share this view that aligning provider incentives with payer goals will require organizational forms that can coordinate care more effectively than the fragmented current system.[4]

There are, fundamentally, no "new" methods of health care payment. Novel approaches such as those described here are new combinations of old ideas, with updated features such as improved risk adjustment. Economic theory, as others have long noted, suggests that such mixed payment models will function better than any single approach.[5] Which recipe will yield the best balance of meaningful incentives for cost control and quality improvement, risk protection for providers, and selection incentives remains to be seen. The prospects for payment reform, however, hinge more on politics than on economics. Given that the two major goals of reform are to constrain spending growth and to move money from more intensive to less intensive settings — from doctors who carry endoscopes and scalpels to primary care physicians, for example — there will be substantial resistance to even the best-designed plans.

Dr. Rosenthal reports having an unpaid role in the design and testing of the Prometheus Payment system. No other potential conflict of interest relevant to this article was reported.

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No Place Like Home — Testing a New Model of Care Delivery

John K. Iglehart

Seeking ways to slow the growth of Medicare spending and to better coordinate the health care it finances, the federal government is preparing to test the concept of the "medical home" in the Medicare program. In response to a mandate in the Tax Relief and Health Care Act of 2006, the staff at the Centers for Medicare and Medicaid Services (CMS) is developing a demonstration program that will operate for 3 years in rural, urban, and underserved areas in up to eight states. Congress has directed the agency to use the program to "redesign the health care delivery system to provide targeted, accessible, continuous and coordinated, family-centered care to high-need populations." Reluctant to constrain the freedom of beneficiaries currently covered under the traditional fee-for-service model, however, Congress placed no limits on patients' freedom to seek treatment, without a referral, from physicians not affiliated with their medical home and made virtually all practices eligible to participate in the demonstration program.

There is no consensus definition of the term "patient-centered medical home," a concept that was introduced by the American Academy of Pediatrics (AAP) in 1967 with the aim of improving health care for children with special needs. Over the years, the AAP, the World Health Organization, the Institute of Medicine, the American Academy of Family Physicians (AAFP), Dr. Edward Wagner (director of the W.A. MacColl Institute for Healthcare Innovation at the Center for Health Studies in Seattle), and others have honed this model, expanding its scope and placing more emphasis on adults with chronic conditions. In 2007, the AAFP, the AAP, the American College of Physicians, and the American Osteopathic Association issued principles defining their vision of a patient-centered medical home.[1] The core features include a physician-directed medical practice; a personal doctor for every patient; the capacity to coordinate high-quality, accessible care; and payments that recognize a medical home's added value for patients. With the possible exception of some multispecialty group practices, this model remains largely an aspiration — a type of care

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that, as the Robert Graham Center of the AAFP recently conceded, "is not currently found in most clinical practices and is unavailable to most people in the U.S.,"[2] although it is more of a reality in many other industrialized countries.

Nonetheless, Fortune 100 companies that purchase health insurance for their employees have launched programs that recognize the value of the model and, joining an array of other organizations, have created the Patient-Centered Primary Care Collaborative to advocate for its widespread implementation.[1] In addition, as of June 2008, a total of 108 bills introduced in 26 state legislatures and the District of Columbia have at least mentioned the term "medical home," according to the AAFP; 20 bills in 10 states reflect an attempt to define the concept and provide for demonstration programs.[3]

Although Congress maintained beneficiaries' freedom to select a doctor, legislators crafted an ambitious set of general requirements that physicians must meet to participate in the federal demonstration program. Many of the requirements resemble the principles set out last year by the AAFP and other primary care organizations.[1] These requirements stipulate that medical homes must have "an integrated, coherent, cross-discipline plan for ongoing medical care developed in partnership with patients and including all other physicians furnishing care to the patient involved and other appropriate medical personnel or agencies (such as home health agencies)." Although it is expected that most participating physicians will be in primary care, Congress emphasized that specialists are eligible to apply, particularly if they care for patients with a chronic condition such as severe asthma, complex diabetes, cardiovascular disease, or a rheumatologic disorder.

In return for participating in the trial, medical homes would be compensated by Medicare for the covered services they provide and would receive monthly payments for relevant infrastructure and care-coordination activities as required by the demonstration program. They would also receive a share of the amount by which expenditures were reduced as a result of their patients' enrollment in the trial, minus their care-management fee; CMS expects that this share could be as much as 80% of any savings above 2 percentage points.

