Group Urges Medicare to Use 'Medical Home'

BY ALICIA AULT
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WASHINGTON — Sensing an opportunity to advance its agenda with the Democrat-controlled congress, the American College of Physicians has set its sights on implementation of the medical home concept by Medicare.

The ACP also is proposing to replace the sustainable growth rate (SGR) formula that governs how much Medicare pays physicians and to expand coverage for the uninsured—two issues high on the to-do list for many legislators and other physician groups, consumers, employers, and insurers.

An "advanced medical home"—in which primary care physicians would receive reimbursement for coordinating care in a way that addresses each patient's individual needs—is the best way to save money and improve patient care, ACP president Lynne Kirk said at a briefing with reporters last month.

"Payment systems used by Medicare, Medicaid, and most private payers reward physicians for the volume of procedures generated and number of office visits performed, rather than for ongoing, continuous, and longitudinal management of the patient's whole health, supported by systems-based practice improvements that lead to better results," Dr. Kirk said.

The patient-centered medical home, initially conceived by the American Academy of Pediatrics, has been actively promoted by the AAP and the American Academy of Family Physicians (AAFP). The Veterans Affairs department is the only federal agency that supports a medical home model.

As described in a January 2006 ACP policy paper, the advanced medical home would offer a new approach to primary care delivery and payment.

The ACP is proposing that Medicare provide primary care physicians with a "bundled," prospective, per-patient payment for serving as the locus of all care. One component would cover practice overhead; another element would cover coordination of care, including paperwork as well as telephone and e-mail conversations with other treating physicians and family members. Face-to-face visits would be covered by a fee-for-service component. Finally, there would be a pay-for-performance element, based on patient outcomes.

Only physician practices that have met the medical home criteria—such as having the ability to track patients and communicate with them electronically—would be eligible for the bundled payment, said Dr. Kirk, associate chief of the University of Texas Southwestern Medical School's general internal medicine division. The criteria are still being developed, said Robert Doherty, ACP's senior vice president for governmental affairs and public policy.

Practices that do not fulfill the criteria would be able to receive separate payments for specific care coordination services, Mr. Doherty told reporters.

It may sound like a return to capitation, but the medical home would avoid the pitfalls of that system, Mr. Doherty said. Under capitation, sicker patients could quickly eat up the monthly per-patient fee. Medical home payments would be risk adjusted to compensate for more severely ill patients, he said. Also, physicians will not be asked to be gatekeepers.

A 3-year, eight-state demonstration of the medical home concept for Medicare was included in the Tax and Health Care Relief Act, signed into law in late December by President Bush.

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ACP president Lynne Kirk (left) and ACP senior vice president Robert Doherty answer questions on the proposal.

A private sector test of the concept is not far behind. The AAFP is working with IBM to launch a pilot project in Austin, Tex., later this year.

A major hurdle for widespread adoption of the medical home is the continuing shortage of primary care physicians. Dr. Kirk acknowledged that issue, but added, "We hope [the medical home] will make it more attractive to practice primary care."

The ACP also wants to replace the SGR, gradually phasing it out over 5 years. During the transition, physicians should be given a baseline and positive annual update, Mr. Doherty said.

The ACP also is seeking an immediate expansion of the State Children's Health Insurance Program (SCHIP), echoing proposals advanced in early January by the Health Coverage Coalition for the Uninsured and the Children's Defense Fund (CDF). SCHIP is up for reauthorization this year.

The CDF is seeking to have all children who receive food stamps or school lunch assistance automatically enrolled in SCHIP. All children whose family incomes are below 300% of the poverty level would be eligible. Families with incomes over 300% could buy in to the program.

Under the Health Coverage Coalition's SCHIP proposal, parents would be urged to enroll children at the same time as they applied for food stamps and other programs, making it a "one-stop shop." The federal government should also provide an estimated $45 billion over the next 5 years to cover all eligible children, and offer tax credits to families earning up to three times the federal poverty level, according to the coalition.

