

INTEGRATING THE PATIENT CENTERED MEDICAL HOME INTO A HEALTH REFORM PROPOSAL

INTRODUCTION: Most Health Reform Proposals take a comprehensive approach at addressing the question of how health coverage is paid for, but few address, in sufficient detail, how to improve the product that is ultimately being purchased and delivered. Some of the proposals will shift a substantial part of the responsibility for funding care to the federal government. Others propose to give individuals a greater share of responsibility for improving their own health care. Many of the proposals include a few reforms intended to improve quality and reduce costs, such as health information technologies, comparative effectiveness studies, cost transparency, and performance-based reimbursement of physicians. While such reforms could move us in the right direction, they will be most effective if implemented in tandem with reforms to improve the quality and efficiency of care being delivered to patients.

The Patient Centered Medical Home (PCMH) is a model of care that is designed to improve quality and achieve efficiencies by recognizing and supporting the value of care that is provided to patients by primary care physicians, working in practices that have the information systems needed to achieve the best outcomes. Our proposal fits in neatly to any reform plan, no matter who the eventual payer is. Indeed we seek not to define the payer, but the method in which care is paid for and providers are compensated.

THE PCMH MODEL APPROACH:

The way in which primary care providers are compensated for their services must be fundamentally reformed. Instead of reimbursing primary care doctors solely on the basis of how many patient face-to-face visits they conduct, primary care physicians should be rewarded for coordinating care through a Patient-Centered Medical Home.

A PCMH is a primary care practice that has gone through an independent evaluation process, such as through the NCQA, to validate that it is able to deliver comprehensive, patient-centered care of the whole person, supported by health information systems and with accountability for results. Key features of a PCMH include:

- Each patient has access to a primary care physician within the practice who is responsible for providing comprehensive, preventive, and longitudinal care of the whole person, working in a collaborative way with nurses, physician specialists and other health care professions involved in the patient's care.
- Enhanced Access and Open Scheduling
- Adopting and Implementing Evidence Based Guidelines
- Systematic, HIT based tracking of tests, results, screens, preventative therapy
- Referral tracking, and follow-up
- Alternate forms of patient-physician interaction (email, phone)
- PCMHs are accountable for reporting on evidence-based measures of quality and patient satisfaction.

The model is based on a large and growing body of evidence that shows that care delivered by primary care physicians, supported with information systems and with the appropriate reimbursement incentives, can improve the quality and efficiency of care provided to patients, especially for patients with multiple chronic illnesses.

This model could be incorporated into health reform proposals by:

1. By creating positive incentives under Medicare, Medicaid and other health programs administered by the federal government for patients to get care from a qualified PCMH and for primary care physician practices to seek to become a qualified PCMH. PCMHs should be paid a monthly case management fee, in addition to traditional fee-for-service payments for office visits, for the work and information systems needed to coordinate care. Such payments could vary based on the level of Medical Home compliance they achieve. Payments could also reward physicians within practices that have a proven track record of achieving cost savings based on projected numbers, adjusted for patient population health and inflation. Savings will come from emergency room cost avoidance, reduction in unnecessary and redundant specialist referrals and tests, and generally healthier patients.
2. Supporting the efforts by states to implement the PCMH in Medicaid, SCHIP, and Medicare-Medicaid dual eligible programs. The federal government could specifically provide grant funding and other economic assistance to states that incorporate a PCMH.