ACP to Medicare: Pilot Test the 'Medical Home'

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WASHINGTON — The medical home, a model for financing and delivering care that has long been endorsed by the American Academy of Family Physicians, is a key part of the American College of Physicians' action plan to reform Medicare payment policies.

Medicare should pilot test the "advanced medical home," where physicians would receive reimbursement for coordinating care in a practice environment that centers on a patient's individual needs, the ACP recommended in a policy paper.

The ACP urged Congress and the Bush administration to apply this model, along with other financial and organizational changes, to counter declining interest in primary care among medical students and practicing physicians.

Medicare's payment system is one of the main reasons that doctors are abandoning primary care, Robert B. Doherty, ACP's senior vice president of governmental affairs and public policy, said at a press briefing to release the ACP plan.

Medicare pays too little for the time that primary care physicians spend with their patients—and discourages them from organizing their practices to achieve optimal results, by failing to reimburse for things such as e-mail consultations, care coordination, or health information technology, he said.

"And despite all of the talk about pay for performance, Medicare continues to pay doctors for doing more, rather than doing better," Mr. Doherty added.

Reconfiguring the payment system and encouraging use of the advanced medical home "would change the way that primary care is delivered and financed by Medicare and other payers," ACP President Dr. C. Anderson Hedberg said.

Primary care physicians who apply the medical home model would partner with patients to ensure optimal management and coordination of care, using evidence-based clinical decision support tools at the point of care, Dr. Hedberg said. For example, an internist might partner with a patient in managing a chronic disease such as diabetes, and the patient would have access to medical advice through telephone and e-mail consultations.

Practices also would have arrangements with a team of health care professionals to provide "a full spectrum" of patient-centered services, Dr. Hedberg said.

Despite its emphasis on coordination of care, the advanced medical home is not the same as a disease management program, the ACP noted in its policy paper. In disease management, the emphasis is on the relationship between the patient and a case manager, with only periodic input from the physician. "In the advanced medical home model, the care and coordination of that care continually resides with the patient's personal physician and his/her health care team," the paper indicated.

Successful use of the advanced medical home would rely on health information technology. Practices would be expected to issue regular reports on quality, efficiency, and patient experience measures, and use "innovative" scheduling systems to minimize appointment delays, Dr. Hedberg said.

Such innovations would require financing, however, which means that the advanced medical home cannot be implemented as an unfunded mandate, Mr. Doherty said. The Centers for Medicare and Medicaid Services (CMS) "will need to change the way it pays physicians who practice in an advanced medical home." As the ACP envisions it, physicians who use the medical home model would receive an additional care management fee to cover the physician work involved in managing and coordinating care that falls outside of the usual face-to-face visit.

Physicians also would receive pay-for-performance bonuses and share in systemwide savings achieved by keeping patients with chronic conditions out of the hospital, he said.

A pilot test would help refine the model and demonstrate its potential to improve quality while lowering costs, Mr. Doherty said. The goal is to start implementing the advanced medical home as policy as early as 2007, "with widespread implementation within a few years."

The advanced medical home "brings additional energy and ideas to the ongoing effort to bring improved and more efficient care to Medicare beneficiaries," CMS spokesman Peter Ashkenaz said in an

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interview. He did not elaborate on whether the agency would pilot test such a system, but said that it was consistent with existing CMS initiatives such as the Medicare Health Support Program, "which works to provide more coordinated and effective care for those with chronic conditions. And it is consistent with our effort to adopt evidenced-based quality measures, which will lead us toward a pay-for-performance program," he said.

The ACP's proposed "advanced medical home" builds on a concept that has been around for decades. In 1967, the medical home was described by the American Academy of Pediatrics' Council on Pediatric Practice as an effective model for caring for children with special needs, the ACP noted in its policy paper. The concept is also a central element of the American Academy of Family Physicians' Future of Family Medicine project.

The ACP added some enhancements to the AAFP's medical home concept, Mr. Doherty explained. For example, "we have a clear qualification process," where practices would be certified as advanced medical homes and required to meet certain standards in order to qualify for additional payments.

AAFP President Dr. Larry Fields declined to comment specifically on the ACP proposal, but said the academy is working to convince Congress and the private sector that the medical home concept is worthwhile "and therefore worth paying for."

An adequate workforce of family physicians providing patients with their own medical home "is the way to bring the promise of quality, affordable, accessible health care for everyone to fruition," Dr. Fields said in an interview. The AAFP "will continue to try and convince those who still need convincing of the validity of our position."

Congress and the private sector should also partner with the AAFP in providing funds for electronic health records, he said.

Although the advanced medical home is geared toward primary care, it wouldn't be limited to generalists, Mr. Doherty said. In most cases, a general internist or family physician would be the principal physician coordinating a patient's care in an advanced medical home. Yet "there may be instances when a patient might select a subspecialist within the medical home as his or her personal physician," he said.

In such cases, the subspecialist is responsible for managing and coordinating care and provides the full range of required primary care services, he noted. ■

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Reference: 1. Clarebout G, Leclercq R. Fluorescence assay for studying the ability of macrolides to induce production of ribosomal methylase. *Antimicrob Agents Chemother.* 2002;46:2269-2272.