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Designing Model Homes for the Changing Medical Neighborhood: A Multi-Payer Pilot Offers Lessons for ACO and PCMH Construction

*Sallie Thieme Sanford**

I. MODEL HOMES FOR REZONED MEDICAL NEIGHBORHOODS

Washington State is in the midst of a multi-payer model home test with implications for the nascent national effort to construct new health care payment and delivery systems. The model homes are redesigned primary care medical practices. Their structural supports include additional upfront payments, potential shared savings, and other elements reflective of “accountable care.” Accountable care, in its basic blueprint, requires an affiliated group of health care providers to accept responsibility for the overall costs and quality of care for a defined population.

Accountable care requires a solid primary care foundation.¹ And that foundation might well be a Patient-Centered Medical Home (PCMH). Indeed, in some formulations, a PCMH is a necessary part of any well-functioning Accountable Care Organization (ACO).² The

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¹ See generally Elliott S. Fisher & Stephen M. Shortell, *Accountable Care Organizations: Accountable for What, to Whom, and How*, 304 JAMA 1715 (2010); Elliott S. Fisher et al., *Fostering Accountable Health Care*, 28 HEALTH AFF. 219 (2009).

² Diane R. Rittenhouse et al., *Primary Care and Accountable Care—Two Essential Elements of Delivery-System Reform*, 361 NEW ENG. J. MED. 2301, 2303 (2009); see also Bruce E. Landon et al., *Prospects for Rebuilding Primary Care Using the Patient-Centered Medical Home*, 29 HEALTH AFF. 827, 831 (2010) and Stephen M. Shortell, *Key to Health Care Reform: Changing How Care is Delivered*, 25 NOTRE DAME J.L. ETHICS & PUB. POL'Y 399, 407 (2011).

PCMH is “not far removed in principle”³ from the ACOs that are the focus of the other articles in this Symposium. “The PCMH is reflective of coordination of care; the ACO is reflective of the continuum of care.”⁴ The two have the potential to be mutually supportive.

To deliver on its promise of care coordination, the PCMH “needs a hospitable and high-performing medical neighborhood.”⁵ Promoting these neighborhoods is a key focus of the Affordable Care Act (ACA) of 2010,⁶ with its multitude of programs and pilots, and of related private-sector initiatives. The new Medicare ACO program functions as a rezoning effort. Its rules allow and encourage development of new health care structures. This rezoning effort supports transformation of the nation’s medical neighborhoods, with the goals of improving their occupants’ health while simultaneously reining in overall medical costs.

Washington’s “Multi-Payer Medical Home Reimbursement Pilot”⁷ shares these goals. It involves most of the state’s major insurers in a thirty-two-month project to provide upfront payments for enhanced primary care in selected practices. These practices will also see shared savings if there are reductions in emergency room (ER) visits or hospitalizations beyond set targets. These practices face downside financial risk for failure to meet quality and usage targets.⁸ This pilot project shares many features of prominent accountable care initiatives, but there are also key differences.

The pilot’s design and early construction thus offer ideas for others attempting similar remodels. And ideas are especially useful as to this type of health care reform because we do not yet have many

³ BARRY R. FURROW ET AL., HEALTH LAW 185 (West, 6th ed. Supp. 2011).

⁴ Gary Scott Davis & Julie Brillman, *Innovative Approaches to Care: Accountable Care Organizations and Medical Homes*, AM. HEALTH LAW. ASS’N, at 8 (June 29, 2010), http://www.healthlawyers.org/Events/Programs/Materials/Documents/AM10/davis_accountable_care.pdf.

⁵ Elliott S. Fisher, *Building a Medical Neighborhood for the Medical Home*, 359 NEW ENG. J. MED. 1202, 1205 (2008).

⁶ See generally Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (March 23, 2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (March 30, 2010).

⁷ WASH. STATE HEALTH CARE AUTH., WASHINGTON STATE MULTI-PAYER MEDICAL HOME REIMBURSEMENT PILOT: INVITATION TO APPLY 2 (2010), available at http://www.hca.wa.gov/documents/medical_homes/invitation_%20multi-payer_medical_home_reimbursement.doc.

⁸ WASH. STATE HEALTH CARE AUTH., *supra* note 7.

generalizable results and “unrealistic expectations . . . abound.”⁹ Even as we await results, construction proceeds on new healthcare delivery and payment systems. As with any fast-track construction project, mid-development blueprint revisions are to be expected.

