Financial Implications of the Patient-Centered Medical Home

Robert J. Reid, MD, PhD; Eric B. Larson, MD, MPH

[+] Author Affiliations

JAMA. 2012;():1-2. doi:10.1001/jama.2012.7661

Published online June 24, 2012

In these early years of the 21st century, a clear consensus has emerged on 2 points: primary care in the United States is in disrepair, and reinvigorating it is critical to improving the nation's health and reining in burgeoning health care costs. Ample evidence now exists that countries that lead in primary care—by providing accessible care that is person-centered, comprehensive, and coordinated—achieve better health outcomes for their citizens at a lower cost.[1] The World Health Organization, in the its 2008 report *Primary Health Care Now More Than Ever*, prompted all countries to strengthen their primary care systems.[2] The United Kingdom, the Netherlands, and others are doing just that by building on their already solid foundations with innovative practice models, funding mechanisms, and new methods to integrate primary care with specialty and community health services.[3]

Playing catch up, the United States is promoting the patient-centered medical home (PCMH) as the main vehicle for addressing its primary care crisis.[4] This model embraces the core attributes of primary care, a population-based approach to chronic care and prevention, a reformed reimbursement mechanism, and a patient-centered philosophy. Since 2007, the medical home has been vigorously piloted and adopted by a wide range of payers, health systems, and clinician organizations. Promising results from various studies involving different populations are now beginning to emerge.[5] The Affordable Care Act (ACA) contains many features to support adoption of the PCMH in the Medicare, Medicaid, and the Children's Health Insurance Programs through better reimbursement rates and new funds for model adoption and testing. However, adoption of the PCMH places substantial demands on the capabilities of practices. The majority of practices do not currently have the necessary infrastructures to be robust PCMHs.[6]

The importance of primary care, as detailed by the World Health Organization and the Institute of Medicine, and embedded in the ACA and Centers for Medicare & Medicaid Services regulations, suggests that it is time to examine what it requires for practices to be medical homes and what these capabilities provide in return. In this issue of *JAMA*, Nocon and colleagues[7] provide a detailed look at some of the financing aspects of a large and presumably diverse set of 669 federally funded community health centers.[7] Although this cross-sectional study does not examine the effects on quality or overall care costs, it provides an estimate of the association between ratings that assessed several aspects of the PCMH and health center operating costs. Overall, a 10-point higher score on the total PCMH rating scale was associated with a $2.26 (ie, 4.6%) higher monthly operating cost per patient.[7]

Supporting an earlier experiment in an integrated delivery system,[8] this study confirms that sizable and ongoing investments are needed to create and sustain medical homes. These findings also complement other research showing that absent investment and payment reform, attempts to implement PCMHs can fail to achieve the desired goals for PCMHs,[9] which can be discouraging to primary care practitioners. Nevertheless, with sufficient staffing and practice support, adoption of the PCMH can lead to greater work satisfaction and less burnout.[8] The study by Nocon et al also reveals that the operational costs associated with features of the medical home vary substantially across practices. This finding is important because it underscores the need for individual health centers to tailor their clinical and management strategies according to the availability of local resources and the case-mix of the served population.[10]

The report by Nocon et al also highlights the cost implications of improved service to medically underserved and vulnerable populations. For 40 years, federally funded community health centers have provided health care services for these patient populations.[11] Gains promised by the medical home should be highest in disadvantaged populations because these patients are more likely to have uncoordinated and episodic care and often rely on emergency departments to receive services. Patient-centered medical homes can potentially narrow the health inequities that exist because of lack of access to health care and because of socioeconomic disparities. A strong primary care system—with its focus on patients first and their diseases second, and its commitment to engaging communities in health promotion—may reduce socially derived health inequities.[12]

The ACA, with its emphasis on delivery system reform and provisions for demonstration projects in areas like the PCMH, should result in more efficient, effective and equitable care. Development of accountable care organizations (ACOs) is an integral part of the ACA, although how the PCMH is integrated into an ACO has not been completely established. Nocon et al demonstrated that there are expenses related to PCMH implementation. Savings attributable to improved access and care occur downstream—through the avoidance of expensive emergency department care and inpatient care. Patient-centered medical homes do not directly benefit from these savings. To support the added infrastructure and staffing costs, ACOs must make deliberate and ongoing investments in PCMH practices. This financial model is not explicitly incorporated in the ACO model.[13]

Many communities in the United States remain dominated by large hospitals, often networked into regional hospital systems. As ACOs develop, there will be a tendency to build them around individual hospitals or hospital systems. This is because hospitals have the largest concentration of capital and income, as well as the greatest requirement for ongoing sustaining capital investments. Nocon et al show that creating effective PCMH practices in local communities will also take an investment, but it remains unclear whether the majority of hospitals will be willing to invest in these practice models.

Organizing care in communities around robust medical homes, which include community health centers, has the potential to lead to important efficiencies in the total cost of care. However, PCMHs must deliver comprehensive care and not simply be a gateway to existing specialty and hospital-based care. With the recently deployed Centers for Medicare & Medicaid Services Advanced Primary Care Practice Demonstration and the Health Resources and Services Administration Patient-Centered Medical/Health Home Initiative, the federal

government is rapidly investing in PCMH transformation in community health centers. However, to date, these practices have been poorly integrated with specialists and hospitals.[11] To be more effective, attention needs to be directed to integrating PCMHs into the developing ACOs.

The report by Nocon et al provides an in-depth analysis of health center finances. In a few years, more information will become available about whether PCMHs improve care and reduce costs, key elements of their architecture, ways to redesign them to meet the needs of diverse populations, and how to efficiently integrate them into larger health systems. Patient-centered medical homes have great potential for remodeling the lagging US primary care system, which will, if strengthened, be able to provide comprehensive health care services to all patients.