concept has been promoted by primary care physician societies. And a broad range of insurers and payers—for example, United HealthCare, Aetna, the Blue Cross Blue Shield Association, and Medicaid programs—are developing medical home initiatives. Likewise, Congress has mandated a medical home demonstration in fee-for-service Medicare.

Although medical home definitions vary and continue to evolve, at the heart of a medical home is a physician practice committed to organizing and coordinating care based on patients' needs and priorities, communicating directly with patients and their families, and integrating care across settings and practitioners. If enough physician practices become medical homes, a critical mass might be attained to transform the care delivery system to provide accessible, continuous, coordinated, patient-centered care to high-need populations—usually considered to be patients with chronic illnesses.

Some advocates ascribe a broader goal to the medical home model—to improve the quality of care, reduce the need for expensive medical services and generate savings for payers. Medical homes are expected to accomplish this goal by changing how physicians practice medicine.

Yet despite the enormous energy and resources invested in the medical home model to date, relatively little has been written about moving from theoretical concept to practical application, particularly on a large scale. What would an effective medical home program look like? And how should it be implemented? Forging ahead with medical home initiatives without such analyses to ground their design and identify potential pitfalls and solutions may result in ineffective programs that alienate patients and/or physicians. That would put at risk not only the resources invested by clinicians and payers/insurers in early initiatives, but also the political viability of the model itself in the long-term as a vehicle for wider health care reform.

The Center for Studying Health System Change (HSC) and Mathematica Policy Research (MPR) are uniquely positioned to address operational issues related to medical homes. Along with conducting independent and collaborative research relevant to medical homes, care coordination, payment policy and the organization of care delivery, HSC and MPR researchers have direct experience with both public- and private-sector medical home

Building Medical Homes on a Solid Primary Care Foundation

Public and private payers are launching patient-centered medical home (PCMH) experiments as one strategy to improve the quality and coordination of care, potentially lower costs, and increase financial support to primary care physicians. These experiments seek to test a medical home concept that emphasizes the central importance of primary care to an organized and patient-centered health care system.[1-3] The medical home concept posits that primary care physicians' direct and trusted relationship with patients, coupled with a depth and breadth of clinical training

Table 1

Commonalities Between the Physician Societies' Joint Principles, the Primary Care Model and the Chronic Care Model that Can Guide Measurement of the Patient-Centered Medical Home (PCMH)

PCMH Elements as Outlined by the Physician Societies' Joint Principles[4]	Capabilities related to this PCMH Element from the Joint Principles, the Primary Care Model & Chronic Care Model
Accessibility of the practice PCMH is an accessible point of entry into the health care system each time new care is needed (i.e. first contact care).	• Open scheduling.[4, 19-21] • Ease of making appointments and wait times.[2] • Expanded hours.[2, 4] • Options for patients to communicate with personal physician and office staff.[4] • 24-7 phone coverage.[2, 4]
Continuity of care "Each patient has an ongoing relationship with a personal physician in the PCMH." Person-focused (not just disease specific) care over time.	• Each patient has an identifiable primary care clinician for ongoing care.[2, 4, 5, 13] • Patient is able to make appointments with that particular clinician.[2, 5, 13] • Discussion about PCMH role and expectations with the patient—Discussion between personal physician and patient on the roles and expectations for the medical home, including making visible to the patient who the team members are.[2, 21, 22] • Registry of patients.[2, 4, 6] PCMH has a list of patients for which it is responsible. • Complete medical records are retrievable and accessible.[2]
Coordination of care "across all domains of the health care system."	• PCMH coordinates care that patients receive from other providers (e.g. specialists, hospitals, home health agencies to assure that patients get the indicated care when and where they need and want it, including medication review and management.[2, 5, 14, 23] • Referral tracking and follow up.[2] • Evidence-based decision making around referrals.[5, 24]
Comprehensiveness PCMH recognizes and provides, or arranges for "care for all stages of life, including: acute care, chronic care, preventive services and end-of-life care."	• Planned visits.[6, 25, 26] • Registry of patients[2, 4, 6] facilitates comprehensive care and population health management by enabling searches of patients with particular conditions and characteristics.[2, 6] • Range of services offered by PCMH.[2, 5]
Physician directed medical practice with a team that "takes collective responsibility for ongoing care of patients."	• A team approach can, in theory, leverage the relative clinical and organizational training skills of each member (e.g. physician, nurse, medical assistant) to ensure that the increasingly complex and inter-related needs of patients with multiple chronic conditions are met. Teamwork can facilitate comprehensiveness and coordination of care.[2, 6, 27]
Quality & Safety	• Decision making guided by evidence-based medicine and decision-support tools.[6] • Quality improvement efforts.[4, 6] • Patients participate in decision making.[4, 6] • Patient feedback is sought to ensure expectations are met.[4, 6]
Information Technology "Uses IT appropriately to support optimal patient care, performance measurement, patient education and enhanced communication."	• Registry of patients.[2, 4, 6] Consensus statement focused on aspects of information systems most relevant to the immediate progress of the PCMH emphasizes the use of a registry to

