

ANNALS OF HEALTH LAW
Advance Directive

VOLUME 21 FALL 2011 PAGES 60-71

You Can't Go Home Again –
Difficulties of Medical Home Implementation
Within Health Reform

Ashley Craig

I. IDEAL PATIENT CARE: THE PATIENT CENTERED MEDICAL HOME

Patient centered medical homes (medical homes) aim to provide patients with higher quality access to healthcare at a lower cost by employing a novel, collaborative method of care.¹ This white knight of healthcare is expected to revolutionize primary care, healthcare collaboration, referrals, and patient involvement.² However, the healthcare community has heard these claims and promises before. Managed care similarly focused on cost containment and the use of primary care physicians as gatekeepers, yet the system disappointed the high expectations.³ Furthermore, the burden placed on primary care physicians is great and potentially unattainable due to the current shortage of primary care physicians.⁴

· Juris Doctor Candidate, Loyola University Chicago School of Law, Class of 2013. Ms. Craig is a staff member of *Annals of Health Law*.

1. Amanda Cassidy, *Health Policy Brief: Patient-Centered Medical Homes*, HEALTH AFFAIRS (Sept. 14, 2010), available at http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_25.pdf.

2. *Id.*

3. Robert J. Stenger et al., *Policy Challenges in Building the Medical Home: Do We Have a Shared Blueprint?*, 23 J. AM. BOARD OF FAM. MED. 384, 389-90 (2010).

4. Cassidy, *supra* note 1, at 1.

The premise behind the medical home concept is that responsibility to integrate patient care across all medical institutions and organizations to provide safe, quality care for the patient would fall to one single person; a physician.⁵ According to the seven basic tenants of the medical home, the patient is entitled to: a personal physician; physician-directed medical practice; whole person orientation; coordinated or integrated care; quality and safety; enhanced access; and value payment.⁶ Recently, under the Patient Protection and Affordable Care Act, medical homes received a great deal of attention as a potential vehicle for primary care reform.⁷ However, medical homes, originally called health homes, were first introduced in 1967 in order to provide a location, or home, for children's medical records.⁸ Medical homes now endeavor to provide effective primary care to all patients, not just children, including individuals with special needs and chronic care patients.⁹ According to legislation in various states, medical homes still retain their original purpose.¹⁰ Furthermore, the National Center for Quality Assurance (NCQA) standards assume all patients are affected by medical home implementation while Medicaid legislation indicates that the medical home target population only includes chronic care patients.¹¹

5. CLAYTON M. CHRISTENSEN ET AL., *THE INNOVATOR'S PRESCRIPTION: A DISRUPTIVE SOLUTION FOR HEALTHCARE* 129-30 (McGraw Hill, 2009).

6. *Joint Principles of the Patient Centered Medical Home*, PATIENT-CENTERED PRIMARY CARE COLLABORATIVE (2007), <http://www.pcpcc.net/content/joint-principles-patientcentered-medical-home>.

7. Cassidy, *supra* note 1, at 3.

8. *Patient Centered Medical Home*, IMPROVING CHRONIC ILLNESS CARE (2006-10), http://www.improvingchroniccare.org/index.php?p=Patient-Centered_Medical_Home&s=224.

9. Robert A. Berenson et al., *A House Is Not A Home: Keeping Patients At The Center Of Practice Redesign*, 27 HEALTH AFFAIRS 1219, 1223 (2008).

10. Okla. Admin. Code § 310:550-1-2 (2008) (describing of 'medical home' as a place for infant to receive care); R.I. Gen. Laws Ann. § 42-12.3-2 (West 2007) (stating that every child and pregnant mother is given access to medical home regardless of coverage).