This Article first describes the ingrained construction incentives in our current health care system and the challenges they present. The Article then turns to key innovations to address these challenges, with a particular focus on accountable care and medical homes. Next, the Article considers the early spec houses¹⁰ that provide the model for the PCMHs under development throughout the country. Then, the Article focuses on the design and finance features of Washington’s ongoing pilot. Finally, the Article concludes with thoughts on a series of questions raised by this pilot and others like it. Ultimately, what medical home designs are best suited for our rezoned medical neighborhoods?

II. PROBLEMATIC INGRAINED CONSTRUCTION INCENTIVES

In their writings, both Atul Gawande and Donald Berwick describe a particular health care project that illustrates a central problem that these new structures—PCMHs and ACOs—both attempt to address.¹¹ The problem is misaligned incentives; the project Gawande and Berwick describe involves pediatric asthma.

In response to repeated hospitalizations of children with severe asthma, health care providers in Boston adopted a coordinated, flexible, patient-centered approach, which went beyond the “tyranny of the 15-minute visit.”¹² Following a child’s discharge from the hospital, nurses conducted home visits to help reduce allergen

⁹ Fisher, *supra* note 5, at 1202.

¹⁰ A “spec house” is one “built on speculation that a buyer will be found.” AM. HERITAGE ABBREVIATIONS DICTIONARY (3d ed. 2005), s.v. “spec house,” available at <http://dictionary.reference.com/browse/spec%20house>.

¹¹ See Atul Gawande, *Now What?*, THE NEW YORKER, Apr. 5, 2010, at 21; see also Donald M. Berwick, *Making Good on ACOs’ Promise—The Final Rule for the Medicare Shared Savings Program* 365, 1753, NEW ENG. J. MED. 1753 (2011). Dr. Berwick was the head of the Centers for Medicare and Medicaid Services during the initial implementation of the Affordable Care Act until his resignation in December 2011, shortly before his recess appointment expired. Doug Trapp, *CMS Chief Dr. Berwick to Step Down Dec. 2*, AM. MED. NEWS (Nov. 23, 2011), <http://www.ama-assn.org/amednews/2011/11/21/gvsg1123.htm>.

¹² Berwick, *supra* note 11, at 1755. Dr. Berwick was the head of the Centers for Medicare and Medicaid Services during the initial implementation of the Affordable Care Act until his resignation in December 2011 shortly before his recess appointment expired.

triggers and teach proper inhaler use.¹³ Allergists and pharmacists consulted with pediatricians on care plans.¹⁴ Nurse practitioners were available for after-hours telephone consultations.

The project saw good results. Hospital readmission rates for these children plunged more than 80 percent.¹⁵ The children were healthier.¹⁶ Their parents had to miss less work. Overall costs decreased.¹⁷ So what was the problem? The financial model. Most of the costs of this approach—outside of the traditional office visits and prescriptions—were not reimbursed. And Children’s Hospital lost revenue from one of its leading sources of admissions.¹⁸

Raising a free-rider issue, the savings basically redounded to the insurers. (Among the insurers in this situation, the state’s Medicaid system probably featured prominently; it, no doubt, could use a financial boost.) In a fragmented system, the hospital business model is not unlike that of a hotel; it is about “butts in beds.”¹⁹ While providers’ interests, ethics, and reputations are tied to their patients’ health outcomes, their payment typically is linked to procedures and office visits. They are rewarded for volume, not necessarily value. The United States’ health care system has “payment and organizational features that reward high volume rather than low cost or high quality.”²⁰

Outside of fully integrated systems, savings do not necessarily flow to those that expend the extra costs that lead to the savings. The current fee-for-service (FFS) system typically does not pay for services such as phone calls for care coordination, extended hours, team meetings, condition tracking, and email communication. And there is usually no direct financial disincentive for unnecessarily high

¹³ Gawande, *supra* note 11, at 22.

¹⁴ Berwick, *supra* note 11, at 1753.

¹⁵ Elizabeth R. Woods et al., *Community Asthma Initiative: Evaluation of a Quality Improvement Program for Comprehensive Asthma Care*, 129 *PEDIATRICS* 465, 468 (2012).

¹⁶ Berwick, *supra* note 11, at 1753.

¹⁷ See generally Gawande, *supra* note 11, at 22; Berwick, *supra* note 11, at 1753.

¹⁸ Gawande, *supra* note 11, at 22.