Table 2
Frequency of Items from the PPC-PCMH Organized by Concept Captured

Percentage*	Number of Items	Capability**
46	77	Information Technology • 19 items on e-prescribing • 18 items on electronic data system for patient demographic data • 14 items on the use of e-mail, e-communication, or interactive Web site • 11 items on electronic system for basic clinical data • 8 items on electronic system for managing tests • 7 items on electronic system for population management
14	24	Care for three specific conditions that the practice identifies as important to their patient panel, e.g. including identifying those patients, use of condition-specific guidelines, care management and self-management support.
13	21	Coordination of care • 1 item on scheduling visits to different providers into one trip for the patient • 4 items on referral-tracking • 6 items on test tracking and follow up • 10 items assess information continuity across settings, e.g. care transitions
9	15	Accessibility
5	8	Performance reporting
4	7	Organizing clinical data via tools such as problem lists and medication lists
2	4	Use of non-physician staff (an important element of team work)
2	4	Does the practice collect data on patient experience with care • 1 item on access to care • 1 item on physician communication • 1 item on patient confidence in self-care • 1 item on satisfaction with care
1	2	Preventive services
1	2	Continuity of care with a personal clinician
1	2	Patient communication preferences

* P rc ntag of th toal of 166 it ms.

** Th s it m counts hav b n organiz d by cont nt ar a rath r than by th ir lab ls in th PPC-PCMH.

ing have predominantly been demonstrated with computerized physician order entry (CPOE) in the hospital setting. In the primary care setting, results have been more mixed.[32, 33, 38-40] The PPC-PCMH's heavy IT emphasis raises the concern that practices with IT structures may score well without necessarily providing better clinical outcomes or continuous and coordinated care. The large number of IT measures in the NCQA tool could also create barriers to qualification among practices that provide good primary care but don't necessarily emphasize IT.

Second, the tool requires extensive documentation around single-condition care. The goal of this requirement was to provide practices with the motivation to consider how a systematic approach to work flow and documentation could promote broader changes within a practice. This incremental approach could help practices to systematically address particular chronic conditions and important population-based health issues. The tool allows

family planning and pulmonary function tests.[2]

Validation that the medical home is indeed patient-centered could be enhanced by the inclusion of patient feedback in a qualification tool. While most demonstrations and pilots will delay enlisting patient feedback until the evaluation phase (rather than doing so in the qualification phase), confirmation of the presence of particular PCMH elements during the qualification phase could be assisted by incorporating patient input using validated measures.[46, 47]

Recognizing many of these concerns, the physician specialty societies endorsed the PPC-PCMH for testing purposes only. NCQA is working to incorporate stakeholder input into future versions of the tool, including measures of coordination between the primary care physician and specialists and an important measure on mutual acknowledgement of the partnership between the patient and the medical home. Unfortunately, these revisions are not likely to be incorporated in time for the tool that will be used in the qualification phase of most pilots. The reality of current medical home initiatives is that payers want to see documentation of improved capabilities from providers if they are going to increase reimbursement for medical home services. In an effort to be responsive to that request, the medical home qualification tool train has, perhaps, prematurely left the station.

Past experience with performance measurement linked to payment suggests that "we will get what we measure." Both the primary care and chronic care models suggest that the qualification of practices as medical homes should be based on the conceptual underpinnings of primary care. Measures in a medical home qualification tool, therefore, should capture the structures and processes that ensure accessibility, continuity, coordination and comprehensiveness. Additional capabilities that could help deliver these elements and enhance chronic care provision include a patient registry, mutual acknowledgement between the patient and the medical home physician on their respective roles and expectations, 24-7 phone access, some same-day appointments, team-based care, and the use of planned care visits.

