REVIEW ARTICLE

The Opportunity for Health Plans to Improve Quality and Reduce Costs by Embracing Primary Care Medical Homes

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Background: The large and growing costs of healthcare will continue to burden all payers in the nation's healthcare system—not only the states that are struggling to meet Medicaid costs and the federal government, but also the private health plans that serve commercial, Medicare Advantage, and Medicaid beneficiaries. Cost will increasingly become a concern as millions more people become newly insured as a result of the Patient Protection and Affordable Care Act (ACA). Primary care delivery through patient-centered medical homes (PCMHs) and other coordinated-care models have improved care and reduced costs. Health plans have a strategic opportunity to promote better care at a lower cost by embracing medical homes and encouraging their growth. Health plans can play an important role in transforming the US healthcare system, as well as better position themselves for long-term corporate success.

Objectives: To discuss several examples of organizations that serve a variety of beneficiaries and have been successful in promoting medical homes and coordinated primary care, and to suggest steps that health plans can take to improve the quality of care and reduce costs.

Discussion: The models discussed in this article take a number of different approaches to create incentives for high-quality, cost-effective, coordinated primary care. Several health plans and groups use enhanced fee-for-service or per-member per-month payment models for primary care physician (PCP) practices that reach a specified level of medical home or electronic health record certification. Most of the examples addressed in this article also include an additional payment to encourage care management and coordination. The results showed a significant decline in costs and in the use of expensive medical services. One Medicaid coordinated-care program we reviewed saved almost $1 billion in reduced spending over 4 years, and achieves savings of approximately 15% within 6 months of the beneficiaries' enrollment into their program. Another PCMH payer program led to an approximate 28% reduction in acute care hospital admissions among Medicare beneficiaries and an approximate 38% reduction in admissions among commercial beneficiaries.

Conclusion: Based on the review of real-world examples, we recommend 6 steps that health plans can use to take advantage of the opportunity to embrace medical homes as a means to improve healthcare quality and to reduce costs. These recommendations include getting feedback from PCPs to improve plan provider networks, creating value-based primary care reimbursement systems, encouraging biannual visits with high-risk patients, funding case managers for high-risk patients, considering Medicaid coordinated-care models, and promoting ACA policies that support primary care.

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The large and growing cost of healthcare, which amounted to 17.9% of the gross domestic product in 2011,[1] will continue to be a burden for all payers in the US healthcare system, not only for states that are struggling to meet Medicaid costs and the federal government's requirements, but also for private health plans that serve commercial, Medicare Advantage, and Medicaid beneficiaries.[2,3] Costs will continue to grow as millions more people become newly insured because of the Patient Protection and Affordable Care Act (ACA).

Primary care that is delivered through patient-centered

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medical homes (PCMHs) and other coordinated-care models has served as a means to improve care and to reduce costs.[4,5] Health plans, therefore, have a strategic opportunity to promote better care at a lower cost by embracing medical homes and encouraging their growth. Using this strategy would enable health plans to play an important role in transforming the US healthcare system, and to be better positioned for long-term corporate success.

Large business groups already have taken note of the potential for primary care and medical homes to reduce their healthcare costs. The National Business Group on Health (NBGH), which has more than 300 large corporate members that provide health insurance for 50 million Americans, has made primary care, and more recently the PCMH model, a priority "for years," said NBGH Vice President Veronica Goff in an April 18, 2012, telephone interview. Several large employers are conducting PCMH pilot programs, including IBM, Boeing, Whirlpool, Dow Chemical, and Perdue Farms. Some state Medicaid programs and private health plans have also launched efforts to establish medical homes.

In this article, we discuss several examples of organizations that serve a variety of beneficiaries and that have been successful in promoting medical homes and coordinated primary care. We review their results and make recommendations to health plans that are interested in seizing this opportunity.

