IMPLEMENTING HEALTH REFORM

Medical Home Demo Project to Launch

The patient-centered medical home, which has been promoted by primary care organizations for decades, is finally getting some attention under the Affordable Care Act.

The concept, which calls for greater coordination of care and a team-based approach, is one of several care delivery improvement ideas being tested under the new health law.

This summer, government officials are accepting applications from Federally Qualified Health Centers to be part of a 3-year demonstration project. The project, which will run from September 2011 through August 2014, is designed to figure out what resources health centers need to become successful medical homes that improve care and reduce costs.

Under the Federally Qualified Health Center Advanced Primary Care Practice demonstration project, the federal government will pay health centers a monthly care management fee for each eligible Medicare beneficiary that receives primary care services, on top of their regular Medicare payments.

In exchange, health centers must pursue level 3 patient-centered medical home recognition through the National Committee for Quality Assurance.

The project is being run jointly by the Centers for Medicare and Medicaid Services and the Health Resources and Services Administration. The CMS and HRSA will spend $42 million over 3 years to fund up to 500 health centers under the project.

Dr. Roland A. Goertz, the president of the American Academy of Family Physicians, explained how this project could shape future payment policy for primary care physicians.

A successful demonstration will show improved care while maintaining or reducing costs.

DR. GOERTZ

CLINICAL ENDOCRINOLOGY NEWS: This project sets out to test what is needed to help health centers make the transition to patient-centered medical homes. What does the existing research tell us about the necessary ingredients?

Dr. Goertz: The five most important ingredients are a true team approach to care; clinical information systems such as e-prescribing, electronic medical records, registries for common chronic illnesses, and electronic patient access via a patient portal; training for all members of the care team in "patient self-management support" and between visit follow-up; care coordination for patients needing care outside of the medical home; and integration with community resources and the medical neighborhood.

CEN: Under the project, health centers will receive a care management payment of $6 per patient per month. Is this enough?

Dr. Goertz: Federally Qualified Health Centers that participate will be paid care management fees only for the Medicare beneficiaries attributed to them. As grantees, the clinic sites will also receive free technical assistance and training resources and funds to cover survey costs.

Health centers will need to make a determination if they are ready for the transformation and whether the care management fees will cover their increased costs.

The fees will not be enough to leverage change if the Federally Qualified Health Center serves only a small number of Medicare patients.

CEN: How important is the adoption of electronic health records to the success of the medical home?

Dr. Goertz: The goal is to have computerized support for important clinical functions and integration so that physicians have the information they need to make the best decisions about diagnosis and management.

Electronic medical records with functions to help with prescribing, registries, e-mail, education, and home monitoring will soon be the standard of care.

Whatever other changes a practice is making, they should continue the momentum needed to get to fully integrated electronic medical records at some point in the future.

Two keys to improved care will be appropriate data collection and use of that data. Electronic tools are very effective in these efforts.

CEN: If this demonstration is successful, what will it mean for Medicare payments for medical home services in the future?

Dr. Goertz: This demonstration will show important additional proof of the value of the patient-centered medical home.

A successful demonstration will show improved care while maintaining or reducing costs, which should result in resources flowing to primary care practices to more appropriately pay them for providing patients the best care possible.

–Interview by Mary Ellen Schneider

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House Debates Independent Payment Advisory Board

BY FRANCES CORREA

WASHINGTON – Partisan squabbling from both sides of the aisle was the highlight of 2 days of House committee hearings on the Independent Payment Advisory Board.

"The Affordable Care Act ends the Medicare guarantee; it ends Medicare as we know it," chairman Paul Ryan (R-Wis.) said during a hearing before the House Budget Committee. "Nobody is arguing against capping spending around here. The only difference is, this law empowers the [Independent Payment Advisory Board] with the unilateral power to decide how to live underneath that cap."

Rep. Henry Waxman (D-Calif.) and Rep. Frank Pallone (D-N.J.) defended the health reform law and its capacity to improve Medicare.

"Republicans just assert [that the Affordable Care Act] doesn't control costs and then they attack the new law's comprehensive approach it takes to control costs," Mr. Waxman said during a hearing of the House Energy and Commerce Committee's subcommittee on health. He argued that Republicans also ignore Congressional Budget Office estimates that the Republican budget proposal could double costs for Medicare beneficiaries once the law is fully enacted in 2022.

The IPAB is a board created by the Affordable Care Act. Slated to start in 2014, the board will consist of 15 members appointed by the president, plus three ex-officio members from the Executive Branch. The IPAB will make yearly recommendations to Congress on how to stay within Medicare budget targets; if Congress does not reject the recommendations by a two-thirds majority or come up with equivalent savings of their own, the recommendations will become law automatically.

During rounds of questioning before both committees, Health and Human Services Secretary Kathleen Sebelius drove home the point that the IPAB recommendations would keep Congress in the "driver's seat," requiring its approval. Ms. Sebelius also argued in favor of the board's potential to improve the health care system, and added that the Republican budget plan would do the opposite.

Republicans ignore the fact that their budget proposal could double costs for Medicare patients.

REP. WAXMAN

"I think [the IPAB] could look at a lot of the underlying rising costs, and recommend payment strategies that much more closely align with what doctors tell me they really want to do," Ms. Sebelius testified. "I would suggest that the House Republican plan just shifts costs onto seniors and those with disabilities, and does not address the underlying costs at all."

IPAB opponents disagree with the requirement that the House and Senate approve IPAB recommendation by a two-thirds vote. They said that this cedes to the board powers that the Constitution gives to Congress, making the IPAB fundamentally unconstitutional.

Although the board is charged with devising recommendations to reduce costs within Medicare, it lacks the ability to increase revenue or change existing benefits. This is one of the reasons opponents argue against the board's potential to enact further cuts in provider payments and, in their view, decrease access to care.

Rep. Tom Price (R-Ga.), who is also an orthopedic surgeon, spoke before the committee: "If I'm told by the federal government that I will not be paid for a service, what happens in my presentation of the options to that patient?

"As that treating physician, I may be coerced by the federal government into not even presenting that option to the patient," Rep. Price said. ■

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