At this critical turning point for the nation's fragile and underfunded primary care infrastructure, a medical home qualification tool that insufficiently e( )20.299116 (m) 12(h)104 (s-13 (i) 9 (z) 9 (e104 (s) 9 ( )) 4 (k) 18(p) 16 (y) 9 ( ) 28 (p) 21 (r) 3 (i) 9 (m) 12 (a) 18 (r) -19

integrating and coordinating care. Without a conversation explaining the new medical home model of care, many patients will continue to use care outside of the medical home without telling their medical home physician. If physicians are unaware of patients' self-referrals to specialists, or emergency room and hospital use, they cannot help patients coordinate their care. Similarly, if medical homes provide expanded access, this should also be explained to patients so they do not simply use the emergency room or seek out another primary care physician for problems that can be addressed in the medical home practice.

Evidence suggests that educating patients about the roles and responsibilities of both the medical home physician and the patient can help patients transform the way they use care. Indeed, the British Columbia Primary Care Demonstration found that patients' use of specialty, emergency room and primary care delivered by other physicians declined only after the program changed the registration process to require that physicians educate patients about the benefits of continuity of care with the primary care physician, as well as providing extended hours.

The final reason patients should be informed of the medical home is to address potential privacy concerns. If patients are not informed, they may be alarmed to find out that payers are sharing confidential information with the medical home physician about their use of emergency room, hospital and specialist care.

Payers, typically insurers, need to link patients to specific physicians for three reasons. First, since most insurers in part use capitated payments, or per-patient, per-month fees, to compensate physicians for providing medical home services, insurers need to know which patients belong to which physicians so that payment goes to the correct physicians. Second, some insurers provide feedback data on quality and utilization for individual patients or the entire patient panel to physicians as part of their medical home initiatives. Finally, insurers need to know which patients belong with which physicians when they evaluate the effectiveness of the medical home.

Payers can link patients to physicians using four general approaches:

- apply claims-based algorithms;
- ask physicians to identify patients;
- ask patients to identify physicians; or
- employ hybrids of these three approaches.

Each of the approaches has different strengths and weaknesses on six important dimensions: patient choice, physician choice, ease for physician, ease for insurer, correct assignments and encouraging patient understanding of medical home rights and responsibilities (see Table 3).

Patients need to know which practice serves as their medical home so they know who to count on to coordinate and manage their overall care. In addition, patients need to be aware of what the medical home will provide if they are to work closely with the medical home and change the way they use care.

Claims-Only Approach Common but Prone to Errors

The most commonly used approach to linking patients to physicians in commercial insurers' medical home pilots relies on claims-based algorithms. Such algorithms typically search historical claims for the physician billing for the most recent claims with an evaluation and management (E&M) code or pharmacy claim, or the largest share of E&M visits for the patient.[48] Claims-based approaches are expeditious because the insurer avoids the costs of collecting information from patients and physicians.

An approach that relies exclusively on claims is operationally easy for both insurers, who simply review historical claims data, and physicians, who do not participate in any way. However, by excluding physician and patient input, this approach does not allow either to select the person with whom they perceive they have a medical home relationship. Moreover, automatic assign-

Table 3
Trade-Offs of Different Medical Home Assignment Procedures

homes are providing and how to use care in a way that facilitates efficiency and coordination. Without involving patients, this opportunity is lost.

Perhaps most importantly, while the efficiency of using historical claims data is tempting from an operational perspective, claims can be inaccurate and may not reflect clinical realities. Because many patients see multiple physicians, claims algorithms cannot always indentify the correct provider. For example, in a given year, Medicare beneficiaries see a median of two primary care providers and five specialists working in four different practices.[49] The Medicare Health Support (MHS) study examined how often a group of physicians identified via a claims algorithm actually included the patient's self-reported primary physician for heart disease. While the algorithm identified on average five doctors per beneficiary that might be the personal physician, it failed to include the primary physician as identified by 17 percent of patients.[50]

Another illustration of the inaccuracy of claims-based algorithms comes from the seeming instability of care relationships suggested by claims data, which may not be consistent with patient self-reports. The Medicare Current Beneficiary Survey indicates that patients' care relationships are more stable than the claims-based algorithm would suggest, as 70 percent of beneficiaries reported having the same physician as their usual provider for at least three years; the analogous figure would be less than 40 percent based on claims assignment.[49]

Anecdotal evidence suggests patients with other types of insurance also see multiple primary care practices. For example, one state Medicaid program found that half of all patients whose claims suggested they saw a large primary care practice as their medical home—they had one or more well-child visits or two or more sick visits with the practice in the prior year—also had visits with other nearby practices. United Healthcare's analysis of claims data convinced the company to supplement claims information with patient and physician input. The analysis used the prior 18 months of claims to identify the likely medical home practice of commercially insured patients aged 18 to 64. A year later, claims data suggested that 72 percent of the patients with a medical home the year before who still had coverage with United had the same medical home practice, 16 percent had moved to another practice, and 12 percent did not use a primary care practice.[51] Claims data alone cannot answer whether these patients truly changed the practice they consider to be their medical home.