KEY POINTS

- As more Americans become insured under the ACA, healthcare costs will increase in our already burdened healthcare system.
- Primary care medical homes, especially PCMHs, have been shown to improve the quality of care for patients and reduce costs by delivering high-quality, cost-effective, coordinated care.
- Typically, health plans and provider groups use enhanced FFS and PMPM payment structures to reimburse primary care practices that reach a specified level of medical home or meaningful use standards.
- One Medicaid coordinated care program had almost $1 billion in reduced spending over 4 years.
- Another PCMH payer program had an approximate 28% reduction in acute care hospital admissions among Medicare beneficiaries and an approximate 38% reduction in admissions among commercial beneficiaries.
- By adopting and paying for PCMHs, health plans can play an important role in transforming the US healthcare system, as well as better position themselves for long-term corporate success.

Defining and Certifying Patient-Centered Medical Homes

The PCMH model has been widely discussed in recent years. In 2007, the 4 major associations representing 333,000 primary care physicians (PCPs) issued joint principles of the PCMH model.[6] These principles indicate that a PCMH should include[6]:

- A personal physician
- A team approach
- A patient-centric focus
- A dedication to quality and safety, including evidence-based medicine and clinical decision support tools
- Coordinated care across settings
- Enhanced access for patients, such as through open scheduling, e-mail, and expanded hours
- Appropriate, enhanced payment.

In 2008, the National Committee for Quality Assurance (NCQA) released its first set of standards and guidelines for PCMH recognition, which were revised and reissued in 2011.[7] Practices that were recognized under the 2008 NCQA guidelines have 3 years from the date of recognition to update their practices to match the 2011 guidelines.

"As of January 2013, 5198 sites with a total of 24,544 clinicians had received NCQA recognition," said Peggy Reineking, NCQA's Director of Clinical Recognition Programs, in a January 8, 2013, telephone interview. "Practice size varied, but about 50% of those recognized were large sites, likely primary care practices from integrated health systems," she said.

The NCQA's 2011 guidelines include 6 standards, each with a number of elements, for practices to meet.[7] Within these 6 standards, there are several must-pass elements for which a practice must earn at least 50% of the total possible points. These 6 standards are[7]:

1. Enhance access and continuity
2. Identify and manage patient populations
3. Plan and manage care
4. Provide self-care support and community resources
5. Track and coordinate care
6. Measure and improve performance.

Based on their point totals in those categories, practices can earn 3 levels of recognition: level 1 (35-59 points), level 2 (60-84 points), and level 3 (85-100 points).[8]

To achieve the highest levels of PCMH recognition, practices must have electronic health record (EHR) systems for activities such as patient and population management. The NCQA aligned its 2011 standards with the "meaningful use" standards from the Office of the National Coordinator for Health Information, which is part of the US Department of Health and Human Services.

Practices with clinicians demonstrating meaningful use standards will also receive credit from the NCQA. Approximately 21,300 family practice and internal medicine specialists demonstrated meaningful use standards as of April 2012, receiving on average approximately $17,000 per practice from the Centers for Medicare & Medicaid Services (CMS) EHR incentives program.[9] In addition, more than 13,800 nurse practitioners have enrolled in the CMS incentives program as of April 2012.[9]

The ACA's policies are expected to increase the importance of and the demand for primary care services, particularly for people who are newly enrolled in Medicaid.

Challenges to Promoting Medical Homes and Primary Care

PCMHs and PCP practices in general face a number of barriers to growth. Yet, the medical home model will likely become an increasingly important way to curb healthcare costs as millions more people across the country become newly insured as a result of the ACA.

Primary Care Reimbursement

The first hurdle is that reimbursement for primary care tends to follow the fee-for-service (FFS) model, and often at lower rates than used for specialist care. For example, in a personal interview on May 8, 2012, Sunanda Sindhwani, MD, of Internal Medicine Associates, Reston, VA, said that at her practice, which treats approximately 10,000 patients in Fairfax County, VA (and has one of the highest county median incomes in the nation[10]), the practice's reimbursement level has changed by only a small amount in the past 5 years. Practice reimbursement is still almost exclusively based on FFS, with commercial plans paying a slightly higher amount than Medicare.

