

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 8-A-09

Subject: The Patient-Centered Medical Home
(Amendment J-3, I-08)

Presented by: David O. Barbe, MD, Chair

Referred to: Reference Committee A
(Steven E. Larson, MD, Chair)

1 At the 2008 Interim Meeting, the House of Delegates adopted Resolution 804 as amended. The
2 resolution established the attached “Principles of the Patient-Centered Medical Home” (Policy
3 H-160.919, AMA Policy Database) and asked the American Medical Association (AMA) to
4 continue to study the medical home concept, with particular emphasis on funding sources and
5 payment structures (Policy D-160.942). The Principles of the Patient-Centered Medical Home
6 were originally developed by the American Academy of Family Physicians, the American
7 Academy of Pediatrics, the American College of Physicians, and the American Osteopathic
8 Association.

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10 During discussion of Resolution 804 (I-08), the House also referred Amendment J-3, introduced by
11 the American College of Obstetricians and Gynecologists, which called on the AMA,

12
13 “working with all interested specialty societies, [to] continue to study the patient-centered
14 medical home concept, with particular emphasis on:

- 15 1. Ensuring that the value added services of the medical home are fully funded by
16 financing mechanisms outside the Medicare Part B physician payment pool
17 including from private insurance, Medicare Parts A and D, and Medicaid;
- 18 2. Ensuring that patient access to necessary quality specialty care without a
19 gatekeeper is preserved;
- 20 3. Ensuring that patients can select any qualified physician practice as his or her
21 medical home; and
- 22 4. Ensuring unity within the House of Medicine.”

23
24 Given the work the Council is already pursuing with respect to physician payment reform, the
25 Board of Trustees assigned Resolution 804 (I-08) (D-160.942) and Amendment J-3 (I-08) to the
26 Council for report back at the 2009 Annual Meeting.

27
28 Also at the 2008 Interim Meeting, the House of Delegates had the opportunity to consider the
29 medical home concept in the context of Council on Medical Service (CMS) Report 4-I-08,
30 “Emerging Medicare Physician Payment Methodologies,” which was intended to stimulate
31 discussion and feedback from the Federation on a series of Medicare physician payment strategies,
32 including the medical home. CMS Report 6-A-09, also before the House at this meeting, makes
33 recommendations to help ensure that any proposals for alternative physician payment
34 methodologies are designed and implemented in ways that do not disadvantage or disenfranchise
35 groups of physicians or patients.

1 BACKGROUND

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3 In its consideration of Resolution 804 (I-08), the Reference Committee noted that:

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5 There was support for the general goals of enhanced care coordination and the “medical
6 home” concept, but also considerable anxiety about the details associated with promoting
7 the medical home as a model for patient care and physician payment... Your Reference
8 Committee was persuaded... that adoption of the “Joint Principles of a Patient Centered
9 Medical Home” would provide our AMA with a common language for subsequent efforts
10 to shape the development and implementation of the medical home concept.
11

12 Currently, the medical home concept is being discussed among policymakers with the goal of
13 increasing value for physician services provided under Medicare. Originally the “patient-centered
14 medical home” referred to a care model advanced many years ago by the American Academy of
15 Pediatrics (AAP) to describe a single source of medical information about the pediatric patient.
16 The concept expanded to denote the delivery of primary health care services that are provided
17 and/or coordinated by a consistent, responsive and accessible physician or medical practice. AAP
18 continues to take a leadership role, along with the American Academy of Family Physicians, the
19 American College of Physicians, and the American Osteopathic Association, in promoting the
20 benefits of a patient-centered medical home care delivery model.
21

22 The more recent alignment of the medical home model with specific financial incentives to
23 enhance care coordination (with the goal of achieving cost savings in Medicare) has shifted
24 attention away from the benefits of the medical home as a care delivery model, and resulted in
25 heightened concern among some about the potential limitations of structuring a physician payment
26 system based on the medical home structure.
27

28 FEDERATION COMMENTS AND CONCERNS REGARDING THE MEDICAL HOME

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30 The comments that the Council received from members of the Federation as a result of the
31 feedback requested in Council on Medical Service Report 4 (I-08) reflected a clear commitment to
32 providing the “right care at the right time” to patients, and to pursuing ways to enhance care
33 coordination overall. However, consistent with the concerns articulated in Amendment J-3 (I-08),
34 several commenters identified issues that merit further attention in the development of future
35 medical home policy. These issues reflect common themes about the need to avoid “budget
36 neutral” financing mechanisms, ensure participation options for a broad range of physicians, and
37 encourage incentive structures that ensure the highest quality patient care.
38