11. Berenson, *supra* note 9, at 1226, 1227.

II. PCMH STANDARDS

The NCQA promulgates six standards for medical homes, allotting points for each element.¹² The factors enumerated by the NCQA are the medical home's (1) ability to enhance access and continuity; (2) identify and manage patient populations; (3) plan and manage care; (4) provide self-care and community support; (5) track and coordinate care; and (6) measure and improve performance.¹³ Under the rating system, NCQA qualified medical homes receive additional bonuses or payments.¹⁴ Health plans and employers also entice medical homes to comply through the use of financial incentives.¹⁵ While these factors are easily evaluated, they are not sufficient to solve the primary care systematic problems.¹⁶ Instead, the standards are "data-centered" versus "patient-centered."¹⁷ Specifically, the standards misplace emphasis on documentation requirements rather than the needs of the patient.¹⁸ The hope of medical homes is that they will revolutionize shortcomings within the primary healthcare system. Unfortunately, the NCQA standards, "do not necessarily correspond to the seven 'joint principles' that define the [medical homes]."¹⁹

Furthermore, each community places significant emphasis on certain standards, not necessarily in accordance with the NCQA points system.²⁰

12. *Patient-Centered Medical Home*, NATIONAL CENTER FOR QUALITY ASSURANCE (last visited Sept. 29, 2011), <http://www.ncqa.org/tabid/631/default.aspx>.

13. *PCMH 2011 Content and Scoring Summary*, NATIONAL CENTER FOR QUALITY ASSURANCE (last visited Oct. 1, 2011), <http://www.ncqa.org/tabid/631/default.aspx>.

14. *NCQA Patient-Centered Medical Home: PPC-PCMH*, NATIONAL CENTER FOR QUALITY ASSURANCE (last visited Oct. 30, 2011), available at <http://www.ncqa.org/Portals/0/PCMH%20brochure-web.pdf>.

15. *Id.*

16. Cassidy, *supra* note 1, at 4.

17. Berenson, *supra* note 9, at 1225.

18. *Id.*

19. Bruce E. Landon et al., *Prospects for Rebuilding Primary Care Using the Patient-Centered Medical Home*, 29 HEALTH AFFAIRS 827, 828 (2010).

20. Anton J. Kuzel & Elaine M. Scoch, *Achieving a Patient-Centered Medical Home as Determined by the NCQA – At What Cost, and to What Purpose?*, 7 ANNALS FAM. MED. 85, 85 (2009).

Each medical home is unique, and encouraging compliance with a set standard may discourage their unique characteristics and ability to meet varied community needs. Utilizing standards encourages medical homes to adhere to those named principles, but the overall goal of primary care transformation is hindered or abandoned.²¹ The transformation itself preaches consistency within the NCQA standards, while also indicating that each practice tailors the transition to their particular goals.²²

III. PCMH WITHIN MEDICAID

Several states, including Nebraska, employ their own standards governing Medicaid medical home pilot projects.²³ Nebraska's pilot program requires five core competencies be met prior to receiving both the medical home designation and Medicaid reimbursement.²⁴ Unfortunately, the implementation of standards for Medicaid reimbursement poses the same risks as those referenced regarding the NCQA standards. In particular, the Nebraska Medicaid medical home pilot entices physicians to transform their practice, yet the enhanced Medicaid reimbursements incentives only apply if the practices adhere to the program standards.²⁵ Once a participating practice achieves a certain standard level, the practice then receives an additional 5% enhanced fee-for-service payment for select

21. Landon, *supra* note 19, at 829.

22. Paul A. Nutting et al., *Initial Lessons From the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home*, 7 ANNALS FAM. MED. 254, 257-58 (2009).

23. See generally NEB. DEPARTMENT OF HEALTH AND HUM. SERVICES, http://dhhs.ne.gov/medicaid/Pages/med_pilot_progress.aspx (last visited Oct. 11, 2011) (presenting information regarding Nebraska's Medicaid Medical Home pilot).

24. *Nebraska Medicaid Patient-Centered Medical Home Pilot Standards*, NEB. DEPARTMENT OF HEALTH AND HUM. SERVICES (Nov. 3, 2010), available at <http://dhhs.ne.gov/medicaid/Documents/standards.pdf>.

25. *Nebraska Medicaid Patient-Centered Medical Home Payment Methodology*, NEB. DEPARTMENT OF HEALTH AND HUM. SERVICES (Jul. 26, 2010), available at <http://dhhs.ne.gov/medicaid/Documents/payment-methodology.pdf>.

procedures and evaluations.²⁶ This particular Medicaid reimbursement method exacerbates existing problems with the fee-for-service method of reimbursement as only specified evaluations receive the enhanced rate, which may circumvent a physician's incentives to become more accessible to patients.

