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THE MEDICAL HOME MODEL: IS THERE REALLY NO PLACE LIKE HOME?

DOMINIC J. CIRINCIONE*

INTRODUCTION

The Patient-Centered Medical Home (PCMH) is a health care model for the delivery of acute, chronic, and preventive patient care by a central primary care physician who facilitates “partnerships between individual patients” to achieve desired health outcomes.¹ For example, an ideal PCMH would provide patients with immediate and around-the-clock access to a primary care physician.² The increased access would facilitate better comprehensive and coordinated care for patients, help to reduce unnecessary and expensive testing or hospitalizations, and eventually reduce medical costs through these improvements.³

The model is considered a value-based and evidence-based strategy aimed at reducing unnecessary health care utilization that leads to increased medical costs, while also increasing patient-provider communication and health outcomes.⁴ The

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1. Patient Centered Primary Care Collaborative, Joint Principles of the Patient Centered Medical Home (Feb. 2007), <http://www.pcpc.net/content/joint-principles-patient-centered-medical-home> [hereinafter Joint Principles].

2. See generally Ass’n of Am. Med. Colls., *Model Home Concept Gains Momentum*, AAMC REPORTER, Mar. 2008, <http://www.aamc.org/newsroom/reporter/march08/medicalhome.htm> (describing a medical home and the physician’s role).

3. See *id.* (characterizing the model as providing personalized care, improving outcomes, and reducing unnecessary emergency visits).

4. See FRANÇOIS DE BRANTES ET AL., ROBERT WOOD JOHNSON FOUND., SUSTAINING THE MEDICAL HOME: HOW PROMETHEUS PAYMENT CAN REVITALIZE PRIMARY CARE 4 (n.d.), available at <http://prometheuspayout.org/publications/pdf/STMH%20Full%20with%20Apps.pdf> (describing how coordination of care and following the principles of the medical home can lead to a revitalization of primary care physician practice and better health outcomes for patients). One of the goals of the model is to provide effective evidence-based practices by a qualified personal physician that would result in fewer emergency room visits and hospitalizations and lower costs. *Id.* Ultimately, this is achieved through better coordination of care and use of evidence-based practices. *Id.*

model is also promoted by several prominent trade organizations, including the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), and others.⁵ There is evidence that the model can provide added value for patients in terms of improved patient quality of care and reductions in medical costs.⁶ However, for all of its benefits, the model has some shortfalls that require review prior to adoption and implementation by America's primary care physicians.⁷

The uncontrolled spending on health care continues to cause great concern among policy-makers and the medical community.⁸ In 2008 alone, the costs related to health care in America were estimated to reach nearly \$2.4 trillion, or an average of \$7,868 per person.⁹ The nation's gross domestic product, the predictor of national spending and output, has seen its share attributed to health care spending rise from a modest 7.6% in 1970 to an overwhelming 16.6% in 2008.¹⁰ With these rising costs, much of the financial burden is placed on families and individuals who already struggle to afford health insurance or on the nation's government programs, such as Medicare, Medicaid, and the Children's Health Insurance Program.¹¹ Unfortunately, the increased cost of medical care has resulted in fewer Americans who are able to afford insurance¹² or pay for important medical care,¹³ resulting in

5. See Joint Principles, *supra* note 1. The Joint Principles, discussed in Part I.B, were crafted in collaboration with the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and the American Osteopathic Association. *Id.*

6. See, e.g., Stephen J. Spann, *Task Force Report 6. Report on Financing the New Model of Family Medicine*, 2 ANNALS FAM. MED. (SUPP. 3) S1, S18 (2004) (noting that if Americans adopted primary care physicians as their main source of health care there would be a net 5.6% decrease in health expenditures nationwide).

7. See, e.g., Am. Coll. of Emergency Physicians, *The Patient-Centered Medical Home Model* (Aug. 2008), <http://www.acep.org/practres.aspx?id=42740> (noting that the model can only work when certain factors have been met, such as passage of universal health coverage and proof of added value, and that a loosely-defined model will bring negative impacts).

8. See, e.g., Doug Trapp, *U.S. Uninsured Total Again Tops 46 Million*, AM. MED. NEWS, Sept. 21, 2009, at 5, available at <http://www.ama-assn.org/amednews/2009/09/21/gvsa0921.htm> (describing the increase in the uninsured during 2008 and the cost consequences as a result).

9. HENRY J. KAISER FAMILY FOUND., *HEALTH CARE AND THE 2008 ELECTIONS: HEALTH CARE COSTS 2* (2008), available at <http://www.kff.org/insurance/upload/7828.pdf>.

10. *Id.*

11. *Id.* Inevitably, this strain on families and publicly funded programs drives the costs of private insurance even further upwards, compounding the already dire issues surrounding health care, such as the rate of the uninsured and underinsured. *Id.* Government programs tend to compensate when employer coverage lapses, which in turn increases the costs of those federal and state programs. HENRY J. KAISER FAMILY FOUND., *THE UNINSURED: A PRIMER: KEY FACTS ABOUT AMERICANS WITHOUT HEALTH INSURANCE I* (2008), available at <http://www.kff.org/uninsured/upload/7451-05.pdf>. The lack of insurance among families and individuals lowers the chance of seeking reliable and quality health care due to affordability. *Id.*

12. Ceci Connolly, *Higher Costs, Less Care: Data Show Crisis in Health Insurance*, WASH. POST, Sept. 28, 2004, at A01. With escalating costs for both care and insurance, the number of uninsured continues to rise, some employers have stopped offering health benefits to cut costs, and more of the population continues to rely on government programs to seek health care. *Id.*

an increased number of individuals and families unable to obtain quality care and access to providers.¹⁴

This Comment touches on the major aspects of the medical home model, beginning with a discussion of the health care crisis in America and the cost containment and quality issues.¹⁵ An explanation of the role of value-based purchasing (VBP) in the health care system follows in Part I, culminating with the introduction of the medical home model as a potential solution and a potential alternative reform.¹⁶ Part I also describes the core principles of the medical home model and discusses some of the major projects utilizing the medical home model.¹⁷ Subsequently, a more detailed analysis of potential medical home payment schemes is presented.¹⁸ In Part II, four major areas of concern regarding the medical home are discussed, along with potential methods to correct these deficits.¹⁹ Finally, Part III provides a summary of the major principles of the model, recent changes that will affect its promulgation, and its potential success as a part of overall health care reform.²⁰

I. HEALTH CARE IN AMERICA—THE MEDICAL HOME MODEL AS A DRIVING FORCE FOR CHANGE

A. The Role of Value-Based Purchasing Initiatives and the Medical Home Model in the United States Health Care System

There is a health care problem in America.²¹ High costs, unaffordable insurance premiums, and the number of uninsured all contribute to the problem.²² Unfortunately, many of the solutions posed come with initial economic²³ costs and

13. *See id.* (“Patients without insurance typically wait longer to see a physician . . .”).

14. Jack Hadley, *Insurance Coverage, Medical Care Use, and Short-Term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition*, 297 JAMA 1073, 1073, 1077 (2007) (describing how as the costs of health care increase, which includes the cost of insurance premiums, Americans become less likely to seek out health care services). Those individuals diagnosed with chronic conditions and diseases, most of whom need to receive and follow treatments on a routine schedule, are the most susceptible. *Id.* at 1073, 1080.

15. *See supra* notes 1–14 and accompanying text.

16. *See infra* Part I.A.

17. *See infra* Part I.B–C.

18. *See infra* Part I.D–E.

19. *See infra* Part II.

20. *See infra* Part III.

21. *See Connolly, supra* note 12 (describing some of the challenges Americans face in the wake of rising health care insurance premiums).

22. HENRY J. KAISER FAMILY FOUND., HEALTH CARE AND THE 2008 ELECTIONS: COVERING THE UNINSURED: OPTIONS FOR REFORM 1–2 (2008), available at <http://www.kff.org/uninsured/upload/7813.pdf>.

23. *See* HENRY J. KAISER FAMILY FOUND., FOCUS ON HEALTH REFORM: HEALTH CARE REFORM PROPOSALS, available at http://www.kff.org/healthreform/upload/healthreform_tri_full.pdf (describing the reform proposals as of October 2009 in the Senate and House of Representatives); DIANE ROWLAND

intense political debate.²⁴ One general approach in combating the problem is the establishment and adoption of VBP programs in health care.²⁵ VBP is essentially a form of “managed competition” that is aimed at penalizing non-performing or under-performing providers of health care²⁶ and providing incentives to increase performance²⁷ or to maintain adequate and above average performance by meeting some benchmark.²⁸ VBP is not a novel concept but it does face criticism and difficulties.²⁹

Despite the faults and controversy, VBP has received support by some employers and employer coalition groups.³⁰ Employers offer health insurance to

ET AL., HENRY J. KAISER FAMILY FOUND., FOCUS ON HEALTH REFORM: HEALTH CARE AND THE MIDDLE CLASS: MORE COSTS AND LESS COVERAGE 17 (2009), available at <http://www.kff.org/healthreform/upload/7951.pdf> (describing how middle class families are most affected by health care treatment and insurance costs). Politicians and policy-makers must account for several viewpoints on reform efforts, including how reforms impact different classes of the population. See ROWLAND ET AL., *supra*, at 17 (noting the importance of providing coverage to low- and middle-income families ought to be a critical element in any reform effort).

24. HENRY J. KAISER FAMILY FOUND., *supra* note 22, at 3. Many solutions promoted by organizations to combat rising health care costs, for example, require initial input costs that often are unfavorable. *Id.* These costs would eventually be absorbed and eliminated, in theory, by the reduction in spending on health care due to a decrease in the uninsured. *Id.* Most reform efforts require an expansion of currently offered services, the adoption of a single-payer system, or some other hybrid approach to meet the reform’s goals. *Id.*

25. See generally JACK A. MEYER ET AL., AHCPR PUB. NO. 98-0004, THEORY AND REALITY OF VALUE-BASED PURCHASING: LESSONS FROM THE PIONEERS (1997), available at <http://www.ahrq.gov/qual/meyerrpt.htm> (describing the use of value-based purchasing in the health care market).

The concept of value-based health care purchasing is that buyers should hold providers of health care accountable for both cost and quality of care. [VBP] brings together information on the quality of health care, including patient outcomes and health status, with data on the dollar outlays going towards health. It focuses on managing the use of the health care system to reduce inappropriate care and to identify and reward the best-performing providers.

Id.

