Connecticut Health Policy Project

703 Whitney Avenue, New Haven, CT 06511
Phone (203) 562-1636 • Fax (203) 562-1637 • www.cthealthpolicy.org

Patient Centered Medical Homes in National Health Reform Proposals

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Patient centered medical homes (PCMHs) are prominently featured in both the current House and Senate versions of health reform. Medical homes are not buildings or hospitals, but a different way of practicing medicine. Medical homes offer coordinated, comprehensive primary health care that is accessible, continuous, compassionate, culturally appropriate, and patient-centered. Coordination of care can reduce duplicate tests and prevent errors in conflicting treatment when patients have several doctors. Care is personalized for each patient and delivered by a team of professionals who put the patient and their needs at the center of care. Proponents argue that medical homes can reduce health care spending, improve health status, support disease management and prevention, improve the quality of care, reduce medical errors, and reduce racial and ethnic health disparities.

Congressional proposals for patient-centered medical homes differ in some significant ways. The Senate bill allows only physicians to serve as the primary care clinician in PCMHs; the House bill also allows nurse practitioners and physician assistants to serve as well as specialists in some circumstances. The Senate bill is less constricted in defining the structure of PCMHs; the House bill includes two discrete models for PCMHs. The Senate bill does not target patient populations for PCMHs; one of the models in the House bill targets higher risk patients. Both bills provide for Medicare funding of PCMHs; the House bill also includes Medicaid waivers for medical homes. The Senate bill provides support for PCMHs in one capitated payment. In one House model, payment is split between a community organization and the medical practice; the other House model provides for risk-adjusted, single payments to practices. The Senate bill provides for state-based support networks; the House bill includes state based support networks in one option. Both could begin operating and supporting medical homes within a year of passage.

The differences between the bills will be reconciled in conference between the House and Senate. Reportedly that will happen early next year.

Senate bill -- H.R. 3590, Patient Protection and Affordable Care Act

The Senate bill includes Medicare provisions and training resources to support medical homes. Section 3502 provides grants to states for "health teams" to support primary care practices as medical homes. PCMHs are paid on a capitated basis by Medicare. The health teams provide support services to the medical home practices. A priority is placed on prevention and chronic disease. There is no specific appropriation for these provisions in the bill and CBO has not scored them separately.

Primary care is defined as the "provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."

Patient centered medical homes include

- A personal physician, including obstetrics and gynecology
- Whole person orientation
- Coordinated and integrated care
- Evidence-based medicine, health information technology, and continuous quality improvement
- Expanded access to care
- Payment that recognizes the added value of patient-centered care components
- Develop care plans for every patient and present it to the health team

Health teams will coordinate with local community resources, develop interdisciplinary, interprofessional care plans, and include patients, providers and caregivers in program design and oversight. Services provided to PCMHs by health teams includes:

- Care coordination to reduce duplication of services
- Medication management
- Coordinate with appropriate use of alternative medicine for those who request it
- Provide local access to care in the most appropriate setting
- Culturally competent care
- Data collection for evaluation of patient outcomes, patient experience of care, and identify areas for improvement
- Early identification and referral for children at risk for developmental or behavioral problems
- 24 hour care management and support during transitions in care
- Liaison to community prevention and treatment programs
- Support electronic health record technology

State health teams may include

- Specialists
- Nurses
- Pharmacists
- Nutritionists
- Dieticians
- Social workers
- Behavioral and mental health providers, including substance abuse prevention and treatment
- Doctors of chiropractic
- Licensed alternative medicine practitioners
- Physician assistants

Sec. 5301 of the current Senate bill includes several provisions for health care workforce training to support patient-centered medical homes. The bill provides $125 million in FY 2010, and as necessary through 2014.

- Supports primary care physician training in community-based settings
- Supports primary care physician faculty training
- Creates a demonstration to train primary care physicians in providing care through PCMHs, developing curricula relevant to PCMHs, and continuing education for physicians about PCMHs
- Gives priority to applicants that provide innovative approaches to clinical teaching using PCMHs and interprofessional team skill training, among other factors

House bill -- H.R. 3962, Affordable Health Care for America Act

The House bill includes Medicare, Medicaid and training support for development and support of patient-centered medical homes. The House bill is more prescriptive about the structure and function of medical homes, but allows a wider range of providers to serve as the primary care clinician for PCMHs, including nurse practitioners, physician assistants and specialists, when appropriate, in addition to primary care doctors.

Sec. 1302 of the House bill creates two types of Medicare demonstration PCMH projects – the "independent patient centered medical home" and the "community-based medical home." $1.8 billion is provided for the pilots, but they will be evaluated both for quality and cost neutrality and demonstrations will only be extended if they meet those tests.

In the House bill, all patient-centered medical homes provide

- Direct and ongoing access to a physician or nurse practitioner who "accepts responsibility for providing first contact, continuous and comprehensive care to such beneficiary"
- Care coordination across settings
- Provide for or arrange care for all stages of life
- Support patient self-management, proactive monitoring, support family caregivers, coordinate with community resources
- Patient-centered processes
- Implement evidence based guidelines

The Independent Patient Centered Medical Home Model is targeted at high need beneficiaries with multiple chronic diseases, is directed by physician or nurse practitioner, and receives risk based monthly payments.

The Community Based Medical Home Model includes physicians, nurse practitioners, and physician assistant led PCMHs and serves all Medicare beneficiaries, not just those at high risk of poor health. The demonstrations can be administered by a state or a nonprofit community or state based organization. These medical homes include community health workers that assist primary care practices in chronic care management such as self-care skills, transitional care services, care plan setting, nutritional counseling, medication therapy

management, and help patients accessing care in their community. There is a preference for projects that address health disparities, small practices, community health centers, or serve rural or other underserved communities. There is also a preference for proposals to cover dually eligible beneficiaries (eligible for both Medicare and Medicaid) with chronic illnesses. Funding for this model comes in two separate payments – one to the community based organization and one to the primary care practice.

The Medicaid medical home provisions in the House bill (Sec. 1722) allow states to apply for waivers for up to five years. The bill provides for higher matching rates for administrative functions such as community care workers. The bill appropriates $1.235 billion over five years for the pilots. Medically fragile children and high risk pregnant women are mentioned as targeted populations. The pilots may test new technologies for wireless provider-patient communication.

The House bill also includes provisions to support PCMH training for health care workers. (Sec. 2252) The bill creates a new Innovations in Interdisciplinary Care Training Program that provides grants and contracts for training programs, including continuing education, in delivery of care through interdisciplinary and team-based models and coordination of care across settings. Grants can go to accredited health professional schools, academic health centers, nonprofits (AHEC or geriatric education centers are mentioned) or a consortium. Preference is given for training professionals serving underserved areas or addressing health disparities. There is no specific appropriation for this section.

Ellen Andrews, PhD