Congress left it to CMS to set the amount of the per-patient care-management fee, but it directed the agency to use the recommendations of the Relative Value Scale Update Committee (RUC) of the American Medical Association to establish the value of services. If fees based on the recommendations of the RUC were adopted by CMS, they would be substantially higher than payments offered in private-sector pilot programs in which patients have fewer medical conditions and reporting requirements are less stringent. Estimates of what Medicare might pay a medical home on a per-patient, per-month basis range from $30 to around $50, depending on the characteristics of the particular practice, the risk profile of its enrolled beneficiaries, and other considerations. By comparison, private-sector payments on behalf of (generally healthier) employees who are enrolled in medical homes range from $3 to $10 per patient per month. Ultimately, the President's Office of Management and Budget will probably set the case-management fees for the Medicare demonstration program and sign off on its overall design.

Designing the trial will pose other challenges for CMS because of the many requirements for participating physicians and the agency's imperative to derive savings from the demonstration program. According to Linda Magno, the director of Medicare Demonstrations Program Group, CMS must first establish specific minimum requirements that would qualify a practice to participate; these would probably include adequate capacity to coordinate care with other providers, the installation of health information technology or a plan for installing it, and certification as a medical home by an independent organization (such as the National Committee on Quality Assurance).

In some respects, the demonstration program will compel practices that operate under the traditional fee-for-service model to adopt methods once favored by managed-care plans, such as placing primary care physicians in the position of general contractors or gatekeepers of patients' care, with the attendant authority. Physician practices that meet this challenge would then need to recruit participants from among their Medicare patients — many of whom have multiple chronic or prolonged illnesses and require regular monitoring, advising, and treatment — and persuade them to allow the practice to become a focal point for care and, if savings goals are to be achieved, the source of specialist referrals. Then the medical homes must deliver on the promise to coordinate care among all the physicians seen by each patient. Pa-

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tients would be free to leave their medical home at any time — with no explanation required — and either enroll in another one or return to the traditional fee-for-service model.

The demonstration program, if successful, will be one small step along what many policymakers view as a path toward slower growth of expenditures and improved care under Medicare. Further steps would involve restructuring the delivery system by providing physicians with financial incentives to aggregate into larger, more integrated groups that could coordinate care more effectively. Such a goal is outlined in the June 2008 report of the Medicare Payment Advisory Commission, an influential agency created by Congress to provide legislators with health policy options.[4] Noting that if it is left unchanged, Medicare will be fiscally unsustainable, the commission asserted that "fundamental change in the organization and delivery of health care is needed." It urged Congress to pursue three initiatives "expeditiously": a medical-home demonstration program, the bundling of Medicare payments for all care provided during a given hospitalization (to be paid to a single provider entity composed of a hospital and its affiliated physicians),[5] and the creation of accountable care organizations that would resemble existing multispecialty group practices.[5]

The commission, while underscoring the need for fundamental change, recommended only targeted reforms, perhaps by way of acknowledging the limits of the American (and Congressional) appetite for sweeping change, as reflected in the decisive defeat of the Clinton administration's comprehensive plan. Should the next administration and Congress take up the challenge of reform in 2009, they would do well to heed the commission's advice, in its latest report, to recognize that "the process of fundamental reform is evolutionary, and not knowing the final design should not deter us from beginning."

Mr. Iglehart is a national correspondent for the *Journal*.

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Building a Medical Neighborhood for the Medical Home

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Recent efforts to improve primary care in the United States have focused largely on the development and implementation of practice models and payment reforms intended to create a "medical home" for patients. The notion of a medical home makes intuitive sense and indeed has great promise. But unrealistic expectations about this approach abound, and insufficient attention is being paid to several important barriers to the clinical and financial success of the medical-home model.

The concept of a medical home first emerged in pediatrics, where it was recognized that children with special needs would benefit from a delivery model that effectively coordinated the complex clinical and social services that many patients require. More recently, organizations representing the major primary care specialties — the American Academy of Family Practice, the American Academy of Pediatrics, the American Osteopathic Association, and the American College of Physicians — have worked together to develop and endorse the concept of the "patient-centered medical home," a practice model that would more effectively support the core functions of primary care and the management of chronic disease.[1] The coalition also argued for payment reforms that would provide support for services that tend to be inade-

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