26. See DENNIS P. SCANLON ET AL., U.S. DEP’T OF HEALTH & HUMAN SERVS., AHRQ PUB. NO. 02-0029, EVALUATING THE IMPACT OF VALUE-BASED PURCHASING: A GUIDE FOR PURCHASERS (2002), available at <http://www.ahrq.gov/about/cods/valuebased/index.html> (follow “The Basics of Value-Based Purchasing” hyperlink) (describing the benefits of VBP initiatives and the function of managing costs through evaluating provider quality of care and distributing payments based on those evaluations).

27. Henry J. Aaron, Commentary, *Budget Limits and Managed Competition: Allies, Not Antagonists*, HEALTH AFF., Fall 1993, at 132, 132–36; James Maxwell et al., *Managed Competition in Practice: ‘Value Purchasing’ by Fourteen Employers*, HEALTH AFF., May-June 1998, at 216, 220.

28. Maxwell et al., *supra* note 27, at 222.

29. MEYER ET AL., *supra* note 25 (follow “What Are the Obstacles” hyperlink). “A number of obstacles are delaying progress in the development of a [VBP] system. Some of these obstacles are technical in nature—involving, for example, the difficulty of building a community-wide electronic information system. Others involve community politics and the tradeoffs that inevitably occur between conflicting goals.” *Id.*

30. Meredith B. Rosenthal et al., *Employers’ Use of Value-Based Purchasing Strategies*, 298 JAMA 2281, 2281 (2007) (explaining the contractual relationships between employers and health care payers for the establishment of appropriate [VBP] strategies to affect cost); see also NAT’L BUS. GROUP ON HEALTH, FEDERAL AND STATE GOVERNMENT HEALTH PROGRAMS, EMPLOYERS, AND HEALTH

approximately sixty percent of the employed population,³¹ making companies and other small businesses one of the major providers of health insurance in America.³² The problem, however, is that even with the growing number of reputable VBP initiatives, such as The Leapfrog Group³³ and Bridges to Excellence,³⁴ the adoption of these programs has been slow by employer executives and decision-makers.³⁵ One explanation is that larger employers have not seen the benefits from VBP quickly enough; consequently, adoption does not justify the cost.³⁶ Adoption of these programs for many employers is simply not economical.³⁷

Several provider groups³⁸ have recently promoted the PCMH model as an alternative solution.³⁹ The PCMH model originated within the AAP, which emphasized the need for a singular “home” for the pediatric records of children.⁴⁰ A centralized location for the storage of records was advocated because, especially among children with special health care needs, there were “many different practitioners . . . independent of each other” and the concern was that the

PLANS (PURCHASERS) SHOULD IMPLEMENT PAY-FOR-PERFORMANCE (2009), *available at* <http://www.businessgrouphealth.org/pdfs/payforperformancepositionstatement.pdf> (describing the policy position of the National Business Group on Health regarding VBP and pay-for-performance).

31. HENRY J. KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2009 ANNUAL SURVEY 34 (2009), *available at* <http://ehbs.kff.org/pdf/2009/7936.pdf>.

32. *See id.* (noting that almost all large firms offer benefits, while small firms offer benefits at a reduced percentage).

33. *See* THE LEAPFROG GROUP, FACT SHEET (2009), *available at* http://www.leapfroggroup.org/media/file/FactSheet_LeapfrogGroup.pdf (describing the creation and mission of the Leapfrog Group). The Leapfrog Group was founded on the principle that the American health care system was dysfunctional and needed significant repair. *Id.* A group of business leaders and employers organized around the belief that changes to the health care system should begin from those who help to sponsor or pay for a large part of consumer health benefits. *Id.* The Leapfrog Group’s aim is to reduce the occurrence of preventable medical mistakes that occur in hospitals through a “value-based” scheme that provides a *Rewards Program* for hospitals that comply with improvement criteria and mechanisms as well as a published reporting method that promotes employers and consumers of care to choose quality hospital providers over non-performers. *Id.*

34. Bridges to Excellence, Overview, <http://www.bridgestoexcellence.org/Content/ContentDisplay.aspx?ontentID=2> (last visited Feb. 24, 2010).

Bridges to Excellence is a not-for-profit organization developed by employers, physicians, health care services, researchers, and other industry experts with a mission to create significant leaps in the quality of care by recognizing and rewarding health care providers who demonstrate that they have implemented comprehensive solutions in the management of patients and deliver safe, timely, effective, efficient, equitable and patient-centered care.

Id.

35. Rosenthal et al., *supra* note 30, at 2285–86 (noting that employers have yet to regard establishing VBP contractual relationships with payers and providers as paramount).

36. *Id.* at 2286.

37. *Id.* at 2287.

38. Ass’n of Am. Med. Colls., *supra* note 2.

39. Joint Principles, *supra* note 1.

40. Calvin Sia et al., *History of the Medical Home Concept*, 113 PEDIATRICS 1473, 1473 (2004). In fact, the “medical home” was deemed to be most necessary for children with special health care needs because of the complexities of their conditions and the frequency of health visits. *Id.*

“duplication and gaps in services that occur as a result of this lack of communication and coordination” would result in poor, perhaps life-threatening, care.⁴¹ As an example of just how important the model was regarded by the AAP, its Council on Pediatric Practice recommended replacing the terms *primary physician*, *pediatrician*, and *family physician* with *medical home*; this recommendation, however, did not pass.⁴²

Now, the medical home model has been trumpeted not only as a method of improving care for children with medical needs but for anyone who participates in the health care system.⁴³ However, the elements to be included in such a model are debatable.⁴⁴ Some envision the medical home model as concentrating on a “patient-centered” component, where the patient is the central focus and a primary physician maintains active and frequent contact with the patient regarding their care.⁴⁵ Others see a more “systems” approach, where the coordination of care is the priority.⁴⁶ Although some disagreement exists regarding the model’s priorities, there is general consensus on its core features. The *Joint Principles of the Patient-Centered Medical Home*,⁴⁷ which summarizes the model’s core features, were crafted and promulgated by several major U.S. primary care physician organizations,⁴⁸ each agreeing on seven core features that should comprise the medical home.⁴⁹ Accordingly, patients participating in medical homes that meet these principles should expect an improvement in care coordination, quality, and management that would eventually lower cost and promote better health.⁵⁰

B. The Core Principles of the Patient-Centered Medical Home

The seven core features outlined in the *Joint Principles* are: 1) that the patient has a personal physician, 2) the practice is physician-directed, 3) the relationship between patient and physician centers on a whole person orientation, 4) patient care is coordinated or integrated, 5) there is maintenance of quality and safety parameters, 6) the practice achieves enhanced medical access, and 7) there is

41. *Id.*

42. *Id.*

43. See generally Prologue, *The Medical Home*, 27 HEALTH AFF. 1218, 1218 (2008) (describing the medical home in general terms as it relates to the distribution of health care to the patient).

44. See *id.* (noting that certain policy circles envision different goals or attributes of the model).

45. *Id.* One of the prime examples of this form of communication would come in the form of telephone calls or email communication between a doctor and patient at all hours of the day and week. *Id.* In sum, the patient-centered approach is a more family-oriented form of care. *Id.*

46. *Id.*

47. *Joint Principles*, *supra* note 1.

48. *Id.*

49. See *infra* Part I.B.

50. James C. Martin et al., *The Future of Family Medicine: A Collaborative Project of the Family Medicine Community*, 2 ANNALS FAM. MED. (SUPP. 1) S3, S8, S11 (2004).

overall payment or reimbursement reform.⁵¹ According to the *Joint Principles*, each of these factors represents the hallmarks of an effective medical home.⁵²

The relationship with a *personal physician* is the first of the core principles. This principle describes an ongoing relationship between the patient and the provider that establishes continuous and comprehensive care.⁵³ This first element is often considered the most important, since, without a common source of care, barriers to access and to quality providers are more likely to occur.⁵⁴ The relationship between patient and physician is meant to remove these barriers by providing continuous care *directed by one primary physician*, the second element, which is also associated with increased health outcomes and lower costs according to some studies.⁵⁵

The *whole-person orientation* is the third principle and requires that a primary care physician arrange and maneuver the patient through the health care system, which includes arranging care with other physicians and specialists throughout the patient's lifetime.⁵⁶ Related to this third principle is the fourth element: the *coordination and integration* of patient care through electronic management (e.g., health information exchanges, technology, and registries) of every level of the health care system.⁵⁷

The *Joint Principles* identifies the fifth component as improved *quality and safety* practices, which incorporate the need for evidence-based medicine and practices that utilize technology and periodic safety audits to ensure compliance.⁵⁸ *Enhanced access to care*, the sixth element, is more of an extension of the other principles because it requires that all medical homes provide expanded access to health care and providers through improved scheduling, broadened communications, and other means.⁵⁹ Finally, the seventh principle, a *reformed*

51. See *Joint Principles*, *supra* note 1.

52. *Id.*

53. Rick Kellerman & Lynne Kirk, Editorial, *Principles of the Patient-Centered Medical Home*, 76 AM. FAM. PHYSICIAN 774, 774 (2007).

54. Michael S. Hendryx et al., *Access to Health Care and Community Social Capital*, 37 HEALTH SERVS. RES. 87, 98–99 (2002). Hendryx explains that social capital, one part of which is interpersonal trust, can help to improve access to care. *Id.* Interpersonal trust, such as with a local hospital or physician, may help improve overall health based on established connections within the community. *Id.*

55. Barbara Starfield et al., *Contribution of Primary Care to Health Systems and Health*, 83 MILBANK Q. 457, 463 (2005); Barbara Starfield & Leiyu Shi, *The Medical Home, Access to Care, and Insurance: A Review of Evidence*, 113 PEDIATRICS 1493, 1493 (2004); Leiyu Shi et al., *The Relationship Between Primary Care, Income Inequality, and Mortality in US States, 1980-1995*, 16 J. AM. BOARD FAM. PRAC. 412, 417–18 (2003).

56. Kellerman & Kirk, *supra* note 53, at 774.

57. *Id.*

58. *Id.* at 774–75.

59. *Id.* at 775.

payment formula, is the most complex and least defined.⁶⁰ Payment models and methodology are difficult to generate for the medical home.⁶¹ At a minimum, any payment methodology should include a combination of a fee-for-service component and a traditional VBP framework that recognizes and rewards physicians based on achievements in health outcomes and efficiencies.⁶²

C. The Credibility Surrounding the Medical Home Model

Evidence surrounding the efficacy of the medical home model is scarce, since it has yet to be utilized extensively by primary care physician practices. Similar models, such as the Chronic Care Model (CCM),⁶³ that do have positive results were important contributors to the evolution of the medical home model.⁶⁴ The CCM, like the medical home model, also relied on a series of distinct principles⁶⁵ that led to improved health care quality and cost-savings for patients with chronic illnesses.⁶⁶ It was tested numerous times on its ability to coordinate care among patients with chronic conditions, while also providing valuable cost-savings.⁶⁷ The medical home, even with the CCM as a building block, does not yet have similar credibility to prove its effectiveness and usefulness.⁶⁸

On the other hand, one important development and impact on the medical home model's credibility came in 2006 with the adoption of the *Joint Principles* by

60. See DE BRANTES ET AL., *supra* note 4, at 4 (noting the complexity of creating a meaningful payment system for the medical home model).