Another problem with most current claims-based approaches is that they do not address patients who lack a primary care physician, or the "medically homeless." One study found that in a one-year period, 15 percent of all Medicare beneficiaries saw only specialists without seeing any primary care doctors, and 6 percent had no E&M visits with any type of doctor.[49] Another study reported that more than one-third of working-age adults did not have an accessible primary care provider, and half of children did not have a medical home.[52] Approaches based purely on claims would not be able to assign these patients.

Physicians May Be Unaware of Other Providers

An approach that asks physicians to identify which patients to assign to their practice still requires insurers to reconcile each physician's patient list to ensure the patients are eligible for coverage and have not been identified by another physician. While physicians would have input into which patients they would like to serve, in many cases, they may not be aware of other physicians that their patients see.

Thus, an approach that relies on physician input without patient input may not always generate correct assignments. And like claims-only approaches, physician-driven approaches would not assist patients in receiving adequate information about the new medical home services.

Patient Reports Operationally Challenging

Turning to a patient-focused approach, where patients would be asked to submit the name of their medical home, the burden on insurers to collect this information from patients would be high. People don't always turn in their forms. For example, often only one-third to one-half of people respond to social science surveys without substantial effort to collect their responses. Even when money is at stake, not all people file the necessary forms. Only 80 percent to 86 percent of tax filers eligible for the earned income tax credit actually claim the credit.[53]

The patient-based approach has three strengths. First, there is no operational burden on physicians. Second, the assignments will be correct from the patient perspective. Third, because insurers will need to inform patients about the medical home concept when their input is solicited, insurers likely would inform patients of their medical home rights and responsibilities. However, the physician's perception of who their core patients are may vary from the patient's perspective.

A Hybrid Approach Can Help Build Medical Home Relationships

A hybrid approach that combines features of the claims-based, physician-driven and patient-driven approaches would best help build medical home relationships while honoring existing patient-physician relationships. For example, insurers could send practices a list of their potential patients (e.g., those who claims indicate they saw the physician one or more times in the prior two years). The physicians would then be expected to obtain the patient's consent to be matched to their practice, and the physician could explain medical home features to the patients. This approach also ensures that patients can decline if they prefer another medical home.

Insurers could send patients who had not seen a physician in the prior two years a list of medical homes in their area that are accepting new patients and ask patients to select one, or opt in. While insurers might not wish to simply assign patients to a practice and give them the opportunity to change that assignment—an opt-out approach—there may be a role for such an approach for patients who do not voluntarily select a medical home. The insurer could assign those patients to a practice and notify both the practice and patient of the assignment and the patient's ability to change to another medical home if desired. Seeking patient input, and only assigning patients if they do not provide it, decreases the burden for the insurer, while still maximizing patient and physician choice.

A hybrid approach that combines features of the claims-based, physician-driven and patient-driven approaches would best help build medical home relationships while honoring existing patient-physician relationships.

The insurer could also require a formal, bilateral acknowledgment between the medical home physician and the patient that explains the respective roles of the medical home and the patient. Patients would retain the right to change their medical home if they are not satisfied with their care.

Accurate Assignment Matters

Accurate and meaningful linkages between the patient and the medical home physician are critical and require the input of physicians and patients. Having a process in place that requires patients to participate actively is pivotal to the potential of medical homes to transform patterns of care.

An approach that balances the needs and preferences of patients, physician practices and payers carries four benefits. First, such an approach helps obtain patient buy in to understand and use new medical home services effectively. Second, physicians will have clear responsibility for individual patients and be better able to coordinate care for those patients. Third, insurers can direct payment and provide information on service use and prevention or treatment needs to each physician for the appropriate patients. Finally, the most accurate approaches to assignment will facilitate rigorous evaluations of the medical home model. ■

Medical Homes: The Information Exchange Challenge

By Myles Maxfield, Hoangmai H. Pham and Deborah Peikes

patient, ideally in person. The agreement should describe the responsibilities of, and benefits to, the patient and the medical home. Patients agree to share information on all aspects of their care with the l

management providers in recent Medicare demonstrations. Such networks minimize the cost of setting information exchange agreements with specialists, as well as minimize the transaction cost of exchanging clinical information.