IV. FEES & REIMBURSEMENT

The current fee-for-service method of primary care reimbursement is highly criticized.²⁷ Many commentators believe a change in payment policy is necessary.²⁸ In fact, moving primary care away from fee-for-service payment will provide medical homes with stronger finances.²⁹ Healthcare reform legislation cites medical homes as the vehicle for change in payment and reimbursement.³⁰ Yet the fee-for service/capitation methods of payment remain the prototypical payment method for medical homes.³¹ This poses a large barrier to the success of medical homes, as physicians strive for payment reform and may not support the medical home proposals without payment adjustment.³² Initial state medical home legislation indicates the fee-for-service model is a jump-off point for additional reimbursement.³³

Currently, fee-for-service is the preferred method of payment for providers, and many providers fear changing their reimbursement

26. *Id.*

27. Landon, *supra* note 19, at 829.

28. *Id.*

29. *Id.* at 833.

30. Katie Merrell & Robert A. Berenson, *Structuring Payments for Medical Homes*, 29 HEALTH AFFAIRS 852, 852 (2010).

31. *Id.* at 858.

32. Stenger, *supra* note 3, at 390.

33. *See generally* NAT'L ACAD. FOR STATE HEALTH POLICY, <http://nashp.org/med-home-states> (last visited Sept. 29, 2011) (presenting information regarding each state's current policy and legislation regarding medical homes).

methods.³⁴ Fee-for-service payments encourage skyrocketing healthcare costs in both primary care and hospital organizations.³⁵ Accordingly, providers are hesitant to change to a new payment model if reimbursement may be jeopardized.³⁶

Moreover, the fee-for-service model is an inappropriate payment method for a successful medical home. Because one tenet of a successful medical home is the collaboration of the physician and all medical personnel, the fee-for-service method is ludicrous. Aspects of the collaborated care within medical homes have not traditionally used the fee-for-service method of payment, which generally only reimburses physicians for face-to-face visits.³⁷ Such payments do not cover phone calls, or additional services provided by other medical staff.³⁸ Therefore, the use of fee-for-service is additionally inappropriate for auxiliary services.

Fee-for-service payments encourage a “more is better” mentality;³⁹ while capitation, the traditional alternative, encourages the opposite mantra of less is more.⁴⁰ Most providers are not enthusiastic about employing capitation payment models, as physicians are not reimbursed for frequent visits, which sometimes leads to the avoidance of sicker patients.⁴¹ Conversely, under the fee-for-service method, primary care physicians desire to see their patients more so they can bill for each service provided.⁴² A successful (and imaginary) payment model must reach a healthy balance where physicians are paid appropriately and provide the appropriate number

34. Stenger, *supra* note 3, at 387.

35. See CHRISTENSEN, *supra* note 5, at 233.

36. Stenger, *supra* note 3, at 390.

37. David Margolius & Thomas Bodenheimer, *Transforming Primary Care: From Past Practice to Practice of the Future*, 29 HEALTH AFFAIRS 779, 783 (2010).

38. *Id.*

39. Merrell & Berenson, *supra* note 30, at 856.

40. *Id.* at 853.

41. Landon, *supra* note 19, at 829.

42. Margolius & Bodenheimer, *supra* note 37.

of services rendered. Until such a payment model is created, medical homes are unable to function successfully.

Clearly, healthcare reform calls for an innovated payment method, yet pilot medical homes were implemented without any resolution in this area. “New” payment methods attempt to solve the need for augmenting reimbursement.⁴³ Two such methods, the supplement fee and boosted fee, require a level of compliance with NCQA standards.⁴⁴ Furthermore, boosted fees exacerbate the underlying healthcare issue: too high of fees for too little service, as this method simply increases the fee-for-service method of payment.⁴⁵ This change is not revolutionary; it is just more expensive. Medical homes cannot fulfill the lofty expectations of revolutionizing primary healthcare unless this issue is addressed.

