Medicare Panel Backs Medical Home Pilot Study

BY ALICIA AULT
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WASHINGTON — The concept of a medical home is a step closer to reality for Medicare patients, after it received strong backing from the Medicare Payment Advisory Commission at its April meeting.

All 17 commissioners present at the meeting voted to urge Congress to instruct the Centers for Medicare and Medicaid Services to develop a large pilot study of medical homes for Medicare beneficiaries. Most of the commissioners also voted to adjust the Medicare fee schedule to increase payment for primary care, which MedPAC has deemed as undervalued.

The medical home concept has been advanced by the American College of Physicians, the American Academy of Family Physicians, and the American Academy of Pediatrics. A demonstration project is authorized under the Medicare program, but the commissioners recommended a larger pilot with clear thresholds.

The commissioners' criteria for a medical home included the ability to provide primary care, use information technology for clinical decision support, conduct care management, offer 24-hour communication with patients, maintain up-to-date records of patients' advance directives, and operate a formal quality improvement program. Also, beneficiaries should agree to adhere to medical home principles by respecting the idea that someone is in charge of coordinating their care, and communicating with the physician when they seek care elsewhere.

There was some debate over whether patients should be allowed to access other providers without a referral, which is permitted under current fee-for-service Medicare. Most commissioners wanted some restrictions, or at least a way to track when patients see specialists, to facilitate assessment of the program.

The medical home would not be limited to primary care physicians; specialists likely would be able to fulfill criteria for participation, according to the commission.

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Dr. Francis Jay Crosson, a commissioner and senior medical director of Permanente Federation in Oakland, Calif., called the proposal a "significant evolution" from what had been presented to the panel in 2007. "I think it's a good evolution," he said.

"This is a very exciting recommendation," said Commissioner Jack Ebeler, a health policy consultant in Reston, Va. Promotion of the medical home approach is a direct way to reform the health care delivery system, he added.

Commissioners also said that the medical home recommendation dovetailed with MedPAC's support of increased pay for primary care services.

An adjustment to the fee schedule is "long overdue," said Dr. Ronald Castellanos, a commissioner and urologist in private practice in Fort Myers, Fla. Increased pay might lure more residents into primary care and help those currently practicing to stay in the workplace, he said.

The commissioners debated how CMS could determine which physicians or other health providers—such as nurse practitioners—would receive the update. MedPAC staff presented the increase as budget neutral, which made some panelists uneasy.

Dr. Nicholas Wolter of the Billings (Mont.) Clinic suggested that the increase be made without trying to maintain budget neutrality. Dr. Karen Borman, professor of surgery at the University of Mississippi, Jackson, expressed concern that rewarding primary care could end up hurting other physicians. "I have some philosophical problems here," said Dr. Borman, adding that primary care was not always linked with a traditional primary care physician. She said that she often provided what would be considered primary care to her breast cancer patients.

Dr. Borman ended up voting against the recommendation for increased pay for primary care.

Medical Home Coalition Wins Backing of Physician Groups

BY JOEL B. FINKELSTEIN
Contributing Writer

WASHINGTON — A who's who list of physician organizations, advocacy groups, pharmaceutical manufacturers, and employers is throwing its weight behind the idea that the medical home model can cure much of what ails the health care system.

At a recent meeting of the Patient-Centered Primary Care Collaborative, 13 physician specialty groups—including the American College of Physicians, the American Academy of Family Physicians, and the American Academy of Pediatrics—signed on to the joint principles for a comprehensive, primary care, evidence-based, and physician-directed medical home. The principles also are supported by a variety of other organizations, including many large corporations.

"I have been a family physician for 31 years … and I have never been more excited about the future of health care," said Dr. Doug Henley, executive vice president of the American Academy of Family Physicians.

In March, the Association of American Medical Colleges adopted the position that everyone should have access to a medical home.

"Many Americans, even among those with comprehensive health insurance, feel 'medically homeless' and lost in a system that is difficult to navigate when they require care," AAMC president Dr. Darrell Kirch said in a statement. "The medical home model holds great promise for improving Americans' health by ensuring that they have an ongoing relationship with a trusted medical professional."

It's not just national groups that are buying into the concept. At least 41 states are preparing or considering pilot projects to implement the medical home model. Medicare is scheduled to launch a demonstration project next year, and Wal-Mart has begun to explore the model.

"We listen to our customers," Dr. John Agwunobi, president of Wal-Mart's professional services division, said at the meeting. "We hear them saying that health care is too costly, too complicated, and too controlled."

There was no apparent consensus on what is needed to make the idea of a medical home into a reality.

Although all of the groups have signed on to the joint principles, that endorsement doesn't imply specific responsibilities. It also doesn't imply that everyone agrees on what defines a medical home. A wide variety of measurement tools now being developed can be used to gauge and document the success of a medical home, and that is just the first step.

"Measurement is an extremely powerful tool. But it is only that. It is not an end in itself. … It gives us a compass so that we can see where we want to go and whether we are going in the right direction," said Dr. David Meyers of the Agency for Healthcare Research and Quality. As director of AHRQ's Center for Primary Care, Prevention, and Clinical Partnerships, Dr. Meyers has helped develop a survey tool for measuring care coordination.

Comprehensiveness is the linchpin. The principles of a medical home include providing all services each patient may need or, if necessary, making sure the patient has access to care outside the practice. In other words, the physician providing a medical home is responsible for ensuring that patients get appropriate care, while avoiding the trap of the gatekeeper era in which doctors found themselves in the position of denying care, Dr. Meyers said.

Using measurement tools to show progress and prove the value of the medical home concept quantitatively will be just one challenge, speakers emphasized.

Physicians, especially those in small or solo practices, will need to be shown that it is worth their time and trouble to adopt quality improvement measures, with only the promise of additional compensation. Patients will have to be educated on what a medical home is, why it benefits them, and how they can get one. And payers will have to be convinced that they are getting more for their money.

"Timing is everything," said Helen Darling, president of the National Business Group on Health. The country is in a recession. Companies are going bankrupt or, at the least, cutting costs. "This is not a good time to talk about spending more money." She encouraged the group to make sure that adoption of the medical home model is budget neutral.

Many of those at the meeting appeared undaunted.

After 29 years of practicing medicine, Dr. William Jagiello said that he found himself frustrated by a system that fell short of expectations—both his and those of his patients.

"I thought about all the things that I should have done for my patients and did not do," said Dr. Jagiello, an Iowa family physician. "It began to dawn on me that the medical home concept would give me the process and the vehicle through which I could be doing all those things for my patients on a daily basis. And perhaps I could come home a lot more satisfied and less exhausted knowing that I have delivered the best care possible."

Joint Principles for a Medical Home

► **Personal physician.** Each patient has an ongoing relationship with a physician who provides continuous and comprehensive care.
► **Physician direction.** A physician-led team collectively takes responsibility for the ongoing care of patients.
► **Whole-person orientation.** A physician is responsible for providing for all of a patient's health care needs or arranging care with other qualified professionals.
► **Coordinated care.** A patient's care is integrated across all elements of the health care system and the community.
► **Quality and safety.** Practices adopt a comprehensive plan of ongoing self-assessment protocols that incorporate accountability, information technology, performance measures, and patient feedback.
► **Enhanced access.** Practices use systems such as open scheduling, expanded hours, and new options for communication among physician, staff, and patients.
► **Appropriate payment.** Payers recognize the added value provided by a medical home, such as care management, care coordination, quality improvement, and savings from reduced hospital visits.

Source: Patient-Centered Primary Care Collaborative