As many as 98% of uninsured children could be covered if these proposals are implemented, estimated Families USA Executive Director Ron Pollack in a briefing with reporters.

The Health Coverage Coalition includes 16 organizations that historically have parted ways on health insurance. AARP, AAFP, American Hospital Association, American Medical Association, American Public Health Association, America's Health Insurance Plans, Blue Cross and Blue Shield Association, Catholic Health Association, Families USA, Federation of American Hospitals, Healthcare Leadership Council, Johnson & Johnson, Kaiser Permanente, Pfizer, United Health Foundation, and the U.S. Chamber of Commerce.

About 47 million Americans, including 8-9 million children, are uninsured. The coalition has proposed expanding Medicaid to cover all adults with incomes below the poverty level, and offering tax credits for those with incomes between 100% and 300% of the poverty level.

The ACP has recommended that low-income Americans be given subsidies to buy insurance coverage through the Federal Employee Health Benefits Program.

In his State of the Union address, President Bush proposed tax breaks to help cover the uninsured, and more federal aid to states that are seeking to cover the uninsured. He also called for expansion of health savings accounts, allowing health insurance to be purchased across state lines, and medical liability reform.

Congress has already started to move. Sen. George Voinovich (R-Ohio) and Sen. Jeff Bingaman (D-N.M.) introduced a bill to provide states with grants to creatively cover the uninsured. Companion legislation was introduced in the House. Sen. Ron Wyden (D-Ore.) introduced a bill seeking to guarantee coverage for all Americans.

"We need more action and less debate," said Dr. Reed Tuckson, senior vice president of the United Health Foundation, speaking at the Health Coverage Coalition briefing. ■

Bonus Pay Linked to Physician Voluntary Reporting Program

BY MARY ELLEN SCHNEIDER
New York Bureau

Physicians who report quality data to Medicare will receive bonus payments of 1.5% starting in July under a provision of the omnibus legislation passed at the end of the 109th Congress.

Under the provision, bonus payments would be linked to participation in the Physician Voluntary Reporting Program administered by the Centers for Medicare and Medicaid Services. The program, which allows physicians to submit quality data to CMS and receive feedback on their performance, was launched in 2006.

In 2007, CMS officials have expanded the number of quality measures included in the program from 16 to 45. CMS also released an additional set of 21 measures that it plans to introduce later in the year. Bonus payments will apply to services delivered from July 1 through Dec. 31, 2007. Under the legislation, CMS must post any changes to the quality measures by no later than April 1.

More details on the program will be forthcoming from CMS, according to an agency spokesperson. For now, Congress has set up some parameters for reporting to the voluntary program. For example, if three or fewer measures are applicable to a physician's practice, participating physicians must report on each relevant quality measure. If four or more are applicable, participating physicians must report on at least three.

CMS is required to publish a set of proposed quality measures for 2008 no later than Aug. 15 with a final set of measures to be published by Nov. 15. Congress also has instructed the secretary of Health and Human Services to address a mechanism for physicians to submit data through a medical registry system, such as the Society of Thoracic Surgeons National Database, in 2008.

Officials at the American Medical Association plan to work with CMS on the implementation of the quality reporting program.

The AMA noted that it will work to ensure that the quality measures developed by its Physician Consortium for Performance Improvement continue to be the foundation of Medicare's reporting program. "We will work closely with the incoming Congress to address concerns with the current reporting framework," Dr. Cecil Wilson, AMA board chair, said in a statement.

Officials at the American College of Physicians voiced concerns about the program. Dr. Michael S. Barr, vice president of practice, advocacy, and improvement at the ACP, said that not all of the 45 measures being rolled out have been endorsed by either the National Quality Forum or the AQA alliance, originally known as the Ambulatory Care Quality Alliance.

"We're concerned about going too fast," he said. ■

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