61. See *id.* (arguing that current payment formulas and methodologies, such as fee-for-service or capitation, do not “promote or sustain Medical Homes”).

62. Kellerman & Kirk, *supra* note 53, at 775.

63. See Katie Coleman et al., *Evidence on the Chronic Care Model in the New Millennium*, 28 HEALTH AFF. 75, 75 (2009) (describing the uses and principles of a CCM for the care of patients with chronic conditions).

64. See, e.g., Jaan E. Sidorov, *The Patient-Centered Medical Home for Chronic Illness: Is It Ready for Prime Time?*, 27 HEALTH AFF. 1231, 1231–32 (2008) (describing the similarities between the chronic care model and the medical home model core features).

65. Coleman et al., *supra* note 63, at 76. There are six recognized principles of the CCM: “self-management support, decision support, delivery system design, clinical information systems, health care organization, and community resources.” *Id.*; see also Thomas Bodenheimer et al., *Improving Primary Care for Patients with Chronic Illness: The Chronic Care Model, Part 2*, 288 JAMA 1909, 1912–14 (2002) (explaining the CCM and its advantages as a model for the care of chronically ill patients).

66. Coleman et al., *supra* note 63, at 81. Evidence suggests that the CCM was and is a meaningful tool to improve health outcomes and bolster the primary care practice. ROBERT L. PHILLIPS, JR. ET AL., AM. ACAD. OF FAM. PHYSICIANS, *THE NEW MODEL OF PRIMARY CARE: KNOWLEDGE BOUGHT DEARLY I* (2004), http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/policy/primarycarepolicy.Par.0001.File.tmp/caremanagementpolicy.pdf.

67. Bodenheimer et al., *supra* note 65, at 1910. This review found that out of thirty-nine programs using the CCM, thirty-two showed improvement in at least one process or outcome measure. *Id.*

68. See Sidorov, *supra* note 64, at 1231 (noting that the adoption of the Medical Home model, but for a few demonstration projects and support enthusiasm, has been relatively infrequent).

the National Committee for Quality Assurance (NCQA).⁶⁹ The NCQA is a not-for-profit health care accreditation and standards organization.⁷⁰ The rationale behind NCQA's endorsement and utilization of the model stems from the dwindling numbers of generalist and primary care physicians in the United States.⁷¹ NCQA developed a mechanism for rating or credentialing physician practices, known as Physician Practice Connections (PPC).⁷² NCQA utilized the proposed framework developed by the Institute of Medicine's 2001 Report, *Crossing the Quality Chasm: A New Health System for the 21st Century*,⁷³ to develop a patient-centered approach to health care that gave rise to NCQA's Physician Practice Connections—Patient-Centered Medical Home (PPC-PCMH).⁷⁴ The PPC-PCMH⁷⁵ specifically targets physicians and physician groups in an effort to propel the *Joint Principles* of the model while also building upon the successes achieved through the traditional PPC accreditation and certification scheme.⁷⁶

Like NCQA, other private organizations, such as the AAFP's subsidiary group, TransforMED,⁷⁷ also developed its own demonstrable version of the

69. NCQA, PPC—Patient-Centered Medical Home, <http://www.ncqa.org/tabid/631/Default.aspx> (last visited Feb. 24, 2010); *see also* NAT'L COMM. FOR QUALITY ASSURANCE, STANDARDS AND GUIDELINES FOR PHYSICIAN PRACTICE CONNECTIONS—PATIENT-CENTERED MEDICAL HOME (PPC-PCMH) 1–11 (2008), *available at* <http://www.ncqa.org/tabid/631/Default.aspx> (follow “PPC-PCMH Overview” hyperlink) (describing the NCQA guidelines and expectations of all Medical Home models and programs that seek accreditation).

70. NCQA, About NCQA, <http://www.ncqa.org/tabid/675/Default.aspx> (last visited on Feb. 24, 2010). NCQA has received accolades for its work in improving health care through a systematic and coordinated effort to accredit hospitals, health plans, physicians, and other health care related entities through a series of standards designed to test performance and quality. *Id.*

71. *See generally* Barbara Starfield et al., *supra* note 55, at 457–66 (discussing the impact of primary care on several areas of health and the continued need for a strong and prosperous generalist population of doctors). *See also* Harris Meyer, *The Disappearing Primary Care Physician*, HOSPITALS & HEALTH NETWORKS, Nov. 2008, *available at* http://www.hhnmag.com/hhnmag/html/2008_Index.html (follow “The Disappearing Primary Care Physician” hyperlink) (describing the use of the Medical Home model as a means to increase the number of internists and other primary care-type physicians).

72. NCQA, *supra* note 69. PPC accreditation involves a review of doctor performance to encourage greater use and access to information about patients, which translates into better care through knowledge of patient histories and backgrounds. *Id.*

73. *See* COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., *CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY* 5–6 (2001).

74. *See* NAT'L COMM. FOR QUALITY ASSURANCE, *supra* note 69, at 1 (providing a general overview of the PPC-PCMH program).

75. The PPC-PCMH provides that physicians and groups be ranked and scored through the assessment of nine standards: access and communication, patient tracking and registry functions, care management, patient-self-management support, test tracking, referral tracking, performance reporting and improvement, and advanced electronic communications. *Id.* at 5–11. Scoring is point-based, which is then converted into tiers or levels of compliance by total points earned. *Id.* at 6.

76. *Id.* at 1–2.

77. TransforMED, Who We Are—TransforMED, <http://www.transformed.com/whoweare.cfm> (last visited on Feb. 24, 2010).

PCMH.⁷⁸ It builds on the traditional core features of the medical home, while also including some of its own home-grown components.⁷⁹ The surge in the development of accreditation programs for the PCMH model lends additional credibility and public support behind the model.⁸⁰

Until recently, however, the medical home in the United States was viewed only as an ideal or “aspiration” of how medical care should be provided.⁸¹ A shift is occurring in the interest that surrounds the model among health care purchasers, payers, employers, and health plans in particular.⁸² The development of the Patient-Centered Primary Care Collaborative (PCPCC)⁸³ is additional evidence of that shift.⁸⁴ The PCPCC not only helps to foster relationships among businesses and other interested parties, but it also has taken the lead in tracking and monitoring existing or start-up pilot programs of the medical home.⁸⁵ According to a report sponsored by the PCPCC, over fifteen states reported active PCMH demonstration

78. TransformMED, The TransformMED Patient-Centered Medical Home Model, <http://www.transformed.com/transformed.cfm> (last visited on Feb. 24, 2010). TransformMED has eight groupings or categories of its model, each with specific sub-group requirements. *Id.* The categories are: access to care information, practice-based services, care management, care coordination, practice-based care team, health information technology, quality and safety, and practice management. *Id.*

79. *Id.*

80. See PATIENT-CENTERED PRIMARY CARE COLLABORATIVE, EXECUTIVE SUMMARY: PATIENT-CENTERED MEDICAL HOME ELECTION STUDY 1 (n.d.), <http://pcpcc.net/files/Harris%20Poll%20Findings%20Summary.pdf> (describing the public’s increased support of health proposals that include a PCMH component).

81. John K. Iglehart, *No Place Like Home—Testing a New Model of Care Delivery*, 359 NEW ENG. J. MED. 1200, 1200–01 (2008) (describing how the current system has not embraced the medical home, except in some multispecialty practices and throughout other industrialized countries).

82. See generally Meyer, *supra* note 71 (noting the adoption of the model by several health plans and hospital organizations).

83. PCPCC was created in 2006 after several large employers and suppliers of health insurance were approached concerning a partnership among those groups that advocated for the PCMH. Patient-Centered Primary Care Collaborative, History of the Collaborative, <http://www.pcpcc.net/content/history-collaborative> (last visited Feb. 24, 2010). The result was the establishment of the PCPCC, the mission of which is to promote patient-physician relationships and to design a new model of health care delivery. *Id.* To achieve its mission, the PCPCC works to develop and expand the PCMH model throughout the United States. *Id.*

84. See Patient-Centered Primary Care Collaborative, Collaborative Members, <http://pcpcc.net/content/collaborative-members> (last visited Feb. 24, 2010) (noting that PCPCC membership is rapidly expanding). The membership of the PCPCC consists of corporations and businesses, many of which are among the Fortune 100. *Id.* In addition, major health plans and insurance companies, along with hospitals and other provider groups, have provided their support to the organization and its mission of expanding the medical home model. *Id.*

85. See, e.g., SALLY BLEEKS ET AL., PATIENT-CENTERED PRIMARY CARE COLLABORATIVE, PATIENT-CENTERED MEDICAL HOME: BUILDING EVIDENCE AND MOMENTUM (2008), http://www.pcpcc.net/content/pcpcc_pilot_report.pdf (reporting the results of a number of PCMH pilot and demonstration projects).

projects in 2008.⁸⁶ In addition, many of the large insurance carriers, such as Wellpoint, CIGNA, Humana, and Aetna, have all expressed interest in adopting the model to reduce costs.⁸⁷ For example, the Blue Cross Blue Shield Association has already developed a model demonstration project that its members can adopt and develop independently.⁸⁸ Such interest has led not only to more interest in the concept, but a flurry in the development of medical home pilot programs across the country.

D. The Medical Home as a Useful Health Care Strategy—Pilot Testing and Its Successes

Despite the lack of research-based studies on the medical home's effectiveness, an increase in the model's attractiveness to medical groups has occurred due to the success of related models that created cost-savings and more efficient practices.⁸⁹ In a surprising move, the organization of America's Health Insurance Plans (AHIP) announced that it too will begin exploring the potential uses of the medical home model on a wide-scale basis throughout its insurance plan membership.⁹⁰ There are some differences in opinion, however, between physician groups and AHIP about how best to implement and maintain the model.⁹¹ Most physician groups do not feel the adoption of health information technology should be a hallmark of the PCMH implementation—AHIP disagrees.⁹² Still, PCMH pilot programs are active and in progress across the country, despite these types of disagreements.⁹³

The federal government also has an interest in the medical home concept. Congress mandated in the Tax Relief and Health Care Act of 2006⁹⁴ that the Centers for Medicare and Medicare Services (CMS) begin a Medical Home

86. *Id.* at 4. These projects are aligned with several different groups including health plans (e.g., UnitedHealth and BCPS of Michigan), local and state advocacy groups, and other well-known industries. *Id.*

87. Leigh Ann Backer, *The Medical Home: An Idea Whose Time Has Come . . . Again*, FAM. PRAC. MGMT. 38, 39 (2007).

88. *Id.*

89. Rebecca Vesely, *Medical Home Push*, MODERN HEALTHCARE, June 30, 2008, at 15, 15 (noting the surge in the attractiveness of the model for its potential for boosting the role of primary care).