39 Proposed payment incentives for practices that serve as medical homes to Medicare beneficiaries
40 envision flat per-patient care management fees that would be paid in recognition of an increased
41 level of care coordination services provided to patients by participating physicians. Such services
42 include more regular and detailed patient follow-up, coordinating care with other providers, and
43 offering patients expanded access in order to address medical needs in a timely manner. In
44 exchange for the care management fees, practices must meet certain infrastructure and process
45 requirements to ensure their ability to provide coordinated, high-quality care.
46

47 The Centers for Medicare and Medicaid Services (CMS) is pursuing the medical home model, as
48 described in the next section of this report, as an option under the current Medicare fee-for-service
49 program because it hopes that the care delivery model will result in significant savings for the
50 Medicare program. It is anticipated that these cost savings will be attributable to reductions in
51 duplicate testing and ineffective treatments, and better management of chronic conditions. In

1 addition, medical homes offer expanded access to care (e.g., extended hours, open scheduling),
2 thereby increasing the likelihood that patients will be able to receive treatment from their regular
3 source of care, rather than making a costly visit to the emergency room.

4
5 Given the extreme financial pressure that all physicians face under the current Medicare fee-for-
6 service system, some physicians are concerned that costs associated with creating incentives for
7 medical homes will necessitate reductions in other areas of the Medicare Part B funding pool. As
8 with other potential payment reforms, Federation comments highlighted the importance of ensuring
9 that payment incentives are not designed in a budget neutral manner, and that mechanisms are in
10 place to evaluate the actual effect a medical home payment structure might have on patient
11 outcomes, physician practice patterns, and health care spending.

12
13 Although there is limited data on the impact of the medical home on subsequent health care
14 spending, there is some evidence that cost savings can be achieved. Community Care of North
15 Carolina is a working example of a patient-centered medical home, consisting of 15 not-for-profit
16 health networks that improve access and coordinate care among physicians, local health
17 departments, hospitals, social service agencies and other community programs. The networks care
18 for approximately 74% of the state's Medicaid beneficiaries, and independent evaluations have
19 indicated that the program saved the state approximately \$77 - \$85 million in fiscal year 2005 and
20 \$154 - \$170 million in fiscal year 2006.

21
22 Even among supporters of the medical home concept, a key area of concern is the extent to which
23 care coordination under a medical home model becomes overly-regulated. As reflected in
24 Amendment J-3 (I-08), many physicians are concerned that the medical home model could be
25 implemented in ways that restrict the ability of some physicians to provide the best care for their
26 patients, and could inadvertently disenfranchise some physicians who are already serving as
27 informal medical homes for their patients.

28
29 Federation comments reflected strong concerns that the medical home model could become
30 synonymous with a "gatekeeper" for participating patients, and the need to ensure that patients
31 continue to have access to specialists without having to receive approval from their primary care
32 physicians. Similarly, comments from the Federation emphasized the importance of ensuring the
33 eligibility of non-primary care specialists to fill the role of personal physician, which is consistent
34 with several AMA policies (e.g., H-230.962, H-160.951, and H-160.943) supporting the ability of
35 patients to access specialists for "primary care" services, if appropriate. It should be noted that
36 many medical specialties are eligible to serve as medical homes under the Medicare Medical Home
37 Demonstration.

38
39 Across all specialties, a concern was raised about the ability of smaller physician practices to
40 qualify for the medical home designation. Many physicians indicated that they already function as
41 a "medical home" to their patients, offering patient follow-up, coordinating care with other
42 providers, and offering night and weekend access for their patients, without the benefit of
43 additional payments for these services. The concern among these physicians is that the
44 requirements – both infrastructure and administrative – associated with qualifying as a formal
45 medical home would be too great, resulting in denial of financial incentives associated with the
46 medical home designation. There was also concern that physicians could be discouraged from
47 pursuing primary care practice because of the additional administrative burdens associated with
48 meeting the qualifications of a medical home.