¹⁹ This paraphrases a presentation given by Dr. Jeffrey Brenner, M.D. Jeffrey Brenner, Founder, Camden Coal. of Healthcare Providers, Keynote Address at the Seton Hall Law Review Symposium: Implementing the Affordable Care Act: What Role for Accountable Care Organizations? (Oct. 28, 2011) (notes on file with author); see also Dartmouth, Camden Coalition of Healthcare Providers, Bending the Cost Curve and Improving Quality in One of America’s Poorest Cities, *YOUTUBE* (May 30, 2012), http://www.youtube.com/watch?v=paiA0Tpw_64.

²⁰ Thomas L. Greaney, *Accountable Care Organizations—The Fork in the Road*, 364 *NEW ENG. J. MED.* e1(1), e1(1) (2011).

utilization elsewhere, in the form of avoidable lab work, ER visits, or hospitalizations. Indeed, one of the ways in which the United States' health care system is an outlier is in its high level of duplicative testing.²¹

This is not a new problem, but it is one in search of new solutions. In the 1980s, many hoped that managed care would both hold down costs and also improve quality, particularly where health maintenance organizations (HMOs) received a set amount per member per month to cover all of a subscriber's health care needs. In this vision, integration and capitation would work to appropriately align incentives. The 1990s saw the managed care backlash, with concerns that quality and access were being sacrificed in the name of cost control.²² Managed care has had successes, and some HMOs have remained popular with high marks for quality and cost-effectiveness.²³ Overall, though, the FFS fragmented system predominates.²⁴

III. NEW OR NEWLY PROMINENT DESIGN INNOVATIONS

There is a multitude of new ideas, or at least newly prominent ideas. They are promoted by private insurance companies, employers, health systems, and governments. They have received a boost from the ACA, which includes a variety of rules, pilots, and demonstrations aimed at transforming the system from one that pays for piecework to one that rewards better outcomes.²⁵ Though the recent health reform effort has been criticized for not focusing more on our nation's extremely high health care costs, it does contain provisions that address the "triple aim": improving the quality of care for patients, advancing the overall health of the population, and slowing the growth of health care costs.²⁶

Within Medicare, for example, the ACA promotes bundled

²¹ THE COMMONWEALTH FUND, WHY NOT THE BEST? RESULTS FROM THE NATIONAL SCORECARD ON U.S. HEALTH SYSTEM PERFORMANCE, 2011 46 (Oct. 2011), available at http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2011/Oct/1500_WNTB_Nat_Scorecard_2011_web.pdf.

²² See generally Robert J. Blendon et al., *Understanding the Managed Care Backlash*, 17 HEALTH AFF. 80 (1998).

²³ See Macaran A. Baird, *The Patient-Center Medical Home and Managed Care: Times Have Changed, Some Components Have Not*, 24 J. AM. BD. FAMILY MED. 630, 630 (2011).

²⁴ Atul Gawande, *Piecework*, THE NEW YORKER, Apr. 4, 2005, at 44.

²⁵ *Id.*

²⁶ Berwick et al., *The Triple Aim: Care, Health, and Costs*, 27 HEALTH AFF. 759, 760 (2008); see also Shortell, *supra* note 2, at 399 (describing programs—notably the ACO and PCMH programs—that address the triple aims).

payments (a set amount to, say, fix a knee, rather than separate payments for office visits, surgery, hospital stay, physical therapy, and a walker)²⁷ as well as limitations on paying for hospital readmissions (to encourage better discharge coordination).²⁸ As to the entire system, for example, the ACA promotes effectiveness research (through a variety of studies and institutes) and expanded use of electronic record-keeping systems (in the form of financial incentives as well as penalties).²⁹ These tend to “reward outcomes of care and not volume of procedures or services delivered.”³⁰

Stephen Shortell argues that to respond appropriately to these financial incentives, physicians and hospitals need new organizational structures, such as ACOs and PCMHs.³¹ One of the ACA systemic reform provisions receiving the most attention is the Medicare Shared Savings Program, which is designed to encourage the establishment of ACOs. The concept of accountable care has been promoted in the work of Elliott Fisher, Stephen Shortell, and others³² and has been tested in the Medicare program.³³ In the ACA’s formulation, an organization of health care providers that agrees to be accountable for the total care of a defined group of Medicare beneficiaries and meets specified quality metrics may share in any savings that accrue to the Medicare system.³⁴ Organizations accepted into the Medicare ACO program agree to participate for three years.³⁵

This program functions as a rezoning effort. It allows and encourages the development of new health care structures. While there are financial incentives to engage in this development, the ultimate goal, as in the best rezones, is not to increase the developers’ coffers, but rather to improve the neighborhood. The hope is that appropriately designed new structures will improve health outcomes while simultaneously reining in overall medical costs. As with any rezone, assessment of its results awaits usage.

