



Forum Session Meeting Announcement

Friday, June 27, 2008

12:00–12:30pm — Lunch

12:30–2:15pm — Session

Building the Medical Home: Evaluating the Blueprints

A Discussion Featuring:

Robert Berenson, MD

Senior Fellow

The Urban Institute

Margaret O’Kane

President

National Committee for Quality Assurance

Mark Miller, PhD

Executive Director

Medicare Payment Advisory Commission

Location

**Reserve Officers Association
of the United States**

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*(Across from the Dirksen Senate
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Building the Medical Home: Evaluating the Blueprints

OVERVIEW

There are various reasons why the concept of a medical home—particularly for patients with chronic disease—has caught the attention of health care advocates and policymakers. Among these are a perceived shortage of primary care, a prevailing absence of care coordination across providers and settings, and an imbalance in earning power between primary care physicians and specialists. This Forum session will look at these perceptions and how a medical home model might be expected to address them. It will also consider how a medical home might be defined, financed, and evaluated and to whom it should most appropriately be made available.

SESSION

Widespread recognition that the United States health care system is expensive, inconsistent, and error-prone has generated pressure for someone (such as the next president) to make it better. Of particular concern is a perceived shortage of primary care services as fewer physicians choose primary care practice. An improvement strategy enjoying broad support is the “patient-centered medical home,” which is seen as a way to make primary care more available, robust, and accountable. Whether success will be measured by an upswing in patient outcomes or in primary care clinicians’ incomes and prestige remains to be seen.

Defining Medical Home

A variety of visions of the medical home exist, but most begin with a series of joint principles adopted in 2007 by the American Academy of Family Practice, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association. In summary, these define a medical home in terms of the following characteristics:

- A **personal physician** for each patient
- **Physician-directed medical practice**
- **Whole-person orientation** in arranging for care across stages of life
- **Care that is coordinated** across all elements of the health care system
- **Quality and safety** as hallmarks
- **Enhanced access** through open scheduling, extended hours, and additional communication options
- **Payment** that appropriately recognizes added value to patients

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Bridges to Excellence, an organization founded by self-insured employers for the purpose of recognizing and rewarding high-quality health care, has implemented a medical home program to reward doctors who “have adopted and are effectively using advanced systems of care to produce good results for their patients.”¹ The National Committee for Quality Assurance has built on the joint principles above, the Chronic Care Model,² and its own work in measuring systematic processes and information technology to craft the Physician Practice Connections – Patient-Centered Medical Home model for qualifying physician practices as medical homes.

Support for Medical Home

Proponents of the medical home concept often tie its import to a current and/or impending shortage of primary care providers (PCPs). The family practice physician, general internist, or pediatrician has been the traditional medical mainstay for most American families, the one most likely to have an ongoing relationship with patients and to have comprehensive knowledge of their needs and preferences. Yet many consider the future of this group to be in doubt.

Such jeopardy is often attributed to several factors. First, compensation differentials are well known, with PCPs earning less than many of their specialist counterparts. Reimbursement by health insurers and public payers such as Medicare favors action—performing a procedure, seeing another patient—over the listening and discussing and advising that are integral to primary care. Reimbursement also remains largely tied to face-to-face encounters between clinicians and patients. It is not surprising that physicians would respond to economic pressure by squeezing in additional patients, but the resulting crowded schedule can make for hurried consultations, additional paperwork, and a much-lamented lack of job satisfaction. In the face of perceived negative incentives, United States medical school graduates increasingly shy away from primary care residencies or choose them only as prerequisites for further subspecialization later.³

Medical home supporters seek financial incentives to encourage the cognitive services that they believe would allow PCPs to serve as “a partner in care, a coach, an advisor, and the person who assumes overall responsibility for coordinating care among all health service providers.”⁴ Through compensating the PCP for spending adequate time with patients, enhancing communication with them and families, and ensuring smooth information transfer among clinicians, supporters expect improved clinical outcomes and greater patient and physician satisfaction.

