

Summary

Will the Patient-Centered Medical Home Transform the Delivery of Health Care?

Timely Analysis of Immediate Health Policy Issues

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The medical home model has the potential to transform health care delivery, but organizations promoting the model should tread carefully. Pilot programs should be completed and evaluated before the model is rolled out nationwide. For the medical home model to transform health care delivery, it must be feasible for primary care practices and have the right components to cut costs and raise quality.

The medical home model for delivering enhanced primary care has been gathering momentum for several years and is now being tested in dozens of pilots nationwide, including in Medicare and Medicaid. The model is likely to gain even greater prominence in 2012, when accountable care organizations (ACOs) begin operating, since many believe that primary care practices that belong to an ACO will need to adopt at least some aspects of the medical home model to manage the care of their ACO's patient panel effectively enough to generate shared savings.

Also known as the patient-centered medical home, the model attempts to orient doctors' offices more to patients' needs, such as by making it easier for patients to access care (through extended hours and greater use of phone calls and e-mails) and by more actively coordinating with other providers to manage all aspects of a patient's care. The model also typically involves relying more on a

team-based approach to delivering care to maximize efficiency and take advantage of the different team members' professional skills. The rationale for adopting this model—which often goes hand in hand with providing enhanced reimbursement rates to primary care clinicians—is that it will increase quality and reduce costs. It is also proposed as a way to reinvigorate primary care and attract more physicians to the field by increasing reimbursement rates and professional prestige.

Interest in the medical home is growing rapidly, with dozens of pilots underway and thousands of practices currently recognized as medical homes. But there is not broad agreement on which care processes or practice capabilities need to be in place for a practice to be considered a “medical home,” evidenced by the proliferation of different medical home definitions and accreditation standards advanced in recent years. For example, these definitions and standards differ on how quickly practices must return patients' phone calls after hours, whether an electronic health record (EHR) is needed to facilitate care coordination, how to proactively manage a patient population, and how quality should be measured and improved.

The closest thing to an agreed-upon definition is a set of principles jointly released by four primary care physician specialty societies in 2007.

These were subsequently endorsed by 19 more physician organizations, including the American Medical Association and the Patient-Centered Primary Care Collaborative (PCPCC), a multistakeholder medical home advocacy group with hundreds of organizational members.

Yet scholars, health plans, federal agencies, and others continue to put forth new definitions for the medical home, suggesting consensus about the model has not yet been achieved. Part of the difficulty is that there is not yet rigorous evidence available about which practice capabilities and processes actually improve the quality of care and reduce costs—though there is evidence of positive benefits associated with primary care more generally.

To answer these and other questions, both public and private health insurance plans are currently sponsoring pilots to test the medical home model and together they expect to reach more than 13 million patients within the next few years. Typically, pilots are sponsored by a health plan that offers practices enhanced reimbursement for its enrollees, which may make up 30 to 40 percent of participating practices' patient panels.

The most common way practices are reimbursed in these pilots involves paying practices their regular fee-for-service payment rates for traditional services, plus a monthly care coordination fee per patient to cover



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medical home activities not easily reimbursed under current fee schedules, as well as performance bonuses if quality measure targets are met. Although there are similarities in the payment approaches used, the payment amounts that physicians receive under medical home pilots vary widely—from an additional \$720 per year to more than \$91,000, according to a recent analysis of 26 pilots.

Within the next five years, evaluations of these pilots could bring clarity to the topic of medical homes—not only by answering the broad questions of whether they improve the quality of care and the health outcomes of patients, but also by teasing out which

components of the medical home model have the largest impact on these outcomes. However, even once these results are in, a key challenge will be to determine whether outcomes produced by early adopters of the medical home can be extrapolated to the rest of the country’s primary care practices, which may be less advanced and less committed than the vanguard practices participating in these pilots.

The medical home model does have the potential to transform the way health care is delivered—but “potential” is the key word here. The danger posed by the current enthusiasm for the concept is that it could cause unproven models to be

adopted on a wide scale before evaluations of existing pilots can show us what works in what situations, and what levels of reimbursement are needed to get providers to engage in all the new activities encompassed by the medical home model. This could lead to a failure to improve quality or save costs, and could result in a good idea being dismissed as ineffective before it has a chance to succeed. Whether we have the patience to nurture and recalibrate the medical home model as evidence comes in from evaluations before jumping to conclusions about its success or failure remains to be seen.

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