90. *Id.*

91. *Id.*

92. *Id.* One principle of the medical home is the adoption of health information technology by physician practices, both large and small. *Id.* The worry among physician groups is that, due to the expense of such technologies, small practices will be unable to comply with the rigors and expenses of the system. *Id.* Thus, these practices will fail to take advantage of medical home implementation. *Id.*

93. *Id.* According to a July 2008 article, the AAFP estimated that over thirty-six private primary care practices were utilizing medical home pilot programs. *Id.*

94. Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, § 204, 120 Stat. 2922, 2987.

Demonstration project to explore the medical home model.⁹⁵ In a later amendment to the law, Congress included that the demonstration project's aim is to help curtail Medicare expenditures through the engagement of primary care physician services.⁹⁶ The project is to be funded through the Federal Supplementary Medical Insurance Trust Fund in the amount of \$100 million.⁹⁷

Much of the development for the program was left to CMS, including the types of providers and practices that should be included with the demonstration.⁹⁸ This could pose a challenge to CMS because of the requirements involved with the establishment of a medical home, particularly if those requirements present a burden to physicians or practice groups that cannot afford or maintain implementation costs.⁹⁹ However, CMS partnered with Mathematica Policy Research Group (MPR Group)¹⁰⁰ in an effort to expedite the implementation process.¹⁰¹

The MPR Group, working jointly with CMS, NCQA, and the Center for Studying Health System Change, published a report on the expected results from practices selected for the demonstration project.¹⁰² The report uses a two-tiered approach to identify compliant practices—a process that recognizes that medical practices often vary in scope and resources.¹⁰³ The tiered approach includes six model components (categories)¹⁰⁴ that physician practices must meet to become medical homes, which are similar to the *Joint Principles*.¹⁰⁵ Practices may meet the medical home requirements either by: 1) adoption of seventeen “core” functions

95. *Id.* The specific language of the mandate requires that CMS use the project “to redesign the health care delivery system to provide targeted, accessible, continuous and coordinated, family-centered care to high-need populations . . .” *Id.*

96. Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No. 110-275, § 133, 122 Stat. 2494, 2531.

97. *Id.* § 133(a).

98. Iglehart, *supra* note 81, at 1201.

99. *Id.* The significant hurdle for physicians would be the development of an infrastructure to coordinate care for the patient (e.g., health information technology). *Id.* The demonstration project's aim is to lower costs for Medicare beneficiaries, which would pose an additional challenge to CMS if the set-up costs outweigh any perceived savings. *Id.* at 1200.

100. Mathematica Policy Research, Inc., About Us, http://www.mathematica-mpr.com/about_us/ (last visited Feb. 24, 2010).

101. MEDICAL HOME DEMONSTRATION: FACT SHEET (2009), available at http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/MedHome_FactSheet.pdf.

102. See MYLES MAXFIELD ET AL., MATHEMATICA POLICY RESEARCH, INC., DESIGN OF THE CMS MEDICAL HOME DEMONSTRATION: DRAFT (2008), available at http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/MedHome_DesignReport.pdf (describing the Medicare Medical Home Demonstration project plan).

103. *Id.* at 3. Specifically, the report notes two reasons for the tiered approach. First, there is wide variation in the capabilities of physician practices to support medical home services. *Id.* Second, the requisite components, also identified in the report, will require significant resource investment. *Id.*

104. *Id.* at 4–5 tbl.1. The categories include: continuity of care, clinical information systems, delivery system redesign, decision support, patient/family engagement, and coordination. *Id.*

105. Compare *id.*, with *Joint Principles*, *supra* note 1.

that span five of the six model components (Tier 1); or 2) adoption of nineteen “core” functions that span five of the six model components, plus any three optional functions spanning only two of the five model components (Tier 2).¹⁰⁶ For example, a Tier 1 Medical Home need only meet five of the component areas by providing evidence of the seventeen core functions listed in Table 1.¹⁰⁷ This tiered methodology requires physicians to meet the legislated minimum mandates outlined in the Tax Relief and Health Care Relief Act.¹⁰⁸ The program began in December 2008 with CMS’s announcement of the eight demonstration sites.¹⁰⁹

The requirements that providers must meet to satisfy the CMS Medical Home Demonstration project are challenging.¹¹⁰ Each requirement coincides with the elements and principles that the AAFP and other organizations agreed should encompass any stable and useful medical home.¹¹¹ Ultimately, the medical home model is based on a VBP methodology, aimed at curbing costs.¹¹² The Medicare medical home is no different from other demonstration projects that focused on cost-containment and quality initiatives.¹¹³

106. MAXFIELD ET AL., *supra* note 102, at 6–8 tbl.2. Both Tier 1 and Tier 2 require metrics that are within five of the six model components. *Id.* Surprisingly, the omitted component for both tiers is the decision support component. *Id.* The report does not give an explanation as to why this component was omitted. *Id.*

107. For a detailed description of the components of a Tier 1 and Tier 2 medical home, see *infra* notes 256–57 and accompanying tables.

108. Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, § 204, 120 Stat. 2922, 2988. The Act requires that practice physicians 1) be board certified and 2) “provide[] first contact and continuous care for individuals” under the care of the practice. *Id.*; see also MAXFIELD ET AL., *supra* note 102, at 9 (reiterating the statutory requirements).

109. MAXFIELD ET AL., *supra* note 102, at 12.

110. See § 204(c)(3), 120 Stat. at 2988 (listing the required services). The statute lists at least four specific functions that a provider of care, who ultimately wishes to gain access to the Medicare Medical Home, must meet, stating:

A personal physician shall perform or provide . . . at least the following services: (A) Advocates for and provides ongoing support, oversight, and guidance to implement a plan of care that provides 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); (B) Uses evidence-based medicine and clinical decision support tools to guide decision-making at the point-of-care based on patient-specific factors; (C) Uses health information technology, that may include remote monitoring and patient registries, to monitor and track the health status of patients and to provide patients with enhanced and convenient access to health care services; and (D) Encourages patients to engage in the management of their own health through education and support systems.

Id.

111. Iglehart, *supra* note 81, at 1201.

112. See, e.g., Ronald A. Paulus et al., *Continuous Innovation in Health Care: Implications of the Geisinger Experience*, 27 HEALTH AFF. 1235, 1239 (2008) (describing the Geisinger Hospital implementation of the medical home model, the goal of which was to improve quality through a cost-savings approach among the poorest and sickest patients).

113. *Id.* at 1235. Many of the changes organized by health care reformers consisted of increased access to care or controlling costs, but not on increasing the value of care. *Id.*

The medical home model has also spread to the States. According to the AAFP, in 2009 thirty-four states had introduced legislation either mentioning the term *medical home* or enacted medical home demonstration projects of their own.¹¹⁴ The bills cited by the AAFP do not necessarily advocate for an outright adoption of the medical home model; rather, most explore changes in current health care policy that would utilize one or more of the principles of the model.¹¹⁵

A prime example of how the medical home model can make a significant improvement in patient quality and outcomes occurred within the Geisinger Health System (GHS). Located in central and northeastern Pennsylvania, the GHS¹¹⁶ is an open and integrated health care system, which provides care directly to approximately forty percent of the Geisinger Health Plan (GHP) enrollees.¹¹⁷ The other services are outsourced to a network of over 10,000 other hospitals and providers.¹¹⁸ The GHS is a unique combination of health care resources; it combines patient services within a centralized and specific health plan, but it also incorporates insurers and patients that are not specifically affiliated with the system, such as Medicare, Medicaid, and other local and regional health plan carriers.¹¹⁹ The introduction of a medical home model of care in such an environment can produce maximum results because of the aligned systems and the organizational structure of the health system.¹²⁰ The success of the Geisinger medical home model was the creation of a *Personal Health Navigator* that became

114. See Am. Acad. of Fam. Physicians, Medical Home Legislation, <http://www.trendtrack.com/texis/app/viewrpt?event=483e340d37b> (last visited on Feb. 24, 2010) (tracking medical home legislation throughout the nation). In June 2008, a total of 108 bills had been introduced in state legislatures across the country that mentioned the term *medical home*, while an additional twenty bills in another ten states attempted to redefine the term and concept through appropriate legislation. Iglehart, *supra* note 81, at 1201.

115. See, e.g., H.R. 4974, 185th Gen. Ct., Reg. Sess. (Mass. 2008). This Massachusetts bill specifically mentions the establishment of a committee to investigate the uses of a medical home model, along with many other components that would lead to reductions in costs of health care expenditures for the state. *Id.* In 2009, the Maryland General Assembly approved a bill that would utilize the medical home model in the state prison system. H.D. 507, 2009 Leg., 426th Sess. (Md. 2009).

116. Paulus et al., *supra* note 112, at 1236. The Geisinger Health system includes 700 employees, specialty and ambulatory hospitals and care centers, a 215,000-member health plan, and several other clinical services, programs, and community-based outreach facilities. *Id.* The traditional name for such a system is an integrated delivery system. *Id.*

117. *Id.* at 1237.

118. *Id.*

119. *Id.* at 1236–37. The most common health carriers in the Pennsylvania area are Highmark, Capitol Blue Cross, and Coventry Health. *Id.*

120. *Id.* at 1243. One of the main issues to consider is the applicability of a medical home in settings where the organization and distribution of care is not already aligned, since the success of the Geisinger experience was attributable to the system itself, which already had a number of facilities in place that made the implementation of a medical home worthwhile and valuable. *Id.*; see also Thomas H. Lee, *Pay for Performance, Version 2.0?*, 357 NEW ENG. J. MED. 531, 533 (2007) (noting the uniqueness of the Geisinger system and its components attributing to its success).

the basic means to deliver valuable care through a coordinated process.¹²¹ Early results from the pilot testing of the Geisinger model led to a reduction in hospital admissions by nearly twenty percent, in addition to seven percent cost savings.¹²²

While the GHS designed its medical home model around its Personal Health Navigator, Geisinger also incorporated several of the major agreed upon *Joint Principles* of the medical home.¹²³ The three areas that the GHS concentrated on were the introduction and maintenance of an electronic health record (EHR) system,¹²⁴ a practice-based payment methodology,¹²⁵ and performance reports.¹²⁶ The payment methodology surrounding the medical home is probably the most obscure and difficult to develop, leading some practitioners to find the adoption of the medical home unrealistic or burdensome.¹²⁷ The GHS had a much easier time of developing its payment methodology because of its organizational structure.¹²⁸ Unfortunately, other primary care practices may not have this advantage; therefore, the development of a universal payment methodology continues to be a major issue to overcome before wide-scale adoption of the model can take place.