Notably, as a sign of the recognition of primary care reimbursement as a problem, the ACA required state Medicaid programs to reimburse PCPs at no less than 100% of Medicare's reimbursement rate in 2013 and 2014.[11] The ACA also provides a 10% Medicare incentive payment for primary care services.[12]

PCMH Certification and Health Information Technology

The NCQA certification for PCMHs has tremendous value as a uniform, nationally recognized set of standards. Achieving NCQA's certification, however, is often challenging for PCP practices, which must invest significant amounts of resources and uncompensated staff time to complete the process. Randall Curnow, Jr., MD, MBA, Executive Vice President and Chief Medical Officer of Summit Medical Group in Knoxville, TN, commented in an April 26, 2012, interview that achieving even the 2008 NCQA standards, which are considerably less challenging than the 2011 standards, required as many as 100 hours in addition to the day-to-day patient care.

The technologic requirements for PCMH certification also can be daunting. In a May 1, 2012, telephone interview, Joel C. White, Executive Director of the Health IT Now Coalition, commented that "Stage 1 represents a fairly low bar." The stage 1 meaningful use measures focus on basic electronic tools, such as e-prescribing, computerized physician order entry, clinical decision support, and recording basic demographic information.

Stage 2 standards, however, are more challenging and require information sharing to allow for care coordination using point-to-point messaging. "Lack of interoperability, for example, between a [PCP] practice and hospitals or with specialists' practices is a significant problem, although it is not a technology or standards issue," Mr White indicated.

Dr Sindhwani reinforced the value of interoperability, particularly as a way to avoid redundancy in services, such as duplicate magnetic resonance imaging or laboratory tests. With the majority of PCP practices being relatively small, and particularly for practices in rural health provider shortage areas, the challenges of moving to an accredited meaningful use EHR system may well be significant, and may "disrupt workflow," he noted.

Effects of the ACA

The ACA's policies are expected to increase the importance of and the demand for primary care services, particularly for people who are newly enrolled in Medicaid. The Supreme Court's decision in *NFIB v Sebelius* gave states a choice of whether to expand Medicaid eligibility up to 138% of the federal poverty level starting in 2014.[13]

The estimates vary widely for how many new people Medicaid programs will enroll. The Congressional Budget Office's latest projection, after the Supreme Court's decision, estimates that 11 million people will become newly insured through Medicaid by 2022, 6 million fewer than it had projected before the Supreme Court's decision.[14] However, of those 6 million, 50% are expected to get coverage through state health insurance exchanges and the other 50% are expected to be uninsured.[14] The Kaiser Commission on Medicaid and the Uninsured estimates that 21.3 million people would become newly enrolled in Medicaid if all states choose to expand the program.[15]

The combination of people who become newly in-

sured, as well as general population growth and aging demographics, will create an additional demand for primary care services. One recent study projected that those factors would increase the number of annual primary care visits from 462 million in 2008 to 565 million in 2025.[16]

Successful Models to Promote Medical Homes, Improve Quality, and Reduce Costs

Health plans have an opportunity to address each of the challenges described above. This section discusses several proved methods that health plans could use to support medical homes, drawn from health plans and other organizations that serve a variety of beneficiaries.

At first, paying more for primary care seems at odds with the goal of reducing overall healthcare costs. However, the right kinds of PCP incentives and models have proved to reduce the use of expensive medical services and cut costs. We review those models and then discuss their results. We divided the incentive methods into 2 broad categories—enhanced payments for high-quality primary care and care coordination.

Examples of Enhanced Payments for High-Quality Primary Care

The payment incentives we examined involved a few basic models:

- Enhanced FFS payments based on NCQA and meaningful use certifications
- Supplementary payments, frequently on a per-member per-month (PMPM) basis
- Value-based payment methods, or pay-for-performance (P4P) payments
- Gain-sharing payments (which are less frequently used).

A 2010 study of PCMH pilot projects showed that medical homes used a variety of payment models, often mixing multiple kinds of payments.[17] For example, typical FFS and PMPM payments were ubiquitous, with 96% of the programs in the study using each of them. Of these programs, 58% had PMPM payments that were adjusted based on the NCQA accreditation level attained and 23% had payments adjusted for risk. The mean annual additional PMPM payment was $22,834 per physician. (This amount represents the mean high and low. The full range of PMPM payments was between $720 and $91,146.[17]) Such results mirror the mixture of incentive payment methods in the examples we discuss for this article.

