

## **Of primary importance**

### **Primary-care physicians seek to legitimize the ‘medical home’ concept to improve quality, costs—but will insurers buy it?**

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For advocates of primary care, and for payers and purchasers looking to improve healthcare quality while lowering costs, apparently there is no place like home—specifically, a “patient-centered” medical home.

The concept is still poorly defined and its payment structure remains unclear, but some organizations are promoting medical homes as the best solution for fixing a broken healthcare system, and they’re committing time and resources to put various models to the test in demonstration projects throughout the country.

“It’s kind of like laying the tracks as we’re running the train,” said Michael Barr, vice president of practice advocacy and improvement at the American College of Physicians. “But, if we don’t do something different, we’re going to lose primary care in the United States. ... It’s time for change, and the patient-centered medical-home model represents the collective thinking of many folks in the healthcare community.”

That was the message delivered Nov. 7 at a national healthcare summit “call to action” in Washington that featured some 250 people representing medical societies, insurance companies, large employers and consumer groups as well as politicians such as U.S. Rep. Patrick Kennedy (D-R.I.) and former Speaker of the House Newt Gingrich, all rallying around the medical-home concept.

“It became very clear in a very public way that all these players are working together,” said Melinda Abrams, a Commonwealth Fund senior program officer and director of its Patient-Centered Primary Care Initiative. “They are all singing off the same song sheet, using the same vocabulary and using similar payment schemes.”

#### **What is it?**

A definitive picture of a medical home has yet to develop, but its principles—as formulated by the ACP, American Academy of Family Physicians, American Academy of Pediatrics and American Osteopathic Association—involve patients having a personal physician who leads an integrated team of healthcare professionals providing coordinated acute, chronic, preventive and end-of-life care facilitated by information technology tools and based on a foundation of safety and quality improvement. Also, patients would have “enhanced” access—meaning extended hours and a secure electronic communication options—and primary-care physicians would be recognized and adequately reimbursed for the care management and coordination services they provide.

The four medical societies, plus a coalition of employers, health plans and others have formed the Patient-Centered Primary Care Collaborative to help advance the cause. One

organization notably absent is the American Medical Association, which is holding its interim House of Delegates meeting this week in Hawaii.

“The AMA supports the medical-home concept, but as an umbrella organization, we think it is appropriate that the specialties most involved in taking care of patients with chronic diseases design the details of the system,” said a spokeswoman. The AMA did not say whether it had been invited to participate.

The medical-home payment model beginning to emerge includes a blend of upfront fees, downstream rewards and typical fees for services. The upfront payments could involve a health plan paying a per-member monthly fee of \$3 to \$15, which practices could use to hire a nurse or other staff to handle care-management activities.

“It’s not ‘Here’s \$50. Do something with it,’ ” said National Committee for Quality Assurance Executive Vice President Greg Pawlson. “This is not going to be sustainable unless it’s linked to reimbursement. ... We’ve seen efforts like this fail before because of no reimbursement.”

While paying proceduralists a fee for services makes sense, using the same system to pay for the management of chronic diseases is seen as creating “an increasingly dysfunctional gerbil-on-a-treadmill syndrome,” said Pawlson, whose organization is involved in the medical-home movement.

For “downstream” reimbursement, the ACP’s Barr said the model calls for both “performance-based compensation” that includes quality-improvement rewards and a “shared-savings model.”

“If the system saves money because of the care you provided, you get rewarded,” Barr said.

### **Keeping money in the bank**

Pawlson said early research shows real potential for savings from fewer “condition-sensitive hospitalizations” resulting from better care in the ambulatory setting. “It’s not taking away money from other physicians,” he said.

AAFP Executive Vice President Douglas Henley agreed.

“Clearly, there’s enough money in the system already,” he said, pointing to a North Carolina medical-home program that reportedly led to savings of more than \$231 million to the state’s Medicaid program in fiscal 2005 and 2006.

While a Medicare medical-home demonstration project is “taking an extraordinarily long time to get launched,” according to the AAFP’s Henley, seven major plans have already signed on with the Patient-Centered Primary Care Collaborative with many announcing their willingness to participate in demonstrations: Aetna, Blue Cross and Blue Shield Association, Cigna Corp., Humana, MVP Health Care, UnitedHealthcare and WellPoint.

Though impressive, it remains to be seen whether this will be enough. Don Liss, a regional medical director for Aetna and Aetna's representative on the Patient-Centered Primary Care Collaborative, said that for a medical practice's transformation to a medical home to be successful, a majority of the plans contracting with that practice have to be on board.

"You can't change your practice for just your Blue Cross patients or just your Aetna patients or just your Cigna patients," Liss said.

Dick Salmon, Cigna's senior national medical director for network collaboration, echoed

Liss' sentiments. "We really believe the best way to move this forward is with multipayer, multiemployer collaborations," he said.

TransforMED, a practice-redesign arm of the AAFP, was launched with \$8 million from its parent organization. Much of the money is going to fund a 36-practice medical-home demonstration (18 medical-home practices and 18 controls) which is scheduled to close in May. The AAFP has committed another \$4 million for two more years of TransforMED operations.

Perhaps to head off any potential turf battles that could bog down this latest attempt to reform healthcare, Barr stressed two points: that the medical-home physician coordinating the patient's care should be seen as a "facilitator" and not a "gatekeeper"; and that any physician could assume the facilitator's role. It could be a cardiologist or rheumatologist, for example, it doesn't necessarily have to be a primary-care doctor, he said.

Dan Heinemann, senior vice president of the Sanford Clinic, Sioux Falls, S.D., also made it clear that the primary-care doctors will not be telling the specialists how to practice.

"Not that a primary-care doctor is going to give direction to the specialist, they are going to direct the patient to the right specialist and give the specialist the information that they need," Heinemann said.

Another announcement made last week was that, under the direction of the four participating medical societies, the NCQA's online Physician Practice Connection tool will be modified to serve as a medical-home assessment instrument. The final version is expected to be released for testing in January, and will include three levels of "medical homeness," Henley said.

He added that it can be used for practices participating in the demonstration projects or for nonparticipants to use for self-assessment so they can see what they have to do to first qualify as a medical home, and then what they must do to move up the scale.

Henley said the AAFP will be making a major grass-roots push to get its members to use

the NCQA assessment tool. “We want to show our members that this is a concrete example of where you have to be, so start moving in that direction and get to level one as rapidly as you can,” he said. “Don’t wait for the world to change before you start to change.”

### **Getting employers’ support**

Although the general consensus has been that this initiative needs payer participation to work, Henley said it’s just as critical to get who he called “the real payers”—the employers—on board. Several have signed on as members of the Patient-Centered Primary Care Collaborative, including: Caterpillar, FedEx Corp., General Mills, General Motors Corp., IBM and Xerox Corp. Henley said he would like to see a large company take a very large leap forward and demand that plans accept the medical-home model.

Another model that may emerge is one in which a single organization is both employer and healthcare provider. For example, Sanford Health, an integrated health system with 23 hospitals and 115 clinics, is trying to steer its 12,000 employees toward medical homes inside the system and then get local payers on board.

Heinemann added that his profession needs the medical-home concept to succeed.

“This is key to the survival of primary care,” Heinemann said. “This is ‘Marcus Welby,’ this is my own personal doctor. It recognizes what primary care does well and it incentivizes and pays for what primary care does well.”

Henley added that the need for the medical-home concept to be successful can’t be understated. “We have tried every solution known to man to get a better healthcare system, but only 55% of patients are getting the care they need, we haven’t controlled costs, and we still have 47 million people uninsured,” he said.