121. Paulus et al., *supra* note 112, at 1239. The specific components of the Personal Health Navigator included:

[R]ound-the-clock primary and specialty care access; a GHP-funded nurse care coordinator in each practice site; predictive analytics to identify risk trends; virtual care management support; a person, called a personal care navigator, to respond to consumers' inquiries; and a focus on proactive, evidence-based care to reduce hospitalizations, promote health, and optimize management of chronic disease.

Id.

122. *Id.* at 1240.

123. For example, payment methodology and an electronic health record system are two important components of Geisinger's model. *Id.* at 1239. Both of these arguably equate to the *Joint Principles'* payment reform principle and the coordinated or integrated care principle, respectively. *See supra* note 51 and accompanying text.

124. Paulus et al., *supra* note 112, at 1240; *see also* Robert A. Berenson et al., *A House Is Not a Home: Keeping Patients at the Center of Practice Redesign*, 27 HEALTH AFF. 1219, 1224 (2008) (describing the emergence and acceptance by proponents of the medical home that electronic record keeping is an important component of efficient, value-based primary care).

125. Paulus et al., *supra* note 112, at 1239. The GHS medical home model instituted a physician-fee system that contained a practice-based and incentive-based structure. *Id.* Physicians were provided monthly payments of \$1,800 to cover the expansion of services and a monthly "transformation" expense of \$5,000 per one-thousand Medicare patients. *Id.* An incentive pool was also funded by differences in the actual and expected cost of care of those patients enrolled in the medical home. *Id.* The incentive payments were split between physician and practice, which the GHS expects to grow enough to cover the monthly practice-based payments. *Id.*

126. *Id.* at 1239–40. Reports were distributed monthly to all medical home practices in an effort to identify areas of improvement, as well as to identify successes that could be adopted among other medical home practices. *Id.*

127. Berenson et al., *supra* note 124, at 1227.

128. Paulus et al., *supra* note 112, at 1238.

E. Medical Home Payment Schemes and Difficulties with Adoption

The most prevailing theme of the medical home model is its potential to act as a cost-savings catalyst; however, there is little evidence on the model's cost-containing benefits.¹²⁹ This lack of evidence is due in part to the implementation barriers of the medical home in many primary care physician practices.¹³⁰

One major issue to contend with is the geographic limitation in utilizing only primary care physician practices to implement the model. The number of primary care physicians continues to decline,¹³¹ making finding enough primary care physicians to embrace the model more difficult.¹³² In addition, physicians that already practice general medicine are not strategically located throughout the country, but are instead likely concentrated in densely populated cities and suburbs.¹³³ This would affect the total population impacted if the model were implemented on a wide-scale basis.¹³⁴ Furthermore, the size and scope of physician practices also play an important role in determining coverage, particularly among small physician practices with few chronically ill patients.¹³⁵ The incentive to switch to a patient-centered model of care in these offices may be low due to the burdens of initial implementation and the uncertainty of the model's effect on the physician's patient population.¹³⁶

Another major barrier to PCMH adoption involves appropriately and properly adjusting reimbursement for physicians. Many physicians feel overwhelmed or underappreciated without the additional requirements of the medical home, which would require adoption of new policies and procedures that may place their practices in extreme financial hardship.¹³⁷ As a result, there is still great reluctance

129. Sidorov, *supra* note 64, at 1232.

130. See generally Mike Mitka, *Large Group Practices Lag in Adopting Patient-Centered "Medical Home" Model*, 300 JAMA 1875, 1875 (2008) (describing one study that found that even moderately sized group practices are finding it difficult to fully implement the medical home model due to limited resources).

131. Ashley Halsey III, *Primary Care Doctor Shortage May Undermine Reform Efforts; No Quick Fix as Demand Already Exceeds Supply*, WASH. POST, June 20, 2009, at A01; see *supra* note 71 and accompanying text.

132. Mark E. Douglas, Note, *Finally Moving Beyond the Fiction: An Overview of the Recent State Rally for Health Care Reform*, 5 IND. HEALTH L. REV. 277, 327 (2008).

133. *Id.*

134. *Id.*

135. See Berenson et al., *supra* note 124, at 1227 (noting the impact of practice redesign on small practices).

136. *Id.* at 1226–27. For example, CMS has written a broad and expansive form of its definition for *eligibility* in its own demonstration project. *Id.* at 1227. The expansive nature of the definition will most likely ensure a minimum of eighty percent inclusion of Medicare beneficiaries in the medical home project. *Id.* Such a large scale operation is hard to conceptualize occurring in a smaller, perhaps rural, general practice office with few patients. *Id.* The costs of implementation would outweigh the potential long-term benefits. *Id.*

137. *Id.* at 1228.

by physicians to move forward with any new model that does not have an appropriate reimbursement scheme for their services.¹³⁸

In response, many organizations began promoting their own fair and equitable reimbursement models.¹³⁹ In 2007, the PCPCC announced a version of a reimbursement methodology that would achieve the balance in payment that doctors sought.¹⁴⁰ The PCPCC worked with physicians to create a “hybrid” reimbursement scheme known as a “bundled care coordination fee.”¹⁴¹ This fee would include three parts: an upfront cost realization payment for physician work “outside” of the normal doctor-patient relationship,¹⁴² a typical fee-for-service payment that is paid based on visits,¹⁴³ and a performance-based component that recognizes any achieved quality or efficiency improvements that were set by earlier benchmarks.¹⁴⁴ This recommendation included a balanced approach where doctors would receive upfront payments, similar to fee-for-service, in addition to reward payments based on any decrease in realized health costs.¹⁴⁵

In another example that was previously discussed,¹⁴⁶ Medicare’s Medical Home Demonstration project provided an alternative scheme that includes many of the same characteristics of the proposed PCPCC hybrid model.¹⁴⁷ Medicare’s design is unique since it places physician practices into two tiers or classes of

138. *See id.* (noting that the American fee-for-service payment methodology may be the reason why a patient-centered primary care model did not emerge earlier).

139. *See generally* Milt Freudenheim, *Trying to Save by Increasing Doctors’ Fees*, N.Y. TIMES, July 21, 2008, at A01 (describing the programs underway across the country to stabilize the primary care practice). Medicare designed its own reimbursement model for its demonstration project and other reimbursement models have been proposed by the PCPCC and TransforMED/AAFP. *See infra* pp. 155–57.

140. PATIENT CENTERED PRIMARY CARE COLLABORATIVE, PROPOSED HYBRID BLENDED REIMBURSEMENT MODEL: A NEW PHYSICIAN PAYMENT SYSTEM TO SUPPORT HIGHER QUALITY, LOWER COST CARE THROUGH A PATIENT-CENTERED MEDICAL HOME (2007), <http://www.pcpcc.net/content/proposed-hybrid-blended-reimbursement-model>.

141. *Id.* The name of the fee is also described as a “monthly care coordination payment.” *Id.*

142. *Id.* A fee based on recognized upfront costs reduces the possibility of volume-based incentives, while promoting efficiency through encouraging information technology adoption and other changes to current practice that improves care coordination. *Id.* PCPCC notes that this payment should be “risk-adjusted” to reduce the potential for inherent incentives when doctors treat more difficult and sickly patients. *Id.*

143. *Id.* “Fee-for-service payment systems carve up each element of care into defined units of service. Each is then associated with a charge or a payment. Obviously, the more services rendered, the more payment will be received.” Alice G. Gosfield, *The Doctor-Patient Relationship as the Business Case for Quality: Doing Well by Doing Right*, 37 J. HEALTH L. 197, 205 (2004).

144. PATIENT CENTERED PRIMARY CARE COLLABORATIVE, *supra* note 140. The performance-based payment component is designed to “recognize[] achievement of quality and efficiency goals.” *Id.* It is unclear how the goals will be determined and what benchmarks will be used.

145. *Id.*

146. *See supra* Part I.D.

147. MEDICAL HOME DEMONSTRATION, *supra* note 101. Medicare uses the term *monthly care management fee*, which is similar to the PCPCC’s *monthly care coordination payment*. Compare *id.*, with PATIENT CENTERED PRIMARY CARE COLLABORATIVE, *supra* note 140.

medical homes.¹⁴⁸ A physician's additional payment is dependent on whether it is a Tier 1 ("typical") or Tier 2 ("enhanced") medical home.¹⁴⁹ Another unique feature is that Medicare will account for other additional factors, such as the severity of patient illness.¹⁵⁰ Like all other Medicare payments, the medical home project will be based on the Relative Value Unit (RVU) scale.¹⁵¹ However, a doctor's initial payment, or per member per month payment, is based on the tier within which the practice falls.¹⁵² For example, a Tier 1 or "typical" physician practice is allowed to receive per member per month payments of \$40.40.¹⁵³ Alternatively, those physician practices that are recognized as Tier 2 or "enhanced" medical homes (the more advanced form) will receive per month per member benefits of \$51.70.¹⁵⁴ Medicare has, unlike the PCPCC recommendation, built into its payment methodology a means to adjust base payments based on severity of patient illness.¹⁵⁵ Medicare uses a hierarchical condition category (HCC) to determine severity of patient illness.¹⁵⁶ For this demonstration project, CMS has set the HCC level at 1.6, whereas approximately twenty-five percent of Medicare beneficiaries have a severity score greater than this number.¹⁵⁷ Risk-adjusted payments are computed based on the twenty-five percent of the population that meet this category, since these beneficiaries normally result in care that is sixty percent higher in cost than the other seventy-five percent of Medicare beneficiaries.¹⁵⁸

Medicare's performance payment is also unique. *Savings*, according to CMS, is the difference between total Medicare Part A and B payments associated with all medical home eligible patients and Medicare Part A and B costs associated with a

148. MEDICAL HOME DEMONSTRATION, *supra* note 101.

149. *Id.*

150. *Id.*

151. See Steven F. Isenberg, *Relative Value Units*, 82 EAR NOSE & THROAT J. 106, 106 (2003) (describing the extent of Medicare's RVU, and how they are determined and applied). An RVU is simply a value assigned to a particular task or procedure that a physician performs. *Id.* These task values are determined through summing the total work involved (46%), the expense to the medical practice (50%), and the cost of liability insurance to the doctor (4%). *Id.*; see also MAXFIELD ET AL., *supra* note 102, at 11 (describing the reimbursement model for the demonstration project).