Another rallying point for medical home proponents is that patients with chronic illnesses, particularly multiple chronic illnesses, are in critical need of care coordination. Where seeing multiple clinicians is the norm,⁵ uncoordinated service delivery often results in inaccessible records, gaps in or duplicative services, and patient confusion. Estimates that approximately two-thirds of Medicare program costs are attributable to the 20

percent of beneficiaries with five or more chronic conditions,⁶ or that three-fifths of program costs result from just three chronic conditions,⁷ led the Medicare Payment Advisory Commission to examine care coordination; ultimately they recommended that a medical home model for chronically ill beneficiaries be tested.

Support for some form of medical home implementation has been growing. The Tax Relief and Health Care Act of 2006 mandated the Centers for Medicare & Medicaid Services (CMS) to conduct a demonstration in up to eight states to “provide targeted, accessible, continuous and coordinated family-centered care to Medicare beneficiaries who are deemed to be high need (that is, with multiple chronic or prolonged illnesses that require regular medical monitoring, advising or treatment).”⁸ The demonstration, now in the design phase, will begin to recruit physician practices in the spring of 2009.

Various bills now before Congress (such as S. 2376, the Medical Homes Act of 2007, and H.R. 2351, the HealthCARE Act of 2007) would authorize medical home demonstrations and a qualification process under Medicaid and SCHIP (the State Children’s Health Insurance Program). Some observers have noted that federally qualified health centers have long offered a medical home to these populations. Some state Medicaid programs are already on board, North Carolina being the most frequently cited. Its Medicaid primary care case management plan, ACCESS, offers beneficiaries coordinated care in a medical home and has been able to document savings as well.

Private-sector support has crystallized in the form of the Patient-Centered Primary Care Collaborative, a coalition of employers, insurers, consumer groups, and physician and other provider organizations. Private-sector demonstrations are also underway; for example, under a grant from the Commonwealth Fund, health plans GHI Inc. and HIP Health Plan of New York will conduct a demonstration to promote medical homes by helping physician practices redesign their offices and by revising reimbursement for patient services. Other insurance companies are discussing multi-payer regional demonstrations. The American Academy of Family Physicians has a national demonstration project called TransforMED operating in 36 family practices.

Reservations and Concerns

While the medical home concept is unlikely to generate outright opposition, there is disagreement about whether and where lines should be drawn. From the patient side, it seems likely that anyone given a choice will want the superior brand of care identified with a medical home. But what is the additional expense, and who will shoulder it? Should only patients whose conditions warrant extra managing and coordination qualify for medical home patient panels?

From the physician perspective, extra money may provide the motivation to attempt to qualify as a medical home, and to make the “primary care” tent as capacious as possible. As the chief executive officer of the American

College of Cardiology wrote recently, “For patients with diabetes, heart failure, and many other chronic conditions, the respective specialty physician of such individuals may prove to be the most effective and cost-efficient means of providing the continuity and coordination of care that are the foundations of the medical home.”⁹ At the same time, it is not clear how many practices will succeed in making the changes and investments necessary to achieve qualification.

The potential cost of implementing a medical home model is under research. While the idea that team-based, prevention-oriented, patient-centered care will promote efficiency as well as effectiveness is appealing, evidence to date is scant. Indeed, the newest Dartmouth Atlas of Health Care found that spending on ambulatory visits, many of them to primary care physicians, is positively correlated with inpatient spending.¹⁰

A medical home financing mechanism is subject to disagreement and potential dispute. Some say that any additional payments should come from new money; other say that what needs to be addressed is the disparity between fees for visits and fees for procedures and that perhaps some existing resources need to be redirected.

Beyond structural performance measures (“is there an electronic medical record system?”), ongoing evaluation of a medical home is challenging. Dimensions such as effective teamwork, communication, and patient-centeredness are difficult to pin down. Clinical effectiveness and patient experience must be factored in along with structures and systems.