Accordingly, medical home legislation ambiguously discusses payment methods for medical homes. As a result, various forms of payment are implemented in the current pilot medical homes.⁴⁶ For example, Maryland retains a traditional fee schedule and added reimbursement for extra visits and after-hours appointments.⁴⁷ Similarly, a North Carolina Medicaid program pays participating physicians an additional small monthly fee to the usual fee-for-service.⁴⁸ Conversely, numerous states, like New Mexico⁴⁹, chose not to legislate on the payment topic at all.⁵⁰

43. Paula Haas, *Medical Home Model Calls for New Payment Methods: Experimentation is the Name of the Game*, AAFP (Feb. 17, 2009, 3:55 PM), <http://www.aafp.org/online/en/home/publications/news/news-now/pcmh/20090217pcmhpayment.html>.

44. *Id.*

45. *Id.*

46. *Id.*

47. *State Involvement in Multi-Payer Medical Home Initiatives*, NAT'L ACAD. FOR STATE HEALTH POLICY, (November 2009), http://nashp.org/sites/default/files/MedHomes_State_Chart_11-2009.pdf.

48. Berenson, *supra* note 9, at 1224.

49. *See generally* NAT'L ACAD. FOR STATE HEALTH POLICY, <http://nashp.org/med-home-states/new-mexico> (last visited Sept. 30, 2011) (demonstrating that no legislation was enacted regarding payment and reimbursement).

Aside from the substantive problems within each model of payment, the lack of regulation regarding payment and reimbursement methods is also troublesome. As previously mentioned, most hospitals and primary care providers are currently fee-for-service. Medical homes face the daunting task of incorporating multipayer systems without standardizing the method of payment. Confusion will ensue if medical homes must deal with one payer using per-patient-per-month payment and another preferring enhanced fee-for-service.⁵¹ “[The Centers for Medicaid and Medicare Services (CMS)] has indicated that it will join multipayer advanced primary care demonstrations only if there is also ‘substantial participation’ by Medicaid and private payers and if there is a consistency in payment methods across the payers in each initiative.”⁵²

V. IMPLEMENTATION

Primary care physicians should not be asked to bear the burden of patient care throughout the healthcare system. Implementation of medical homes requires coordination inside and outside the primary care physician’s practice.⁵³ Most practices, both independent and affiliated with hospitals, are not currently equipped to shift to medical homes.⁵⁴ Primary care physicians are already overwhelmed, and many may balk at the undertaking medical homes require.⁵⁵ Medical home implementation is a lengthy and laborious process for all practices, yet smaller practices may find implementation particularly difficult. Smaller practices have fewer incentives to transform as their patient base is smaller, and certain

50. *Id.* .

51. Merrell & Berenson, *supra* note 30, at 857.

52. *Id.* at 857.

53. Berenson, *supra* note 9, at 1227.

54. Robert L. Phillips Jr. & Andrew W. Bazemore, *Primary Care and why It Matters for U.S. Health System Reform*, 29 HEALTH AFFAIRS 806, 809 (2010).

55. Berenson, *supra* note 9, at 1228.

components of the medical home, such as integrated and coordinated care, are not feasible for such small practices.⁵⁶ Additionally, confusion remains regarding the target population for medical homes. While Medicaid expanded their definition of “chronic patients,” many smaller practices are unwilling to redesign their practices for the small percentage of patients “eligible” for medical home care.⁵⁷

Time constraints also intimidate practices, as the transformation to a medical home “requires a continuous, unrelenting process of change.”⁵⁸ Financial distress, staff burnout, and turnover are all hindrances practices face if they attempt to transform their practices too fast.⁵⁹ A significant period of time is necessary to adjust any issues which may arise during the transition to a medical home model. The medical home transformation must not occur in incremental steps as the components are interdependent and require a simultaneous transition.⁶⁰ Furthermore, a primary care physician must allocate his or her time differently under the medical home model, yet this is impossible until the reimbursement method is dramatically transformed.⁶¹ Proponents of medical homes gloss over the significant implementation costs and time constraints placed on the primary care physicians.

Physicians may question why they should bother to change their practice to the medical home model. Under the fee-for-service method, practitioners are reimbursed, perhaps disproportionately, as this method of payment focuses on personal visits instead of other services that may prove more

56. Berenson, *supra* note 9, at 1226-27.

57. *Id.*

58. Nutting, *supra* note 22, at 255.

59. *Id.* at 256.

60. *Id.* at 255.