152. MAXFIELD ET AL., *supra* note 102, at 10.

153. *Id.* at 10–11. This per member per month payment is designed as a "base" payment, which will be received based on the number of Medicare enrolled beneficiaries jointly enrolled as medical home beneficiaries. *Id.* This fee will not change throughout the demonstration and will only adjust upon changes in enrollment. *Id.* Similar to the PCPCC cost realization reimbursement payment, fees received through this should be used to cover general practice changes to conform to the Tier 1 or Tier 2 levels of the medical home. *Id.*

154. *Id.*

155. *Id.* at 10.

156. See generally Gregory C. Pope et al., *Risk Adjustment of Medicare Capitation Payments Using the CMS-HCC Model*, HEALTH CARE FIN. REV., Summer 2004, at 119, 122–23 (describing the CMS HCC risk adjustment methodology).

157. MAXFIELD ET AL., *supra* note 102, at 10–11.

158. *Id.*

control (non-eligible) comparison group.¹⁵⁹ CMS promises participating practice groups that if savings total more than two percent, a majority of those savings will be split among participating practices.¹⁶⁰ This is tantamount to the PCPCC's recommendation for providing performance-based rewards to participating physicians.¹⁶¹

The array of different groups, government agencies, and private organizations that are embracing the model's potential is encouraging.¹⁶² However, there are still several issues that require further clarification and design, which, without attention, may detrimentally impact further promulgation of the model.¹⁶³

II. THE KEY OPERATIONAL DEFICITS OF THE MEDICAL HOME AND ITS IMPACT ON ADOPTION AND IMPLEMENTATION: FOUR AREAS OF CONCERN

The medical home model provides a suitable framework for primary care physician practices to begin integrating and coordinating care.¹⁶⁴ However, putting the theoretical constructs of the medical home into practice on a large scale is not so simple.¹⁶⁵ The medical home concept, after all, does conflict with some of today's current practices, and, if implemented without proper analysis, may spell trouble for practitioners and for the model itself.¹⁶⁶ As a result, the medical home model is less likely to be adopted and implemented by physician groups and legal and policy wings of major government bodies.¹⁶⁷ The Center for Studying Health System Change¹⁶⁸ has identified four leading areas where the medical home

159. *Id.* at 11.

160. *Id.* Medicare intends to determine overall savings at the end of the demonstration project. *Id.* If total savings are greater than two percent, Medicare will convey eighty percent of the savings to participating physician groups and practices. *Id.* CMS and Medicare presume that medical home implementation will prevent or reduce expected hospitalizations due to increased health outcomes of beneficiaries. *Id.* Subsequently, this will lower the costs associated with both Part A and Part B enrollees. *Id.*

161. See PATIENT CENTERED PRIMARY CARE COLLABORATIVE, *supra* note 140 (proposing rewards based on performance).

162. See *supra* Part I.C (discussing federal, state, and private plans offering the model or a version of it).

163. Areas of concern include: 1) the differing approaches towards payment methodology, 2) the difficulties in locating and qualifying physician practices for implementation of the medical home, 3) the undefined patient recruitment techniques, and 4) the lack of health information technology. See *infra* Part II.

164. See *supra* Part I.B.

165. *Making Medical Homes Work: Moving from Concept to Practice*, POL'Y PERSP., Dec. 2008, at 1, 2, available at <http://www.hschange.com/CONTENT/1030/1030.pdf> [hereinafter *Making Medical Homes Work*].

166. *Id.*

167. See *id.* (noting the risk to the political viability of the medical home model).

168. Ctr. for Studying Health Sys. Change, General Information: Mission Statement, <http://www.hschange.com/index.cgi?file=about> (last visited Feb. 24, 2010). The Center is a policy wing of the MPR Group. *Id.*

requires further clarification.¹⁶⁹ These areas include: 1) the lack of a complete and agreed upon payment methodology; 2) difficulty in locating and qualifying physician practices for participation and implementation of the medical home; 3) haphazard and undefined patient recruitment techniques; and 4) the lack of and resistance towards obtaining health information technology.¹⁷⁰

A. The Lack of a Real and Fully Accepted Payment Model

Although many groups and organizations have created their own version of a medical home payment methodology, there remains no universally accepted medical home physician payment framework.¹⁷¹ One reason behind the lack of consensus is that the medical home model includes payments for services that traditionally do not have a quantifiable billable source.¹⁷² For example, *integration* of care is a principle of the medical home, but how doctors meet that goal varies from program to program.¹⁷³ These uncertainties lead payers to adopt only traditional process-based payment methods, as opposed to utilizing both process and outcome-based payments.¹⁷⁴

Another major disadvantage, in terms of developing a universal payment methodology, is the medical home's novel and untested status.¹⁷⁵ Although several demonstration and pilot projects are in progress, it is unclear if the payment methods they adopt will continue after the pilots terminate.¹⁷⁶ Additionally, Medicare, so far, is the only organization that has taken the extra step of

169. *Making Medical Homes Work*, *supra* note 165, at 2.

170. *Id.*

171. See Hoangmai H. Pham et al., *Paying for Medical Homes: A Calculated Risk*, POL'Y PERSP., Dec. 2008, at 15, available at <http://www.hschange.com/CONTENT/1030/1030.pdf> (describing the different payment approaches advocated for by various groups). Although there are payment models available, several of which have been mentioned in this Comment, there is still considerable disagreement on what payment form is best. *Id.*

172. *Id.* Under a traditional fee-for-service payment scheme, doctors are paid based on what they perform through the regular course of care. *Id.* In a medical home environment, non-traditional care practices are adopted and implemented that have no recognizable means to quantify, which leads practitioners and plans to guess at cost-based prices. *Id.* at 16.

173. *Id.* at 16.

174. *Id.* at 15. Outcome measures are important for increasing value. See, e.g., Jonathan Mant, *Process Versus Outcome Indicators in the Assessment of Quality of Health Care*, 13 INT'L J. QUALITY IN HEALTH CARE 475, 477-78 (2001) (describing the advantages and uses of process or outcome measurers in health care). Process measures, although important, rely mostly on the front-end of care, whereas outcome measures may be used to determine if appropriate processes were used and also take into account patient health status. *Id.*

175. Pham et al., *supra* note 171, at 15. As a result, it is more difficult to set payment levels both in terms of budget neutrality and to cover initial implementation costs. *Id.*

176. See *id.* (describing both public and private programs and the payment methods in use by those programs). "Most payers [of health care] are taking a wait-and-see approach on" any additional form of payment other than traditional process-oriented and fee-for-service methods. *Id.*

incorporating case-based changes in payments related to patient illness severity.¹⁷⁷ This deficiency is significant because sicker patients will undoubtedly require more care, and payments will need to reflect different types of patients.¹⁷⁸ Without this complexity, condition-specific practices could emerge due to the overwhelming number of patients with one or more chronic conditions.¹⁷⁹

B. The Qualification of Medical Home Practices Is Complex and Difficult

A second area of concern is how best to qualify physician practices as candidates for adoption of the medical home model. NCQA's PCC-PCMH certification program appears to be the leading, accepted means of identifying and confirming medical home physician practices.¹⁸⁰ However, the NCQA standards are complex and data-intensive.¹⁸¹ The demonstrated use of e-prescribing and EHR are a few of the most challenging of the NCQA requirements, since most physician practices do not always know if adoption of such technology is even feasible because of a lack of relevant cost data.¹⁸² Still, the integration of these new technologies into our health system is considered vital. For example, President George W. Bush, through an executive order in 2004, launched a massive effort to propel the use of EHR in America's health system.¹⁸³ However, an EHR system is expensive, difficult to navigate, and often manifests hardships for groups when it is not internally developed.¹⁸⁴

To counteract some of the financial burden, the Department of Health and Human Services amended its safe harbor exceptions to the federal Anti-Kickback statute¹⁸⁵ to include donations of EHR technology and software to physician groups and practices.¹⁸⁶ However, wide-scale adoption of EHR technology will continue to

177. *Id.*; see also *supra* Part I.E.

178. Pham et al., *supra* note 171, at 16.

179. Cynthia M. Boyd et al., *Clinical Practice Guidelines and Quality of Care for Older Patients with Multiple Comorbid Diseases: Implications for Pay for Performance*, 294 JAMA 716, 721–22 (2005).

180. Ann S. O'Malley et al., *Qualifying a Physician Practice as a Medical Home*, POL'Y PERSP., Dec. 2008, at 1, 5, available at <http://www.hschange.com/CONTENT/1030/1030.pdf>.

181. *Id.* For example, the NCQA standards do not emphasize the relationship between the primary care doctor and a patient's specialists, and, instead, groups that relationship under a broader category of "referral tracking." *Id.*

182. *Id.*; see also Basit Chaudhry et al., *Systematic Review: Impact of Health Information Technology on Quality, Efficiency, and Costs of Medical Care*, 144 ANNALS INTERNAL MED. 742, 748–49 (2006) (describing that the lack of cost data regarding the adoption of health information technology poses a barrier to its adoption by physician practices).

183. Exec. Order No. 13,335, 69 Fed. Reg. 24,059 (April 30, 2004). The effect of the order created the Office of the National Coordinator of Health Information Technology. *Id.*

184. Chaudhry et al., *supra* note 182, at 749 (describing how most of the literature surrounding EHR adoption concentrates on internally developed programs).

185. 42 U.S.C. § 1320a–7b(b) (2006).

186. 42 C.F.R. § 1001.952(x)–(y) (2009).

be slow without taking better account of the associated benefits and costs.¹⁸⁷ Therefore, the dependence by the NCQA and other groups on the use of EHR technology in a medical home may limit the potential population of eligible practices.¹⁸⁸ Although EHR technology is and should remain a vital part of the medical home model, temporarily reducing the emphasis on EHR could increase its potential for wide-scale adoption by increasing the eligible physician population.¹⁸⁹

C. Current Pairings of Medical Homes to Patients Is Not Preference-Based and Relies Solely on Claims Analysis

In most cases, assigning patients to eligible physician practices under traditional medical home model methodology occurs through a review of claims data.¹⁹⁰ This process uses a physician's past evaluation and management claims to group patients.¹⁹¹ Although efficient, this process is not exhaustive since patient claims analysis relies on algorithms that do not take into account patients who seek care from multiple primary care physicians.¹⁹² As an example, the MPR Group conducted a survey of Medicare beneficiaries to simulate an algorithmic, claims-based approach to identifying a patient's primary care doctor.¹⁹³ Results of the experiment showed that the model missed the identified primary care provider of the beneficiary seventeen percent of the time.¹⁹⁴

A claims-based method also omits changes in a patient's doctor over time. For example, United Healthcare experimented with their claims-based approach by examining beneficiaries' claims over an eighteen month period.¹⁹⁵ Results showed that approximately twenty-eight percent of the population under a United Healthcare plan at the end of the survey had either changed their primary care doctor or did not have one at all.¹⁹⁶ As the United Healthcare survey found, a large portion of the population is without a primary care physician. In another study,

187. Chaudhry et al., *supra* note 182, at 749.

188. O'Malley et al., *supra* note 180, at 7.

189. *Id.*

190. Deborah Peikes et al., *Matching Patients to Medical Homes: Ensuring Patient and Physician Choice*, POL'Y PERSP., Dec. 2008, at 8, 9, available at <http://www.hschange.com/CONTENT/1030/1030.pdf>.