1 MEDICARE MEDICAL HOME DEMONSTRATION

2
3 The medical home model is one of the more fully developed proposals for reforming Medicare
4 physician payment. In October 2008, CMS released detailed information about the Medicare
5 Medical Home Demonstration, a three-year demonstration authorized by the Tax Relief and Health
6 Care Act of 2006. Under the project, physician practices that qualify as a medical home will be
7 paid a monthly care management fee to “provide targeted, accessible, continuous and coordinated,
8 family centered care to high need populations,” which includes patients with prolonged or chronic
9 illnesses.

10
11 According to CMS, medical home status “represents an expectation that the practice has the
12 capability and intention to provide a certain level of care management and coordination services to
13 patients.” CMS anticipates selecting approximately 50 practices from each of eight sites (states or
14 portions of states) to participate in the demonstration. Primary care and non-primary care specialty
15 practices are eligible to participate, except for specifically excluded specialties and subspecialties
16 (radiology, pathology, anesthesiology, dermatology, ophthalmology, emergency medicine,
17 chiropractic, psychiatry and surgery).

18
19 Under the CMS demonstration, practices are eligible to participate as a medical home if they can
20 document their ability to meet qualifications developed specifically for CMS by the National
21 Committee on Quality Assurance (NCQA). CMS has established two tiers of medical home
22 eligibility to encourage and accommodate practices with increasing levels of capability. Tier I
23 practices must meet 17 basic medical home capabilities, including the use of health assessment and
24 integrated care plans; the ability to track tests, provider follow up, and referrals; and the ability to
25 review all medications. Tier II practices must be able to document four additional capabilities: the
26 use of an electronic medical record, application of a systematic approach to coordinate facility-
27 based and outpatient care, use of mechanisms to measure performance of physicians on clinical
28 quality and patient experiences, and use of a process to report to physicians on performance.
29 Practices that qualify initially for Tier I participation may advance to Tier II by submitting
30 additional documentation at a later date.

31
32 The AMA/Specialty Society RVS Update Committee (RUC) provided CMS with its
33 recommendations for Relative Value Units (RVUs) for the care management fee. Care
34 management fees will be paid to participating practices on a per member (i.e., eligible patient) per
35 month basis, at a blended rate of approximately \$40 for Tier I practices, and \$52 for Tier II
36 practices. Amounts will then be risk-adjusted according patient severity based on the Hierarchical
37 Condition Code score, which reflects disease burden and predicted future costs to Medicare.

38
39 As noted, CMS hopes that the Medical Home Demonstration will ultimately yield overall savings
40 to Medicare. Under the current demonstration design, participating practices will be eligible to
41 receive 80% of the savings above the first 2% of savings, less care management fees. Although
42 CMS is finalizing implementation details, payment of the monthly medical home fee to qualified
43 practices is expected to begin in January 2010, and continue through December 2012. Additional
44 information about the CMS Medicare Medical Home Demonstration is available at
45 www.cmsmedicalhome.com.

1 DISCUSSION

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3 The medical home model offers many potential benefits, both as a care-delivery model, and as a
4 means of increasing the value of health care spending. By placing a priority on care coordination
5 and expanding access to care for patients, the medical home reinforces the importance of the
6 patient-physician relationship as the basis for high-quality, appropriately delivered health care.
7

8 One of the greatest strengths of the medical home model is its explicit focus on the value of
9 patient-centered care management work that falls outside the face-to-face patient visit. Several
10 long-standing AMA policies (e.g., H-385.951, H-390.878, H-390.896) support physician payment
11 for these types of services, and the medical home model is designed to offer explicit incentives for
12 care-coordination activities.
13

14 The Council believes that the value of the medical home is its ability to enhance care coordination
15 and increase accountability for patient care by fostering a team approach to care delivery.
16 However, this does not necessarily require that a single physician approve all aspects of a patient's
17 care. The Council urges vigilance to ensure that the medical home payment structure does not get
18 implemented in such a way that it becomes a gatekeeper model that restricts access to specialty
19 care.
20

21 A key element of the medical home is that it retains some level of responsibility as a centralized
22 "clearinghouse" of all information related to a patient's care. While an individual's primary
23 physician need not approve all care, it is critical that he or she be aware of all care the patient
24 receives. In this regard, the medical home design must include incentives for all physicians
25 responsible for a patient's care to ensure that communication and data-sharing functions operate
26 between the medical home and other physicians providing care for the patient. The Council
27 believes that CMS should be encouraged to identify ways to engage all physicians, regardless of
28 specialty or practice model, in the success of the medical home model.
29