KEY QUESTIONS

- What can a medical home model achieve for the health care system? What needs to be changed in order to implement the model?
- Can an optimal medical home be defined? What structural and process elements must be included? Can a single clinician constitute a medical home? What should be the role of nurses, physician assistants, and other mid-level providers? Does the medical home concept invite review of the scope of various licenses to practice?
- How can the incremental benefit to patients of a medical home be gauged? How can patient expectations, preferences, and outcomes be built into the model?
- How effective can PCPs be in reducing unnecessary services, that is, going beyond eliminating duplication to eradicating services of questionable value? Can PCPs successfully challenge the judgment of specialists in the specialists’ areas of expertise? Would such challenges raise liability issues?
- Can a medical home model be expected to address racial and ethnic disparities in care delivery?

- What will motivate specialists and other providers who are not designated medical homes to cooperate in the care coordination efforts of medical-home PCPs?
- How will physician training change if the medical home model is broadly adopted?

SPEAKERS

Robert Berenson, MD, will review the development of the medical home model. Dr. Berenson, a senior fellow at the Urban Institute, has experience practicing medicine as a board-certified internist, serving in senior positions in two administrations, and helping organize and manage a successful preferred provider organization. **Margaret O’Kane**, president of the National Committee for Quality Assurance (NCQA), will describe her organization’s model for qualifying and evaluating physician practices as medical homes. **Mark Miller, PhD**, executive director of the Medicare Payment Advisory Commission (MedPAC), will describe the Commissioners’ recommendations for testing and implementation of the medical home model.

ENDNOTES

1. “Bridges to Excellence Launches Medical Home Program,” January 31, 2008; available at www.bridgestoexcellence.org/Content/ContentDisplay.aspx?ContentID=119.
2. The Chronic Care Model was developed by Ed Wagner, MD, MPH, director of the MacColl Institute for Healthcare Innovation, Group Health Cooperative of Puget Sound, and colleagues of the Improving Chronic Illness Care program with support from The Robert Wood Johnson Foundation.
3. For more discussion, see Statement for the Record of the American College of Physicians to the Senate Committee on Health, Education, Labor, and Pensions, “Addressing Healthcare Workforce Issues for the Future,” February 12, 2008, available at www.acponline.org/advocacy/where_we_stand/workforce/pc_workforce.pdf.
4. Patient-Centered Primary Care Collaborative, “Patient Centered Medical Home,” available at www.pcpcc.net/content/patient-centered-medical-home.
5. Research by Hongmai Pham *et al.* showed that beneficiaries saw a median of two primary care physicians and five specialists working in four different practices. (“Care Patterns in Medicare and Their Implications for Pay for Performance,” *New England Journal of Medicine*, 356 (March 15, 2007): pp. 1130–1139.)
6. Partnership for Solutions, “Medicare: Cost and Prevalence of Chronic Conditions,” July 2002; available at www.partnershipforsolutions.org/DMS/files/Medicare_fact_sheet.pdf.
7. Medicare Payment Advisory Commission, *Report to the Congress: New Approaches in Medicare*, June 2004, p. 46; available at www.medpac.gov/documents/June04_Entire_Report.pdf.
8. Centers for Medicare & Medicaid Services, “Medicare Demonstrations,” available at www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=dual,%20keyword&filterValue=medical%20home&filterByDID=0&sortByDID=3&sortOrder=descending&itemID=CMS1199247&intNumPerPage=10.
9. The Commonwealth Fund, “Medical Home Responses”; available at www.commonwealth-fund.org/General/General_show.htm?doc_id=454155.
10. Rob Cunningham, “New Atlas Features Roadmap to Medical Homes,” *Health Affairs Blog*, April 7, 2008; available by subscription at <http://healthaffairs.org/blog/2008/04/07/new-atlas-features-roadmap-to-medical-homes>.