191. See Roger A. Rosenblatt et al., *The Generalist Role of Specialty Physicians: Is There a Hidden System of Primary Care?*, 279 JAMA 1364, 1367 (1998) (noting the limitations associated with using reimbursement-based secondary data sets to review specialist and generalist use by patients).

192. Peikes et al., *supra* note 190, at 10.

193. Sam Simon, Presentation at the AcademyHealth Annual Research Meeting: Identification of Usual Source of Care Providers for Frail Medicare Beneficiaries: Development and Use of a Claims-Based Approach (June 4, 2007), <http://www.mathematica.org/Publications/PDFs/identificationusual.pdf>.

194. Peikes et al., *supra* note 190, at 10.

195. *Id.*; see generally VERA DVORAK & ERIC SULLIVAN, UNITED HEALTHCARE, PATIENT-CENTERED MEDICAL HOME (2008), available at http://www.dhmh.md.gov/hcar/pdf/june2008/UHC_061008.pdf (describing United Healthcare's medical home model).

196. Peikes et al., *supra* note 190, at 10.

approximately one-third of adults lacked a primary care doctor.¹⁹⁷ Therefore, most, if not all, of this segment of the population would be missed using a strict, case-based, algorithmic method of assigning patients to medical homes.

Another method, relying exclusively on physicians to assign patients, would be equally erroneous.¹⁹⁸ It is common for patients to seek care from multiple providers without informing their other providers.¹⁹⁹ Therefore, potential sources of primary care would be omitted if one physician, who lacked full and accurate information, were given the responsibility of assigning patients to a particular medical home.²⁰⁰

A third method, relying on patient reporting of their primary care doctor, also would result in inaccurate or incomplete reporting²⁰¹ since many patients do not have a regular primary doctor to report.²⁰² Furthermore, the costs of retrieving this information would be very high, resulting in further burdens on either providers or payers.²⁰³ To ensure full and appropriate assignment, therefore, a mixing or hybrid of both a claims-based and input-based method should be utilized.²⁰⁴ Insurers, for instance, would *catch* all of the medical homeless by sending appropriate information and choices about nearby medical home practices.²⁰⁵ Additionally, patients with a primary physician may choose to keep that physician, which lessens the need to find suitable replacements.²⁰⁶ The hybrid model, therefore, would help fill the gaps in patient assignment that the other methods create.

D. The Use of Crucial Medical Information Exchange Among Patients, Primary Care Physicians, and Specialists Has Not Developed Along with the Model

The development of a healthy and robust health information exchange (HIE) is notably one of the important attributes of a well-defined health care system.²⁰⁷ Such coordination is also one of the principles of the PCMH.²⁰⁸ This type of coordination does pose a challenge, especially within a system where almost every

197. Cathy Schoen et al., *U.S. Health System Performance: A National Scorecard*, 25 HEALTH AFF. w457, w461 (2006).

198. Peikes et al., *supra* note 190, at 10.

199. *Id.*

200. *Id.* at 11.

201. *Id.*

202. Schoen et al., *supra* note 197, at w461.

203. Peikes et al., *supra* note 190, at 11.

204. *Id.*

205. *Id.*

206. *Id.*

207. Jan Walker et al., *The Value of Health Care Information Exchange and Interoperability*, HEALTH AFF., Jan. 2005, at W5-10, W5-17 (describing the importance of a system based on the exchange of medical information over all levels).

208. *See Joint Principles, supra* note 1 (listing the use of HIE as a means of achieving coordinated care).

patient has multiple providers and seeks care from a variety of establishments.²⁰⁹ For example, some patients may find the idea of providing a single doctor with all of their medical history not only a cumbersome chore, but also an issue of privacy.²¹⁰ Overcoming these obstacles between the patient and the medical home will be the first challenge.

On the other hand, if a patient were somehow convinced to submit their medical information to a centralized medical information repository, there is still the challenge of sharing that information.²¹¹ This is most clearly the case with Medicare beneficiaries and chronically-ill patients.²¹² The financial cost of developing a practical HIE that stores, shares, and protects information is too high for most primary care, specialty, and other health care providers to afford.²¹³

Providing transparency and coordination, through a HIE and a medical home, will require an agreement between the patient and his or her physician.²¹⁴ Just how this agreement should be formed is not clear. At a minimum, the agreement should provide that a patient will be under the care of a physician that participates in a medical home and that additional medical information will be required of the patient.²¹⁵ In regards to providing information transparency between practice groups, collaboration on both sides of the exchange will be warranted, since such an information flow will require investment in health information technology.²¹⁶ On the other hand, models of HIE have worked and could be adopted to suit the needs of the medical home. One of these models was found effective in providing admitting physicians remote access to patient information through a localized "hospital-physician portal."²¹⁷ This concept would be a positive step towards a fully-functioning, reciprocal sharing of data between providers, aside from more

209. Myles Maxfield et al., *Medical Homes: The Information Exchange Challenge*, POL'Y PERSP., Dec. 2008, at 12, 12, available at <http://www.hschange.com/CONTENT/1030/1030.pdf>.

210. *Id.*

211. *Id.*

212. Hoangmai H. Pham et al., *Primary Care Physicians' Links to Other Physicians Through Medicare Patients: The Scope of Care Coordination*, 150 ANNALS INTERNAL MED. 236, 240 (2009). A recent study found that a typical primary care physician that accepts Medicare patients normally must share those patients with 229 other physicians in 117 different practices. *Id.*

213. Maxfield et al., *supra* note 209, at 13.

214. *Id.* at 13–14.

215. *Id.* at 14.

216. See Julia Adler-Milstein et al., *The State of Regional Health Information Organizations: Current Activities and Financing*, 27 HEALTH AFF. w60, w66–67 (2007) (describing how the state of current electronic HIE have not come as far as predicted, despite the promises of cost-containment and quality improvement).

217. Joy M. Grossman et al., *Hospital-Physician Portals: The Role of Competition in Driving Clinical Data Exchange*, 25 HEALTH AFF. 1629, 1630 (2006) (describing the creation of so-called hospital physician portals, which allow admitting physicians to access remotely patient information electronically through a secure hospital database).

complex national or regional information sharing organizations.²¹⁸ However, the use of the system on such a broad scale is often derailed due to provider-on-provider resentment towards sharing information about patients.²¹⁹

III. MOVING FORWARD: UTILIZING THE MEDICARE MEDICAL HOME MODEL

There are clear operational deficits to the model's sustainability.²²⁰ Wide-scale adoption of the medical home model will depend on whether these issues are resolved in a manner that is beneficial to all parties. The current health care system dealt the primary care practice a harsh blow, and the medical home model is intended to revive it.²²¹ It is hard to expect major change immediately, however, especially after years of working under the policies of managed care that eroded away the traditional medical practice.²²² However, there are glimmers of hope surrounding the acceptance of the medical home by practitioners. In 2008, for example, the American Medical Association's House of Delegates passed a resolution adopting a new set of educational recommendations for medical schools to promote the medical home model and to prepare students for practicing within it.²²³ This may be the first of many future steps in redeveloping and redesigning the nation's health care practices from the bottom-up.²²⁴

More recently, Secretary of the Department of Health and Human Services, Kathleen Sebelius, declared that CMS will launch a new initiative that ties in with the original Medicare Medical Home Demonstration project.²²⁵ Titled the *Medicare-Medicaid Advanced Primary Care Demonstration Initiative*, the project is administration-directed and aims to create further investments in primary care.²²⁶ Although the initiative uses a different name for the model, the goals appear to be similar—to improve quality by decreasing hospitalizations and reduce overall costs.²²⁷

218. *Id.* at 1636.

219. *Id.* at 1634–35. Specifically, it is the element of competition between hospitals that drives the success of the hospital-physician portal concept, since hospitals wish to compete for provider admissions. *Id.* On the other hand, the same cannot be said about the competition between doctors, who will often take sharing patient information among other doctors to be repugnant to their business. *Id.*

220. *See supra* Part II.

221. Backer, *supra* note 87, at 41.

222. *Id.*

223. Barbara Bein, *Delegates Seek Closer Ties Between Medical Education and PC-MH*, AAFP NEWS NOW, June 25, 2008, <http://www.aafp.org/online/en/home/publications/news/news-now/resident-student-focus/20080625ama-pcmh.html>.

224. *Id.* Additionally, the House of Delegates asked for a review of school accreditation standards, which could mean an upcoming alteration to all medical schools' curricula is on the horizon. *Id.*

225. HealthReform.gov, Fact Sheet: Medicare-Medicaid Advanced Primary Care Demonstration Initiative, <http://www.healthreform.gov/newsroom/factsheet/medicalhomes.html> (last visited Feb. 24, 2010).

226. *Id.*

227. *Id.* The term *advanced primary care* model is the same as *patient-centered medical home*. *Id.*

Unfortunately, as of October 2009, CMS announced that it had abandoned its original Medicare Medical Home Demonstration project.²²⁸ Due primarily to some of the 2009 health reform legislation, CMS realized that at least one House bill included additional medical home projects that would otherwise coincide with the current CMS demonstration projects.²²⁹ CMS believed that the legislation will repeal the existing demonstration project, which was under review by the Office of Management and Budget.²³⁰ As a result, CMS decided to halt its current program and await any new objectives from the passage of new legislation.²³¹ This may appear as a setback to the government's involvement in implementing the medical home; however, Secretary Sebelius's declaration regarding the administrative-led program is still ongoing.²³² Furthermore, the CMS demonstration will, in all likelihood, begin again once health reform legislation is passed.²³³

Although CMS placed its medical home demonstration on hold, this does not indicate that the Medicare medical home program is somehow flawed. In fact, in many cases CMS has strategically developed health care reforms along with or prior to other private health care policy organizations.²³⁴ Furthermore, CMS has the advantage of servicing a large pool of Americans,²³⁵ thereby speeding up implementation and the impact of any potential reforms the government finds worthy. Therefore, the Medicare medical home should be considered a viable option for broad reform, especially since the demonstration's design is unique in at least two ways.²³⁶

First, the Medicare medical home provides a payment form that incorporates a fee-for-service component, a per member per month fee, and a rewards structure.²³⁷ This methodology applies both evidence-based and value-based

228. Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs., Medicare Demonstrations: Details for Medicare Medical Home Demonstration, <http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1199247> (last visited Feb. 24, 2010).