Geisinger Health System. Geisinger Health Plan's medical home model—ProvenHealth Navigator—is "an intensive multidimensional medical home model that addresses care delivery and financing."[18] Janet Tomcavage, RN, MSN, Geisinger's Health System Chief Clinical Transformation Officer, said in a May 2, 2012, telephone interview that the program follows a "value-based reimbursement model," which includes FFS and performance-based PMPM payments. Practices can earn up to 3 P4P stars, which are based on quality indicators, such as Healthcare Effectiveness Data and Information Set (HEDIS) measures, emergency department utilization, and medication adherence. The performance-based payments can reach $6 PMPM. Ms Tomcavage illustrated that a 3-star practice with 1000 Geisinger Health Plan members could earn an additional P4P payment of $6000 monthly, or $72,000 annually.

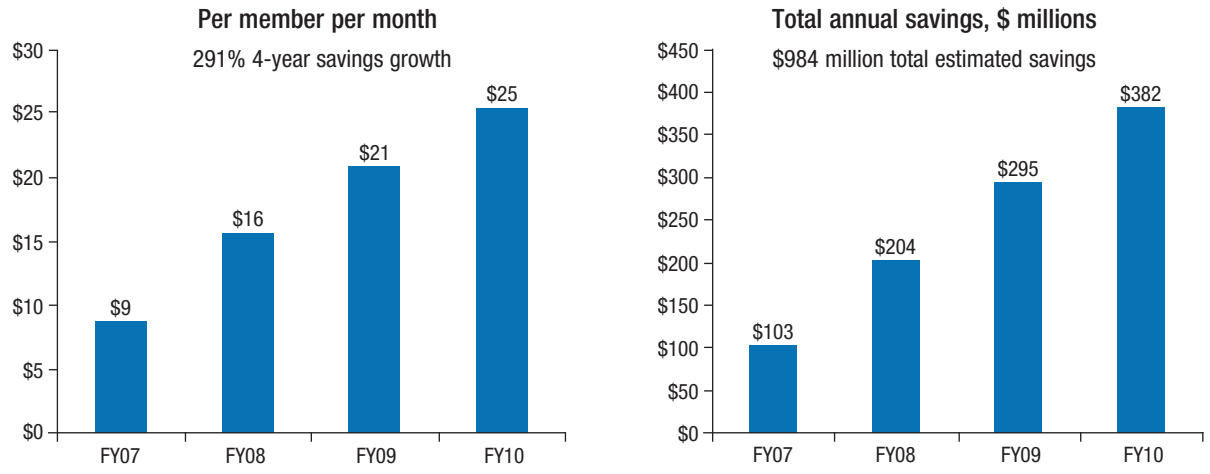
Paying more for primary care seems at odds with the goal of reducing overall healthcare costs. However, the right kinds of PCP incentives and models have proved to reduce the use of expensive medical services and cut costs.

In the same interview, Ms Tomcavage said that Geisinger's model also includes "quality gated results sharing." Practices receive a portion of the estimated cost-savings if, compared with the previous 2 years, they meet targets for efficiency and medical expenses. Practices must also show improvement in quality measures, such as better patient outcomes in diabetes and cardiovascular disease, and enhanced patient satisfaction.

BCBS of North Carolina. Blue Cross Blue Shield (BCBS) of North Carolina is another health plan that has been successful in promoting medical homes. Through its Blue Quality Physician Program, it provides an approximately 25% enhancement to fee schedule payments for practices serving as medical homes and for practices making other clinical improvements. During the 3-year pilot project leading up to the Blue Quality program, BCBS of North Carolina paid financial rewards to physicians who achieved NCQA performance measures. A separate BCBS of North Carolina program helps PCPs to develop EHRs and to demonstrate meaningful use standards. Demonstrating meaningful use standards allows PCP practices to receive substantial incentive payments, often approximately $17,000, from CMS.[9]