A second approach specific to ambulatory care physicians is for payers to require specialists to enter into service agreements with medical homes as a condition of inclusion in their plan network. Third, payers could leverage other financial incentives they may already be offering providers to use electronic information systems. For example, Medicare could combine the financial incentives in its electronic health record (EHR) demonstration with the Medicare medical home demonstration. The combined incentive may encourage more practices to invest in EHR technology, which would in turn reduce the transaction cost of the information exchange. For this strategy to be effective, payers would have to require interoperable EHR systems.

Fourth, payers could use claims data to provide feedback to the medical home on the patient's health care from other providers. Information on hospital admissions, emergency room use and the need for preventive services would be particularly useful. Clearly this strategy raises privacy concerns, but the agreement between the medical home and the patient could include the patient's informed consent for the release of such information to the medical home.

Fostering Care Delivery Changes

The medical home model can serve as an impetus for increasing primary care physicians' responsibility and authority to coordinate the care of their patients, as well as foster greater patient self-management of medical conditions. Ultimately, piecemeal incentives will likely have limited ability to ensure effective coordination of care across multiple providers that remain unaffiliated and poorly integrated in their management, culture and financing.

Policy makers might consider an improved medical home model as a bridge to broader reforms of the organization of delivery systems, in which they encourage the "virtual" networks defined by service agreements to gradually become actual networks of affiliated providers. Favorable payment systems that focus on provider organizations that *are* integrated can create incentives for medical practices—and health care markets—to evolve toward greater cohesion through enlarging existing practices, mergers among practices or practices and hospital systems, or other creative arrangements. The medical home model is unlikely to result in sustainable, meaningful improvements in care coordination and outcomes without confronting and addressing these underlying issues in the organization of care delivery.

Paying for Medical Homes: A Calculated Risk

By Hoangmai H. Pham, Deborah Peikes and Paul B. Ginsburg

The resurgence in interest among polic makers in the medical home concept stems from goals of improving qualit and reducing health care costs. Another driver of recent advocac for the model is the search for vehicles to increase financial support for primar care ph - sicians, whose services are widel acknowledged to be undercompensated in current fee-for-service pa ment s stems. Moreover, e isting fee-for-service pa ment s stems t picall do not pa for important activities that primar care ph sicians perform, such as care coordination and patient education.

Partial Capitation Payment Dominates Medical Home Pilots and Demonstrations

Payment approaches for medical homes under current fee-for-service payment systems essentially focus on additional payment for currently uncovered services. But the signal challenge is that payers have limited data both on what these uncovered services are in current practice and what the ideal array of services should be—that is, services that dependably result in high-quality, efficient patient care.

Payers recognize that medical home services, such as care coordination, are difficult to itemize, may occur outside face-to-face patient visits, and can legitimately vary in type and intensity across different patients or over time for a given patient. Paying for medical home services effectively requires some sort of capitation, or fixed per-patient fees. Most payers sponsoring medical home demonstrations or pilots offer additional payment in the form of partial capitation—a single per-patient, per-month or per-practice, per-year fee that is prospectively calculated.

Across public- and private-sector medical home initiatives, it is also clear that payers are more focused on paying for the *processes* that medical homes engage in than on the *outcomes* of those processes. Generally, if medical home initiatives incorporate any variation in payment levels, they tend to link payments to levels of medical-home capability. Frequently they do not consider patients' disease burden or physicians' performance on standardized quality measures. Although a few medical home initiatives—for example, those sponsored by the state of Vermont and the Blue Cross Blue Shield Association—recommend incorporating bonuses tied to physicians' performance on clinical quality or patient satisfaction measures, most payers are taking a wait-and-see approach on bonuses. Even fewer payers are considering payment adjustments based on patients' illness burden, a posture that makes it difficult to adapt payment levels from one program to another if the programs serve markedly different patient populations—for example, working-age, healthy commercially insured patients vs. sicker Medicare patients. One major exception is the Medicare medical home demonstration (MMHD), which will adjust payment rates based on illness severity.

The Constraint of Budget Neutrality

The most straightforward approach to setting capitated payments would be to first identify the services to be covered—those payers deem effective and currently not reimbursed—and then estimate their unit costs and frequency of delivery to the typical patient. Summing the product of unit costs and service frequency for a given time period would yield a per-capita amount, such as a monthly care management fee. However, calibrating even limited capitated payments proves a thorny endeavor, because payers currently place a high priority on budget neutrality. The hope is that potential savings from delivery of medical home services, such as reduced hospitalizations from improved care coordination, will offset any additional payments to physician practices for serving as medical homes.