30 Similarly, the Council believes that another key element to the successful implementation of the
31 medical home model will be the ability to ensure maximum opportunity for participation by all
32 interested physicians. Medical home eligibility guidelines should be designed to facilitate and
33 encourage practices to meet the challenges of comprehensive care management for their patients,
34 not create administrative barriers to care coordination. Policy H-160.919, "Principles of a Patient-
35 Centered Medical Home," clearly articulates the key components and responsibilities that a
36 medical home is expected to fulfill. To the extent that a practice is able to meet these
37 responsibilities, the Council believes that any practice should be eligible to qualify as a medical
38 home. Physicians should also have access to resources to help them successfully achieve "medical
39 home" status, and to continue to improve care delivery to their patients.
40

41 Finally, the Council recognizes the tremendous pressure all physicians face as a result of
42 Medicare's sustainable growth rate formula and stagnant fee-for-service payment rates. Previous
43 Council reports (Report 10-A-07, Report 6-I-07 and Report 6-A-08) have detailed the ways in
44 which improvements in medical care and technology have led to a distorted distribution of funds
45 across the Medicare program. The AMA opposes "budget neutral" policies. Accordingly, the
46 Council believes the AMA should work to ensure that support for the medical home model is
47 funded through sources other than Medicare Part B.

1 The Council believes that this report addresses the issues raised in Amendment J-3 (I-08), as well
2 as the intent of Policy D-160.942. Accordingly, the Council recommends that Policy D-160.942 be
3 rescinded.

4
5 RECOMMENDATIONS

6
7 The Council on Medical Service recommends that the following be adopted in lieu of Amendment
8 J-3 (I-08), and that the remainder of this report be filed:

- 9
10 1. That our American Medical Association (AMA) support the patient-centered medical home
11 model (as defined in Policy H-160.919) as a way to provide care to patients without
12 restricting access to specialty care. (New HOD Policy)
13
14 2. That Policy H-160.919, “Principles of a Patient-Centered Medical Home,” be amended by
15 addition of the following statement: “It is the policy of our AMA that medical home
16 participation criteria allow any physician practice to qualify as a medical home, provided it
17 can fulfill the principles of a patient-centered medical home.” (Amend HOD Policy)
18
19 3. That our AMA urge the Centers for Medicare and Medicaid Services to work with our
20 AMA and national medical specialty societies to design incentives to enhance care
21 coordination among providers who provide medical care for patients outside the medical
22 home. (Directive to Take Action)
23
24 4. That our AMA urge the Centers for Medicare and Medicaid Services to assist physician
25 practices seeking to qualify for medical home status with financial and other resources.
26 (Directive to Take Action)
27
28 5. That our AMA advocate that Medicare incentive payments associated with the medical
29 home model be paid for though system-wide savings—such as reductions in hospital
30 admissions and readmissions (Part A), more effective use of pharmacologic therapies (Part
31 D), and elimination of government subsidies for Medicare Advantage plans (Part C)—and
32 not be subject to a budget neutrality offset in the Medicare physician payment schedule.
33 (Directive to Take Action)
34
35 6. That our AMA advocate that all health plans and the Centers for Medicare and Medicaid
36 Services use a single standard to determine whether a physician practice qualifies to be a
37 patient-centered medical home. (Directive to Take Action)
38
39 7. That our AMA rescind Policy D-160.942. (Rescind HOD Policy)

Fiscal Note: Staff cost estimated to be less than \$500 to implement.

References are available from the AMA Division of Socioeconomic Policy Development.

AMA Policy H-160.919 – Principles of a Patient-Centered Medical Home

Our AMA adopts the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association “Joint Principles of the Patient-Centered Medical Home” as follows:

Principles

Personal Physician - Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician Directed Medical Practice - The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole Person Orientation - The personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient’s family.

Evidence-based medicine and clinical decision-support tools guide decision making.

Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

Patients actively participate in decision-making and feedback is sought to ensure patients’ expectations are being met.

Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.

Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.

It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.

It should support adoption and use of health information technology for quality improvement.

It should support provision of enhanced communication access such as secure e-mail and telephone consultation.

It should recognize the value of physician work associated with remote monitoring of clinical data using technology.

It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).

It should recognize case mix differences in the patient population being treated within the practice.

It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.

It should allow for additional payments for achieving measurable and continuous quality improvements. (Resolution 804, I-08)