229. See, e.g., H.R. 3200, 111th Cong., 1st Sess. § 1302 (2009) (detailing the proposed medical home pilot program).

230. Ctrs. for Medicare & Medicaid Servs., *supra* note 228.

231. *Id.*

232. HealthReform.gov, *supra* note 225. The program will begin in early 2010 and is scheduled to continue for the next three years. *Id.*

233. *Id.*

234. See Meredith B. Rosenthal, *Beyond Pay for Performance—Emerging Models of Provider-Payment Reform*, 359 NEW ENG. J. MED. 1197, 1198 (2008) (describing how Medicare has helped usher in new forms of payment to providers and reforms to health care).

235. As of July 2008, there were 44,831,390 Medicare beneficiaries. Henry J. Kaiser Family Foundation, Total Number of Medicare Beneficiaries, 2008, <http://www.statehealthfacts.org/comparemappable.jsp?ind=290&cat=6> (last visited Feb. 24, 2010).

236. See *supra* Part I.E (discussing the use of tiers to classify medical homes and the use of illness severity in payment determinations).

237. MAXFIELD ET AL., *supra* note 102, at 10–11.

initiatives, which aligns with the medical home design.²³⁸ Furthermore, the rewards portion of the payment plan creates a valid incentive structure, based on actual *savings* realized.²³⁹ Most importantly, Medicare's model recognizes the differences in illness severity among Medicare patients and reflects that in the per member monthly fee.²⁴⁰ As a result of these factors, the Medicare model meets almost all of the elements within the *payment* principle of the *Joint Principles*.²⁴¹ Other organizations also employ a similar *hybrid* approach to payment.²⁴² Although CMS's use of the HCC to determine risk adjustments to cases and payments is specific to Medicare, other options exist that can replicate the concept in the private marketplace using episode-based adjustments.²⁴³ In short, mimicking Medicare's payment methodology among non-Medicare eligible patients could provide primary care practices with added consistency during implementation of the medical home.²⁴⁴

The Medicare model's other important contribution is the bifurcated physician eligibility system. A tiered approach, like Medicare's, allows physicians to decide on their initial investment into the model, which is often overwhelming to many resource-limited practices.²⁴⁵ Additionally, the tiered approach also provides a type of *incentive*—an increase in their monthly payment—for practices to reach the next level of care.²⁴⁶ Medicare's plan entices practices to join initially through the prospect of lower implementation costs, while also encouraging practices to increase the medical home services they provide by an added payment incentive.²⁴⁷ Furthermore, the Medicare model utilizes the NCQA PPC-PCMH goals and standards.²⁴⁸ This could spell success for other NCQA-like organizations in need of

238. DE BRANTES ET AL., *supra* note 4, at 4.

239. MAXFIELD ET AL., *supra* note 102, at 11. Actual savings realized refers to the difference in payments from Medicare Parts A and B for the *medical home* patients and the traditional fee-for-service Medicare patients. *Id.*

240. *Id.* at 10–11.

241. See *Joint Principles*, *supra* note 1. The payment principle, in part, calls for a fee-for-service component, a *care management* (non-traditional face-to-face service) fee, and an additional rewards payment. *Id.*

242. See, e.g., DE BRANTES ET AL., *supra* note 4, at 9–11 (describing the *Prometheus Payment* model).

243. Rosenthal, *supra* note 234, at 1199. Episode-based payment systems include both a risk calculation for specific conditions (e.g., heart disease, cancer) and a warranty for care if complications related to the condition were to arise. *Id.*

244. See *id.* at 1199–1200 (describing how an alignment of goals among payers and providers is needed to coordinate care effectively in our fragmented system).

245. See MAXFIELD ET AL., *supra* note 102, at 3 (“[F]or most practices, developing all the capabilities listed . . . requires a substantial investment of time and resources.”).

246. See *id.* at 10–11 (discussing how participating physicians are reimbursed).

247. *Id.* at 3, 10–11.

248. *Id.* at 19–21.

a useful payment methodology and recruitment tool since it should be relatively simple to replace the NCQA measures with their own instruments.

Many of today's health care payment reforms are not radically new ideas.²⁴⁹ In fact, most are just updated forms of old ideas, some of which were combined to resemble a novel approach to health care reform.²⁵⁰ The medical home is no different, and, like all other reforms, the political environment is often the most important factor in determining whether adoption is likely.²⁵¹ Considering there are numerous stakeholders in reforms involving the medical home, including specialist and generalist providers, patients, the public, and local and national governments, the politics involved here are extraordinarily important. Therefore, realization of wide-scale adoption requires consensus on a single *best model* and ought to be the priority of medical home advocates, even though there is still no guarantee that this will culminate in success.²⁵² The Medicare design could be the baseline approach for future efforts surrounding the medical home.

CONCLUSION

There are still challenges to implementation of the PCMH that have yet to be discovered, but these challenges are not without remedy.²⁵³ The most vital omission so far is our unwillingness to implement the medical home model along with additional reforms that align the interests of physicians, hospitals, and other providers.²⁵⁴ As Elliott Fisher notes in his article on the model, the medical home can only be successful if it is brought-up in "a hospitable and high-performing medical neighborhood."²⁵⁵ Until then, the PCMH will simply be a theoretical concept that is, itself, homeless.

249. Rosenthal, *supra* note 234, at 1200.

250. *Id.*

251. *Id.* ("The prospects for payment reform . . . hinge more on politics than on economics.")

252. Meredith Rosenthal notes that since all reforms aim to constrain spending and to shift spending from more intensive practices to less intensive ones (i.e., from specialists to general practitioners), there will always be "substantial resistance to even the best-designed plans." *Id.*

253. Elliott S. Fisher, *Building a Medical Neighborhood for the Medical Home*, 359 NEW ENG. J. MED. 1202, 1204 & tbl.2 (2008) (noting that several approaches are available to overcome the barriers to implementation).

254. *Id.* at 1205.

255. *Id.*

TABLE 1: EXAMPLE OF A TIER 1 MEDICAL HOME²⁵⁶**TIER 1**

All Seventeen of the Following Requirements Must Be Met (Seventeen Core Functions)

Continuity

- 1) The practice discusses with patients and presents written information on the role of the medical home that addresses up to 8 areas.
- 2) The practice establishes written standards on scheduling each patient with a personal clinician for continuity of care and the practice collects data to show that it meets its standards on continuity.

Clinical Information Systems

- 3) The practice uses an electronic data system that includes searchable data such as patient demographics, visit dates and diagnoses and the practice uses an electronic or paper-based system to identify clinically important conditions or risk factors among its patient population.

Delivery System Redesign

- 4) The practice establishes written standards to support patient access, including policies for scheduling visits and responding to telephone calls and electronic communication.
- 5) The practice collects data to demonstrate that it meets standards related to appointment scheduling and response times for telephone and electronic communication.
- 6) The practice defines roles for physician and non-physician staff and trains staff, with non-physician staff, involved in reminding patients of appointments, executing standing orders and educating patients/families.
- 7) The practice uses electronic or paper-based tools including medication lists and other tools such as problem lists, or structured templates for notes or preventive services to organize and document clinical information in the medical record.
- 8) The practice conducts a comprehensive health assessment for all new patients to understand their risks and needs including past medical history, risk factors and preferences for advance care planning.
- 9) For three clinically important conditions, the physician and non-physician staff conduct care management using an integrated care plan to set goals, assess progress, and address barriers.
- 10) For three clinically important conditions, the physician and non-physician staff conduct care management planning ahead of the visit to make sure that information is available and the staff is prepared as well as following up after the visit to make sure that the treatment plan (including medications, tests, referrals) is implemented.

256. MAXFIELD ET AL., *supra* note 102, at 6 tbl.2.

TABLE 1 (CONT'D): EXAMPLE OF A TIER 1 MEDICAL HOME

11) The practice identifies appropriate evidence-based guidelines that are used as the basis of care for clinically important conditions.

Patient/Family Engagement

12) The practice supports patient/family self-management through activities such as systematically assessing patient/family-specific communication barriers and preferences, providing self-monitoring tools or personal health record, and providing a written care plan.

13) The practice supports patient/family self-management through providing educational resources, and providing/connecting families to self-management resources.

14) The practice encourages family involvement in all aspects of patient self-management.

Coordination

15) The practice systematically tracks tests and follows up using steps such as making sure that results are available to the clinician, flagging abnormal test results, and following up with patients/families on all abnormal test results.

16) The practice coordinates referrals designated as critical through steps such as providing the patient and referring physician with the reason for the consultation and pertinent clinical findings, tracking the status of the referral, obtaining a report back from the practitioner, and asking patients about self-referrals and obtaining reports from the practitioner(s).

17) The practice reviews all medications a patient is taking including prescriptions, over the counter medications and herbal therapies/supplements.

TABLE 2: EXAMPLE OF ADDITIONAL REQUIREMENTS FOR A TIER 2 MEDICAL HOME²⁵⁷**TIER 2**

All of Tier 1 Functions & Two Additional Coordination Requirements

Coordination

18) The practice on its own or in conjunction with an external organization has a systematic approach for identifying and coordinating care for patients who receive care in inpatient or outpatient facilities or patients who are transitioning to other care.

19) The practice reviews post-hospitalization medication lists and reconciles with other medications.

Plus Any Three of the Nine Additional Requirements from the Following Components

Clinical Information Systems

20) The practice uses an electronic system to write prescriptions and that can print or send prescriptions electronically, clinicians in the practice write prescriptions using electronic prescription reference information at the point of care, which includes safety alerts that may be generic or specific to the patient, and clinicians engage in cost-efficient prescribing by using a prescription writer that has general automatic alerts for generic or is connected to a payer-specific formulary.

21) The practice provides patients/families with access to an interactive Website that allows electronic communication.

22) The practice provides for patient access to personal health information such as test results or prescription refills or to see elements of their medical record and import elements of their medical record into a personal health record.

Delivery System Redesign

23) The practice measures or receives data on performance such as clinical process, clinical outcomes, service data or patient safety issues, and the practice collects data on patient experience with care, addressing up to three areas.

24) The practice reports performance data to physicians.

25) The practice uses performance data to set goals and take action where identified to improve performance.

257. *Id.* at 7–8 tbl.2.

