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Enhance Care Coordination through the Patient Centered Medical Home (PCMH)
Background

History and Problem:
Medicare is the single largest purchaser of health care in the United States and serves as the standard for health plan payment policies in the private sector. Unfortunately, Medicare payment systems do not adequately recognize the care coordination services provided by primary and principal care physicians. This payment structure undermines and undervalues the relationship between patients and physicians and prevents practices from transforming in a way to enhance system in which care is delivered. The lack of Medicare recognition and the adverse impact on the ability of primary and principal care physicians to provide optimal care to patients is an important driver in the need for broad healthcare reform. Examples of Medicare payment policies that adversely affect the ability of primary and principal care physicians to coordinate their patients' care and work in partnership with them to achieve the best outcomes include:

- **Payment system rewards physicians for increasing volume of visits and procedures**

  Medicare payment is based on the face-to-face encounters for visits, which often require that the patient makes a trip to the office for the physician to receive payment—regardless if it is the most efficient way to provide the needed medical care. Under the fee-for-service payment system, the more the physician does, the more the physician gets paid. The often time-consuming nature of primary care services, which frequently involve working with patients to address multiple, complex problems, limits the ability of the physicians who commonly furnish them to significantly increase volume.

- **Payment structure that does not provide incentives for physicians to coordinate care.**

  Medicare currently does not provide payment for many activities that facilitate the provision of patient-focused, longitudinal, coordinated care—activities essential to good primary care. These include physician services provided by telephone, e-mail and related technology***;*** physician care coordination services (e.g., care coordination across treatment settings, intensive care follow-up, use of patient registries and population-based treatment protocols, patient disease management training); and the use of health information technology (HIT) that will allow practices to effectively provide this type of care. Research demonstrates that these activities improve patient access to care and quality of care, and facilitate physician productivity.

- **No mechanism for physicians to share in the savings that physician-guided care coordination activities generate in other areas of Medicare**

  Studies show that improved care coordination can improve the quality of care provided to patients and generate savings to the overall system through a reduction in unnecessary emergency department visits and reduced hospital admissions/re-admissions. Busy physicians in practice have little financial incentive to make the investments needed to improve processes despite their intent to optimize the care of their patients in the outpatient setting. Further, primary care physicians are often managing the care of the patients at highest risk of visiting the emergency department and/or being hospitalized. According to the Starfield Report to the Commonwealth

Fund, increases in primary care physicians in the U.S. are associated with fewer premature deaths from all causes, increased longevity, and decreased health care spending per capita. However, primary care doctors do not receive any additional benefits as a result of these savings.

- The flawed sustainable growth rate (SGR) formula

  While the flawed SGR formula produces/threatens annual Medicare payment cuts that harm all physicians, the adverse impact on primary care practices can be devastating. The high, fixed overhead costs, Medicare payment updates that are signify an outright cut or are below the rate of medical inflation, and the limited ability to increase visit volume severely threaten the viability of primary care practices. With the dark cloud of the SGR hanging over their head, these practices are not only unable to invest in the capability to enhance care coordination they struggle to even keep their doors open to patients.

Solution:

Physician payment reforms are needed that adequately compensate primary care physicians to provide patient–focused, coordinated care and to acquire the health information technology necessary to provide such care. Payment reforms will support physicians in delivering this type of care through the Patient Centered Medical Home (PCMH).

What is a Patient-Centered Medical Home?

The PCMH is an innovative model for delivering care to improve quality, promote efficiency, and increase patient and physician practice satisfaction. Physicians providing services under the PCMH model would engage in the following key practices:

- Primary and principal care physicians would be responsible for partnering with the patient to assure that their care is managed and coordinated effectively.
- Use innovative scheduling systems to minimize delays in getting appointments.
- Use evidence-based clinical decision support tools at the point of care to assure that patients get appropriate and recommended care.
- Partner with patients with chronic diseases, like diabetes, to manage their own conditions to prevent avoidable complications.
- Provide patient access to non-urgent medical advice through email, telephone consultations, and related means.
- Have arrangements with a team of health care professionals to provide a full spectrum of patient-centered services.
- Be accountable for the care they provide, by using HIT to provide regular reports of quality, efficiency, and patient experience measures.

How would services provided in a PCMH be compensated?

The PCMH delivery model must be supported by payment reforms to truly enable physicians to provide the full range of comprehensive care that patients want and need. ACP advocates a PCMH support payment structure that includes:

- A prospective, per patient, per month bundled care coordination component: this care coordination fee would be risk adjusted, so that practices that take care of patients with more complex diseases would receive an appropriately higher care coordination fee for such patients. The amount of the care coordination payments would also vary based on how advanced a practice

is in acquiring the health information systems to help them improve quality and outcomes. The care coordination fee would also include services, such as the time that physicians and their staff spend on coordinating care with family caregivers or other clinicians that are not included in the usual office visit fee.

- A fee-for-service payment for the face-to-face encounters with patients.
- A performance-based component based on the achievement of defined quality and cost effectiveness goals as reflected on evidence-based quality, cost of care and patient experience measures.

ACP envisions that practices need to receive voluntary recognition as PCMH practices through an independent, third party-administered process to receive the enhanced payments available through the reformed payment structure. Working with ACP and other primary care physician organizations, the National Committee on Quality Assurance (NCQA) recently adopted standards to qualify PCMH's as medical homes.

How can Congress support the PCMH?

The College is pleased with the interest by Congress and other policymakers in the PCMH concept. There are a number of bills in Congress that aim to promote care coordination and various components of the PCMH. While ACP applauds these efforts and review and support specific bills as appropriate, the College views the PCMH as the most comprehensive and promising model for achieving the goals of improved quality, efficiency, and satisfaction.

The College is grateful that Congress passed a law in 2006 to test the PCMH in the Medicare fee-for-service population. ACP is working with CMS to design this Medicare medical home demonstration project, which the agency expects to launch in 2009. This demonstration project may have a limited impact, however, because of the lack of dedicated funding from Congress to support the project and because it is limited, by law, to practices in only up to eight states.

In July 2008, the *Medicare Improvements for Patients and Providers Act* (H.R. 6331) became law. This legislation contained numerous measures benefiting primary care, one of which was a provision to increase funding for the Medicare medical home demonstration project and authorize the Secretary to expand it if the demonstration achieves measurable improvements in patient care.

In addition, ACP has been working very closely with key members of Congress to introduce comprehensive primary care legislation that would address, among other things, advancement of the medical home model.

Toward that end, in September 2008, Representative Allyson Schwartz (D-PA) introduced the *Preserving Patient Access to Primary Care of 2008* (H.R. 7192), which is designed to address the growing shortage of primary care physicians in this country and to improve access to primary care services. One of its chief provisions is to reform the Medicare payment system to support the medical home, namely through new, separate payments for designated primary care services and comprehensive care coordination services.

With Congress having concluded most legislative business for the year, ACP will be working to advance this legislation when it is reintroduced early next year. In the meantime, the College continues to urge members of Congress to review the legislation and to contact Rep. Schwartz's office to become original cosponsors. A companion bill to H.R. 7192 is also expected to be introduced early next year by Senator Maria Cantwell (D-WA).

For more information on ACP's positions, please visit the Advocacy section on ACP Online, http://www.acponline.org/advocacy.