Summit Medical Group. An example of a provider group that has embraced the PCMH model and benefited from enhanced quality- and certification-based payments is Summit Medical Group. The group has approximately 220 physicians (almost exclusively PCPs) with level 3 NCQA certification, and is recognized as a top practice in the NCQA's certifications for diabetes, heart, and stroke care. Dr Curnow believes that the healthcare industry is moving from an FFS model to a "fee-for-val-

Figure 1 Community Care of North Carolina Cost-Savings to the North Carolina Medicaid Program



FY indicates fiscal year.
Source: Reference 5.

ue" model, with P4P and gain-sharing. Dr Curnow expects that in the next few years a substantial portion of Summit Medical Group's revenue will be related to its NCQA accreditations, meaningful use criteria, and its gain-sharing payments.

Community Care of North Carolina's PCMH is one of the best-known examples of how care coordination can improve outcomes and reduce costs for Medicaid beneficiaries.

Summit Medical Group recently sought relationships with commercial insurers who were interested in making value-based FFS payments. Those relationships have led to significantly enhanced FFS payments for its commercial and Medicare Advantage populations as a result of Summit's verified quality, size, and market power, Dr Curnow noted. The practice also receives payments based on its NCQA and meaningful use certifications.

In addition, the group is seeking gain-sharing programs with some of its commercial insurers. Gain-sharing typically provides practices with savings based on how actual costs compare with the expected risk-adjusted costs of their beneficiary population. Dr Curnow expects gain-sharing to be adjusted, including potential reductions, based on patient satisfaction and quality scores, such as performance on preventive care, care coordination, and selected HEDIS measures.

Care Coordination and Management

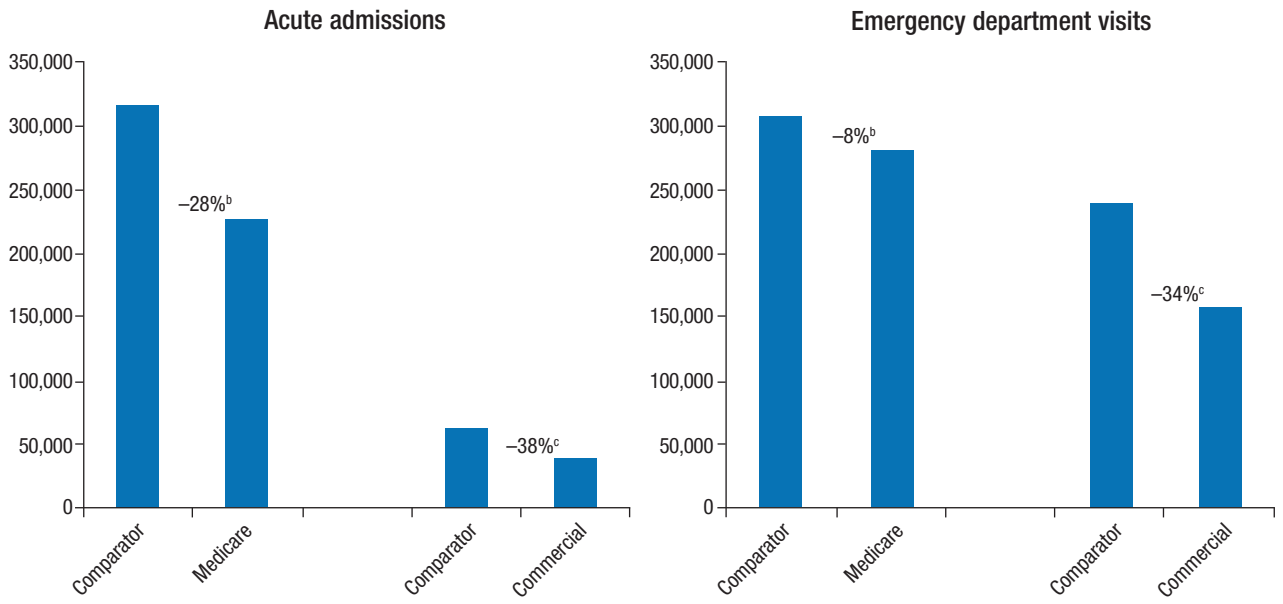
In addition to enhanced payments for quality measures, health plans and other organizations have made additional payments to promote care coordination, which is a fundamental component of PCMHs.

