown that FFS does not encourage high quality or positive outcomes, but rather a large volume of fragmented services. With the shift to value-based payment for PCMHs, models that support population-based payments with incentives for higher quality and reduced costs enable and encourage better care.

Concern: Am I paying for practice transformation that mostly benefits patients that are not in my population? Will I get employer-specific results?

Answer: A PCMH practice contracts with a health plan to transform care for all of that payer's patients, and achieving PCMH recognition by impartial evaluators requires that a PCMH provide the same standard of care for everyone. However, the higher the percentage of patients a payer has in a practice's population, the higher the incentives for true practice transformation. For example, the Comprehensive Primary Care Initiative aimed for a 60% penetration among its contracted practices. Employers should ask their health plans if they fund PCMH contracts across all lines of business (e.g., self-insured, fully-insured, Medicaid, Medicare), and if they participate in multi-payer PCMH arrangements that increase incentives to improve.

Regarding reporting, employer-specific data is only available in the aggregate, because relatively few employees get care from any given practice and sample sizes are too small to be meaningful. Employers are understandably concerned that they can't see practice-specific results for their attributed members (i.e., direct proof of improvements for their members), but are being charged up-front fees and must pay out "shared savings" for these members. Employers, in past efforts, have wasted money chasing improvements that did not materialize, such as with some unsuccessful chronic disease management programs. But true transformation requires investments, including the implementation of HIT, standardized protocols to reduce clinical variation, payment for nontraditional services and team expansion. With improved HIT and reporting, employers should ask their health plans to identify which contracted PCMHs are beating the market when it comes to outcomes improvement and cost per patient, and steer their patients toward these high-performing groups.

Concern: Are PCMHs and ACOs just "HMO-light"?

Answer: HMOs in the 1990s relied on rigid "utilization requirements" directed by the insurer and gave the impression that care was being rationed. There weren't good measures of quality, and there was minimal use of information technology. Today, public programs, employers, payers, and providers are partnering to support primary care transformation, and the PCMH model is the foundation of that redesign. Payers are no longer heavy-handedly controlling care, and they are putting dollars on the table to support practice transformation and reward value and quality. Additionally, the physician, nurse practitioner, and care team—which includes the patient and their family—determine the correct use of services. The tools and technology of today make this possible, like effective risk-stratification based on patient health status to manage practice resources, combined with requirements for patient satisfaction, safety and quality. These processes and strategies are necessary for the new payment models to succeed in rewarding efficient and appropriate care. Another counterpoint to the "HMO-light" criticism is that PCMH practices are required to provide enhanced access to health care providers for their patients, such as same- or next-day appointments with less than a 30-minute wait. Enhanced access is a win-win-win for providers, patients and employers. It supports a patient's/employee's ability to go back to their primary care provider for acute care and chronic care follow-ups, rather than using urgent care or skipping appointments.

Concern: Is my population too small in a given market to succeed? Is critical mass essential?
Answer: Although employers with a small population of employees and dependents in a given market have less clout to push health plans to be more aggressive in creating PCMH contracts, they do have multiple avenues to support primary care transformation. These include joining a health care purchasing coalition that can collectively partner with its health plans to contract with PCMHs; requiring or providing incentives to employees to select primary care providers that are in PCMHs; and communicating the benefits of health plan PCMH arrangements to employees (many health plans automatically include both fully-insured and self-insured employers in PCMH arrangements).

Concern: Should primary care be my top priority when it represents such a small portion of my health care spend?
Answer: High-cost specialty drug spending, complex patients with multiple chronic conditions, and other major health and cost concerns are often top of mind for employer benefit managers. While primary care only accounts for four to seven percent of total health care spend, a highly functioning PCMH can help address patient health holistically and hold down costs across the system. For example, a PCMH using smart referrals, which take into account cost and quality of specialty providers, can help direct patients with chronic conditions to high-value facilities for infusions, high-tech imaging and other care.