61. Lawrence P. Casalino, *Analysis & Commentary A Martian's Prescription for Primary Care: Overhaul the Physician's Workday*, 29 HEALTH AFFAIRS 785, 788 (2010).

helpful to the patient.⁶² Thus, this form of reimbursement promotes face-to-face service while neglecting other services that may help the patient but do not fall within the fee-for-service method.⁶³ Additionally, physicians fear that medical home implementation will merely increase their workload.⁶⁴ While the medical home standard preaches collaboration, particularly regarding electronic health records (EHR), between practitioners and hospitals, coordination of the patient's medical care is left to the primary care physician.⁶⁵ Specialists also lack any incentive to conform to the medical home model, and primary care physicians have little leverage over other practitioners.⁶⁶

A significant factor in the success of medical homes is the use of EHR in collaboration with a higher level of patient care previously not achieved with paper records.⁶⁷ However, current EHR systems are frequently not compatible between hospitals and primary care physicians.⁶⁸ The updated NCQA standards emphasize collaboration and EHR, yet provide no regulations for standardization or how well the EHR systems are integrated.⁶⁹ Proponents of the standards underestimate the difficulty of merging various EHR programs. Unfortunately, hospitals do not even have centralized EHR, let alone EHR in accord with corresponding physician practices.⁷⁰ Under the Health Information Technology for Economic and Clinical Health Acts (HITECH), hospitals and practices that fail to

62. Merrell & Berenson, *supra* note 30, at 853.

63. *Id.*

64. Casalino, *supra* note 61, at 787.

65. Elliot S. Fisher, *Building a Medical Neighborhood for the Medical Home*, 359 NEW ENG. J. MED. 1202, 1203 (2008).

66. *Id.* at 1204.

67. Berenson, *supra* note 9, at 1224.

68. Joy M. Grossman et al., *Hospital-Physician Portals: The Role of Competition in Driving Clinical Data Exchange*, 25 HEALTH AFFAIRS 1629, 1633 (2006).

69. Fisher, *supra* note 65.

70. Grossman, *supra* note 68.

implement EHR systems face penalties.⁷¹ Such penalties include cuts in Medicaid and Medicare payments.⁷² Incentives to avoid penalties encourage health systems to quickly implement EHR.⁷³ However, per patient costs of EHR are higher for smaller practices, placing these practices at risk for penalties associated with EHR.⁷⁴ Health reform heralds EHR as a means to reduce administrative costs in hospitals and practices⁷⁵, yet recent studies demonstrate that there is no evidence to support this conclusion.⁷⁶ Conversely, computerization may lead to increased administrative costs.⁷⁷

VI. CONCLUSION

At this point, actual implementation of the medical home without further refinements may jeopardize the model's future use within the healthcare system.⁷⁸ Significant barriers, including payment reform, must be addressed prior to transitioning primary care practices into medical homes. Current standards promulgated by the NCQA address factors that are easily evaluated, but not the true concerns within primary care. Additionally, the implementation of delivery systems such as collaboration and EHR are greatly emphasized, but are ambiguous and impossible to complete without further standardization.⁷⁹ Physicians are unlikely to transition from their steady fee-for-service primary care practices without increased incentives. Moreover, Medicaid's current model reimbursement methods do not encourage this transition, as many pilot programs only provide financial

71. Nancy Ferris, *Health Policy Brief: 'Meaningful Use' of Electronic Health Records*, HEALTH AFFAIRS (Aug. 24, 2010), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=24

72. *Id.*

73. *Id.*

74. Berenson, *supra* note 9, at 1226.

75. David U. Himmelstein et al., *Hospital Computing and the Costs and Quality of Care: A National Study*, 123 AM. J. MED. 40, 40 (2010).

76. *Id.* at 44.

77. *Id.*

78. Nutting, *supra* note 22, at 254.

incentives once certain standards are met. Additionally, practices must be made aware of the significant time, effort, and finances involved in transitioning into a medical home model. In sum, medical homes contain the potential to assist in transforming the primary care practice. However, without further regulation, guidance, and financial assistance in both technology development and reimbursement, medical homes will flounder and fail like other healthcare beacons of hope.

79. Stenger, *supra* note 3, at 391.