In the Geisinger Health Plan model, Ms Tomcavage noted that "case management is embedded in the practices." Case managers are registered nurses who are Geisinger Health Plan employees and who are physically located in practices with other team members. Geisinger Health System (the parent company of Geisinger Health Plan) also has superb information technology that links health system components, such as practices, hospitals, and laboratories. The system provides substantial and valuable data for the case managers, practices, and physicians who use these data for patient and population management.

CCNC. Community Care of North Carolina (CCNC)'s PCMH is one of the best-known examples of how care coordination can improve outcomes and reduce costs for Medicaid beneficiaries. CCNC consists of 14 locally owned and locally led care networks. As Paul Mahoney, Director of Communications at CCNC, stated in an April 17, 2012, interview and in personal communications, the networks allow CCNC to tailor its services to North Carolina's diverse geography and populations, and CCNC staff members consider the networks to be an important part of CCNC's success. Local ownership and control also help to achieve a high level of buy-in from physicians and their practices.

The state Medicaid program pays primary care practices 95% of Medicare's reimbursement rates and makes PMPM payments of $2.50 for beneficiaries who are women and children and $5 for beneficiaries who are elderly, blind, and disabled. North Carolina also gives

Figure 2 Reduction in Hospital Admissions and Emergency Department Visits: Geisinger's ProvenHealth Navigator Members versus Control Group[a]



[a]Control group includes Geisinger members who are not in the ProvenHealth Navigator medical home.
[b]Percent reduction in Medicare members versus comparator group. Medicare beneficiaries are from Geisinger Health Plan's Medicare Advantage population.
[c]Percent reduction in commercial members versus comparator group.
Source: Reference 19.

CCNC networks a variable PMPM payment of between $3 and $11, depending on the populations enrolled. These payments fund care coordination, care management, and quality improvement. CCNC has 600 care managers who are embedded in medical practices and hospitals, and sometimes in emergency departments, according to Mr Mahoney.

Pharmacists are also important participants in CCNC networks, because they support medical practices through medication management and reconciliation. CCNC pharmacists combine patient feedback and clinical data with prescription and claim data to produce comprehensive patient drug profiles. The profiles improve medication adherence and give clinicians a more complete view of their patients' progress.

CCNC now has interventions that identify and focus on the highest-need and highest-cost Medicaid beneficiaries, which include approximately 1% of women and children and 3% to 4% of elderly, blind, and disabled beneficiaries, according to Mr Mahoney. PMPM payments to Medicaid providers and CCNC networks allow for concerted efforts to reduce major cost-drivers, such as preventable readmissions, psychiatric readmissions, inpatient costs, and the overall cost of the elderly, blind, and disabled population. CCNC also focuses on patients with behavioral and chronic conditions, who may need extra support and for whom care is often expensive.

Vermont Blueprint for Health. An example of a statewide multi-insurer PCMH program is Vermont Blueprint for Health. In addition to its primary care network, it employs additional, locally based community provider teams, including nurse coordinators, behavioral health providers, and social workers who support multiple practices.[4] Those providers know the local resources and connections, and can therefore help to integrate community agencies or other resources into the patients' care.

MDVIP. The final coordinated care model considered in this review is the MDVIP program, a national "concierge" program. MDVIP members pay an annual fee of $1500 and are paired with PCPs in the MDVIP program who give enhanced personalized care, develop wellness plans, and help to manage chronic or acute conditions. Keith W. Michl, MD, FACP, a physician in Manchester Center, VT, with 30 years in practice, said in an April 26, 2012, telephone interview that he had considered leaving clinical medicine or moving to an area where primary care reimbursement was better. Instead, he chose to join MDVIP and reduced his prac-

tice size from 2000 patients to 500 patients. His patients now include self-employed people, some of whom have foregone health insurance in the past because of its cost, as well as wealthy retirees and teachers. Dr Michl receives approximately $1000 of each patient's annual MDVIP fee. Having an MDVIP practice, he said, allows him to spend more time with his patients, to communicate with them via e-mail and phone, as well as after hours, and also to do more disease management, such as nutrition and lifestyle counseling.