Employer Perspectives on PCMHs – Growing, But Cautious Engagement

According to the 2016 NBGH Large Employer Plan Design Survey, only 30% of large employers will have added or expanded high performance networks, ACOs and PCMHs beyond what their health plans offer by 2016, but another 50% are considering doing so for 2017.[17] In the same survey, just 4% of large employers consider PCMHs and ACOs as the most effective tactic to control medical costs. While engagement is still relatively low, there is clear interest by employers in accelerating health care delivery system reforms. Moreover, significant changes in how Medicare is paying providers, as part of recently passed legislation, will drive payment reforms that support PCMHs and ACOs. These payment reforms will drive changes in the commercial marketplace.[18]

Other survey data suggest that interest in the PCMH model among employers is likely to increase. In the 2014 Towers Watson/NBGH Purchasing Value in Health Care Survey:[19]

- 37% of employers considered the availability of ACOs and/or PCMH contracts very important when selecting a health plan vendor, and 40% said it was somewhat important.
- 28% of employers predict more care will be delivered through highly coordinated provider models like PCMHs in the next five years, while 44% are unsure.
- Among employers with the lowest cost trends, 47% considered PCMH availability a positive factor in selecting a health plan vendor, compared to just 32% for the employers with the highest costs.

Recommendations for Supporting Primary Care Transformation

The National Business Group on Health and the Patient-Centered Primary Care Collaborative recommend that employers consider the following actions to support comprehensive primary care transformation.

1. *Work with your health plan to identify opportunities for a PCMH strategy.* Employers should understand how many of their employees have selected a primary care provider and which markets with employee bases have PCMH programs in place.

2. *Contract with health plan partners that identify PCMH providers who are improving outcomes and reducing costs.* Ask your health plans for information on payment and delivery reform programs in your markets that are achieving appropriate targets in key outcomes. Consider working with the health plan in locations where the cost controls are sufficient to warrant incentivizing employees (e.g., with health reimbursement arrangement/health savings account contributions, lower copays, no fees for annual physicals) to select those providers.

3. *Push to get the most from PCMHs for your members.* Many employers are paying PMPM care coordination fees or paying out shared savings/pay-for-performance incentives through their health plans to support primary care transformation already. However, they may not be aware of saturation levels, or they are not actively working with their vendor partners to best take advantage of care improvement. Employers should receive regular reports of participation and results from their partners.

4. *Incentivize and engage employees to become active partners in their health.* Remove cost as a barrier to encouraging employees to be proactive about their health or chronic disease management. This can be done by offering first-dollar primary care or reduced cost sharing, as allowed under the plan.

5. *Promote transparency in the health care market to drive member behavior toward top PCMH providers.* This is accomplished through educational materials sent to members, using price transparency and advocacy tools that highlight which providers operate within a PCMH; in addition, by working with health plans to make it clearer to members, when they are selecting a provider, which in-network providers are operating within high-quality primary care practices.

6. *When partnering with your health plan is not possible, consider direct-contracting with PCMH providers in markets with large employee bases and providers with high quality track records.* Direct-contracting requires due diligence, but gives employers greater flexibility and potential cost-savings opportunities consistent with company objectives.

7. *Study and consider joining multi-payer PCMH collaboratives in your markets.* The PCPCC Innovations Map identifies PCMH programs across the U.S., many of which are multi-payer and are looking for additional purchasers to increase market penetration and accelerate transformation.

Conclusion

The U.S. health care delivery system is in dramatic flux, and all health care stakeholders must work together with similar goals to transform the system successfully. Public and private payers have made strong commitments to reforming the way care is paid for and delivered, but many of these reforms are, relatively, in the early stages. Employers have the opportunity to get involved and drive changes that make sense, improving quality and reducing costs for their employees and dependents. PCMH initiatives with primary care that is well-coordinated, team-based and patient-focused, and that is supported with actionable data and rewarded for outcomes improvement, have significant potential to reduce overall health care costs by keeping people healthy and out of high-cost care settings. Paying for comprehensive, advanced primary care is imperative for employers that want greater value and better results for their employees and for their bottom lines.

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A *National Business Group on Health*® Publication March 2016

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About the *National Business Group on Health*®

The Business Group is the only non-profit organization devoted exclusively to representing large employers' perspectives on national health issues and providing solutions to its members' most important health care and health benefits challenges. The Business Group fosters the development of a safe health care delivery system and treatments based on scientific evidence. Members share strategies for controlling costs, improving patient safety and quality of care, increasing productivity and supporting healthy lifestyles.

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About the Patient-Centered Primary Care Collaborative

Founded in 2006, the Patient-Centered Primary Care Collaborative (PCPCC) is a not-for-profit membership organization dedicated to advancing an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home. The PCPCC achieves its mission through the work of its five Stakeholder Centers, led by experts and thought leaders dedicated to transforming the U.S. health care system through delivery reform, payment reform, patient engagement, and benefit redesign. Today, PCPCC's membership has grown to over 1,200 diverse stakeholder organizations who represent health care providers across the care continuum, payers and purchasers, and patients and their families.

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