But there is so little experience with medical homes that, as yet, there is no certainty that additional services will actually increase efficiency through lower costs and/or improved quality. This uncertainty makes it difficult to set payment levels that will achieve spending neutrality and to determine whether such levels will be sufficient to underwrite the costs of the activities that payers expect medical homes to perform.

Setting payments is particularly challenging in the context of demonstrations and pilots. Physicians naturally are concerned about how they will fare financially in a program of limited duration. They have reason to worry about payers' long-term commitment to pay for medical-home capabilities and the amount of time practices would have to amortize costs incurred to become medical homes. And physicians' perception of the adequacy of payments arguably carries more weight for medical home services than other services, because physicians have to be willing to participate if payers are to establish and sustain this new model.

Lastly, not all patients need the same amount of care coordination and not all medical homes offer the same services—the "typical" unit of medical home care is more difficult to define than that of more discrete services, such as a colonoscopy. For example, one medical home practice might attempt to improve coordination by implementing electronic data exchange with other providers—a resource-intensive strategy—while another practice might opt instead to implement team meetings for particular patients—a

which to base the new fees. Payers can improvise hybrid approaches that try to balance all three objectives of accurately reflecting costs, budget neutrality and adequate physician participation.

In most currently planned public- and private-sector initiatives, the overriding priority is achieving budget neutrality for payers. For example, this is an explicit consideration in the multi-payer medical home pilot in Rhode Island. Payers base payment levels on estimates of the savings they might achieve—for example, from reduced use of emergency department services and redundant testing. Payers would expect these savings to be offset by increases in

cover investment costs, and the size of a physician's patient panel is largely fixed. Therefore, physicians' interest in participating may depend on whether they believe that payments exceed their likely operating costs by a large enough margin to offset their investment costs. Multi-payer initiatives would cover a larger percentage of a physician's patient panel, dangling the promise of greater revenue gains to entice physicians to invest in practice improvements.

With the many uncertainties in the cost and value of medical home services, there is a golden opportunity for payers and physician organizations to collect detailed information on how physician practices transform themselves to achieve medical-home capabilities and the associated costs of those changes. Such data could not only help inject scientific rigor into the correction of payment levels as programs evolve, but also could clarify the level of effort that patients with different disease burdens require of medical homes, help identify the medical-home capabilities that are most cost effective, and inform judgments about the long-term sustainability of the model.

Taking Reasonable Risks Ahead of Data

From a broader policy perspective, it is worth questioning whether the earnest efforts to accurately price medical home services are a useful first step to achieving lasting payment reform. If the risk to the primary care infrastructure of doing nothing is as grave as consensus suggests, then payers may need to take a comparable risk to address the problem. At the moment, payers have much greater capacity to assume risk than do physicians—both in terms of resources and their potential to influence the behavior of other providers. Moreover, physicians are far less likely to invest in transforming their practices for pilots of limited duration than for an ongoing program with sustained political support.

Broad and lasting reform involves many technical and political steps pursued over many years. Demonstrations and pilots may merely be the first step in reform. Physicians are trained to order diagnostic tests only when they expect the results to affect future decision making, and not just to gather information for its own sake, because of the inconvenience and potential risk of complications to patients and the expense involved. Similarly, payers might consider whether their commitment to paying for medical home services or increasing their financial support for primary care in other ways will wane if they discover that medical home initiatives do not save money.

If payers are committed to increasing support for primary care regardless of the outcomes of medical home pilots, then they could design payments that at best achieve budget neutrality or even result in spending increases. That is, budget neutrality may be an admirable long-term goal, but an unrealistic expectation at every step of reform. Payers could implement such payments broadly—for all primary care physicians who achieve medical-home capabilities—rather than just in isolated initiatives. Then they could track physician performance and patient outcomes and adjust the program as needed over time. Precedents for this more aggressive approach include some of the most dramatic changes to Medicare payment policy—establishment of the Medicare inpatient prospective payment system and the resource-based relative value scale for physician services.

The daunting constraints of already soaring health care spending imply that long-term improvements in primary care payment might need to occur in a zero-sum fashion involving shifts of resources from non-primary care services.

Medical Homes as a Stepping Stone to Broader Payment Reform

In the long term, medical home payment approaches could serve as a model for transitioning payment for care of chronic conditions from fee for service to capitation as manmaa rmtaerve

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