CCNC is generating savings from an intensive patient-centric focus on high-cost beneficiaries and savings of approximately 15% per beneficiary 6 months after their enrollment in CCNC.

Results of PCMH Models

Data from PCMH models demonstrate the clinical and cost benefits of the PCMH model for members with commercial, Medicaid, or Medicare coverage.

As shown in **Figure 1**, (page 34), CCNC has generated substantial estimated savings for the North Carolina Medicaid program.[5] In addition, CCNC is generating savings from an intensive patient-centric focus on high-cost beneficiaries and savings of approximately 15% per beneficiary 6 months after their enrollment in CCNC, according to Mr Mahoney.

With 4 million members in 39 states receiving care in primary care medical homes, BCBS has been a leader in the move to the PCMH model.[4] In one of the BCBS of North Carolina programs—Blue Quality Physician Program—patients who belonged to NCQA-recognized PCMHs had 52% fewer visits to specialists and 70% fewer emergency department visits.[4]

For Horizon BCBS of New Jersey's PCMH, the PMPM costs were reduced by 10%, and 26% fewer emergency department visits and 21% fewer inpatient admissions were reported in 2012.[4] Similarly, BCBS of Nebraska's PCMH had 27% fewer emergency department visits and 10% fewer hospitalizations in 2012.[4]

Other programs have shown similar results for Medicare Advantage, traditional Medicare, and commercial insurance beneficiaries. For example, Geisinger Health Plan's ProvenHealth Navigator medical home model significantly reduced the use of costly hospital-related services for the program's patients (**Figure 2**, page 35).[19] Acute admissions were reduced by 28% for Medicare members in the ProvenHealth Navigator medical home compared with those not in the medical home. Similarly, a 38% reduction was seen among commercial members in the ProvenHealth Navigator medical home versus those who were not (Figure 2).

Intermountain Healthcare, an integrated health system in Utah, has a medical home model called "Care Management Plus." For Care Management Plus patients, the odds of dying in the first and second years of participating in the program were significantly less for all patients, with greater benefits for patients with diabetes (at 1 year 6.2% vs 10.6% for all patients with diabetes in the control group, at 2 years 21.0% vs 24.2% for patients with diabetes in the control group).[20,21] The odds of admission for any cause were reduced by 27% to 40%.[20]

A Call to Action

Healthcare plans covering the gamut of patient populations have an opportunity to improve care and to reduce costs for their beneficiaries by taking steps to support the growth and the evolution of PCP practices and PCMHs. Based on our review of the plans discussed in this article, we recommend the following 6 actions that health plans can take to achieve these goals.

1. Get Feedback from PCPs

Managed care organization executives involved with network management should have frank and open conversations with PCPs representing a variety of practices with varying sizes and locations to learn from their experiences. Doing so will help health plans to craft policies that strengthen networks by retaining PCPs, who are vital to improving care and to reducing costs.

2. Create Value-Based PCP Reimbursement

Enhanced and value-based reimbursement policies for PCPs, particularly those in PCMHs, are vital to improving care and to reducing costs. We recommend that:

- Commercial insurer and Medicare Advantage FFS payments for primary care services are roughly 10% higher than Medicare payments; the ACA requires state Medicaid programs to reimburse PCPs at no less than 100% of Medicare's reimbursement rate in 2013 and 2014
- Enhanced PMPM payments to practices that meet higher levels of NCQA accreditation and CMS meaningful use standards, or for smaller or rural practices or older physicians, other medical home models, HEDIS scores, use of nonphysician providers, health information technology infrastructure, and expanded patient access
- Gain-sharing or bonuses when cost-savings are demonstrated, which can be actuarially imputed or otherwise estimated
- Substantial total increased payments, representing as much as a 20% increase in payment.

3. Encourage Biannual Visits with High-Risk Patients

Pay practices an enhanced FFS payment, of roughly $125 to $150, for biannual visits for patients whom practices or plans identify as being at a moderate or an increased risk based on their health status.

4. Fund Case Managers for High-Risk Patients

Assist PCPs in identifying the 2% to 5% of patients who have the highest morbidity and costs. Then identify a provider who can be an overall case manager for the care of those patients and help to identify or to provide resources for patient and practice assistance.

5. Consider Medicaid Coordinated-Care Models

With the dramatic expansion of Medicaid under the ACA, it will be particularly important to consider models, such as CCNC, that have reduced costs.[5]

6. Promote ACA Provisions that Support Primary Care

Health plans should advocate that the components of the ACA that support primary care are brought forward and funded, whether as ACA components or as separate bills.[22]

Conclusion

The cost of healthcare in the United States presents a tremendous burden to all stakeholders, including federal and state governments, employers, commercial payers, and individuals. With millions of new health insurance beneficiaries expected in 2014 as a result of the ACA, there will most likely be an increased demand for healthcare. Primary care is the front line for delivering preventive care and the care for chronic conditions, such as diabetes, hypertension, and hyperlipidemia, which are the major drivers of morbidity, mortality, and costs. Robust primary care models, such as the PCMH model, have shown to improve outcomes; reduce the use of higher-cost resources, such as hospital admissions and emergency department visits; and lower the total costs of care. Payers' support of primary care (eg, via enhanced payment and support for the PCMH model) is key in transforming the US healthcare system to improve healthcare quality and outcomes and to reduce the current unsustainable trajectory of growth in healthcare costs. ■

Author Disclosure Statement

Dr Owens is a consultant to Allergan, Biogen Idec, Boston Scientific, CardioDx, Crescendo Biosciences, Eli Lilly, Genzyme, Iroko, Johnson & Johnson, and Novocure. Ms Collins has nothing to disclose. Mr Piper has no conflicts of interest to report.

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STAKEHOLDER PERSPECTIVE

Enhancing Health Outcomes and Quality of Care with the Medical Home Model in Primary Care

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The passage of the Affordable Care Act (ACA) has highlighted the importance of a renewed focus on enhancing health outcomes, while also promoting the quality of care delivered with both economic and structural benefits.

HEALTH PLANS: This exceptionally well-written article provides information, instruction, and guidance pertinent to how health plans, and other payers, can use primary care medical homes for multiple purposes to improve outcomes. The descriptions of currently successful models provide templates for other groups to utilize for advantageous outcomes.

The examples presented in this article by Ms Collins and colleagues range from models providing enhanced fee-for-service payments to supplemental per-member per-month models, as well as value-based or pay-for-performance models. The Call to Action section of the article outlines key action steps for models that are currently in existence and for those groups that may be anticipating instituting such plans in the future.

In 2010, a document written by Meyers and colleagues and published by the Agency for Healthcare Research and Quality outlined roles for medical homes and accountable care organizations from a coordination of patient care standpoint.[1] Evidence of the success of such innovations has been documented, but this current article expands on this perspective to a considerable degree by citing even more informative increases in quality of care and positive outcomes that have ensued over the succeeding years.

In this article by Ms Collins and colleagues, the statewide, public–private partnership known as Community Care of North Carolina is being discussed. It may further be useful to note the beneficial aspects of the North Carolina program through the incorporation of a successful primary care medical home model for the population of at-risk pregnant Medicaid beneficiaries as another example of lowering healthcare costs and improving health outcomes with the medical home model.[2]

PATIENTS/PROVIDERS: Economic, patient-, and provider-related benefits have been shown to materialize with patient-centered medical homes. In a comparative study carried out within the Seattle-based Group Health of Puget Sound, results indicated that patients whose care was managed via a medical home reported increased levels of patient satisfaction compared with the comparator group with no medical home involvement. In addition, physicians and other providers experienced less burnout associated with providing care, and the economic benefits were reported to be an average of $10.30 per patient per month in the study protocol over a 2-year period.[3]

The crucial next steps for the evaluation of the quality enhancement aspects of the ACA, as outlined in the current article by Ms Collins and colleagues, will enable further assessment and innovative components that will facilitate an evaluation of the positive application of the primary care medical home to enhance outcomes—in terms of the economic, patient, and provider components of medical homes. Enhanced quality of care should be an expected and a welcome outcome of such system changes. ■

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