²⁷ Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 3023, 124 Stat. 119, 399 (2010) (to be codified at 42 U.S.C. § 1396cc-4).

²⁸ § 3025 (a) 124 Stat. at 408; Hospital Readmissions Reduction Programs (HRRP), 76 Fed. Reg. 51660 (Aug. 18, 2011).

²⁹ See, e.g., Pub. L. No. 111-148 § 1561, 124 Stat. at 262 (codified at 42 U.S.C. § 300jj-51).

³⁰ Shortell, *supra* note 2, at 400.

³¹ *Id.* at 402–03.

³² Fisher & Shortell, *supra* note 1, at 1715; see also Fisher, *supra* note 1, at 219.

³³ Fisher & Shortell, *supra* note 1, at 1715.

³⁴ § 3022, 124 Stat. at 395 (codified at 42 U.S.C. § 1395jjj).

³⁵ *Id.*

Lessons from the managed care backlash feature in this program's design. The Medicare ACO program imposes no restrictions on the ability of beneficiaries to seek care outside the ACO.³⁶ And the ACOs must meet quality standards.³⁷ Developing and tracking these standards is presumably much more feasible now than in prior decades given the expansion of electronic health records (EHRs) and evidence-based practice guidelines. In addition, while accountable care requires coordinated working relationships, the Medicare ACO program does not necessarily require corporate integration.

The federal model is intended to work synergistically with private accountable care initiatives, and requires a significant primary care presence. The Centers for Medicare and Medicaid Services (CMS) published proposed rules in April 2011,³⁸ issued extensively revised final rules in October 2011,³⁹ accepted initial applications in January 2012, and announced the first group of 27 ACOs in April 2012.⁴⁰ CMS announced the second group of 89 ACOs in July 2012.⁴¹ This is a new and complicated program. A fast-track "Pioneer Program" kicked off in 2011 for 32 entities that are already highly integrated and willing to accept more financial risk in the form of partial capitation.⁴²

Particularly because of the involvement of commercial payers, ACOs bump up against legal issues related to tax-exempt status,

³⁶ Press Release, U.S. Dep't of Health & Human Servs., New Affordable Care Act Program to Improve Care, Control Medicare Costs, Off to a Strong Start (Apr. 10, 2012), *available at* <https://www.cms.gov/apps/media/press/release.asp?Counter=4333>.

³⁷ *Id.*

³⁸ Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 19528 (proposed April 7, 2011) (to be codified at 42 C.F.R. pt. 425).

³⁹ Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67802 (Nov. 2, 2011) (to be codified at 42 C.F.R. pt. 425).

⁴⁰ Press Release, U.S. Dep't of Health & Human Servs., *supra* note 36.

⁴¹ Press Release, U.S. Dep't of Health & Human Servs., HHS announces 89 New Accountable Care Organizations (July 9, 2012), *available at* <http://www.hhs.gov/news/press/2012pres/07/20120709a.html>. Among these 89 is the Polyclinic Management Services Company, one of whose clinics is a participant in the PCMH pilot described in this article.

⁴² Press Release, U.S. Dep't of Health & Human Servs., Affordable Care Act helps 32 health systems improve care for patients, saving up to \$1.1 billion (Dec. 19, 2011), *available at* <http://www.hhs.gov/news/press/2011pres/12/20111219a.html>.

antitrust rules, and fraud and abuse prohibitions.⁴³ Thus, with publication of the 696-page Medicare ACO final rule, the relevant federal agencies released guidance documents setting out ACO exemptions and special procedures.⁴⁴

The ACA also separately promotes a variety of PCMH projects.⁴⁵ The two models can be viewed as interlocking components in support of systemic reform. “The PCMH is reflective of coordination of care; the ACO is reflective of the continuum of care.”⁴⁶ So just what is a PCMH?

IV. EARLY SPEC HOUSES

The concept of a “medical home” is not new. In fact, in its basic outlines, it dates back nearly half a century.⁴⁷ The American Academy of Pediatricians introduced the idea in 1967 with the aim of improving the care of children with special needs.⁴⁸ It recognized that the health care needs of these children were often quite complex and could benefit from active coordination among the disparate treatment sites.⁴⁹ The medical home is now “trumpeted not only as a method of improving care for children with medical needs but for anyone who participates in the health care system.”⁵⁰

⁴³ Timothy S. Jost, *Health Reform Requires Law Reform*, 28 HEALTH AFF. w761, w767 (2009) (describing legal challenges of partial integration and possibility of federal revisions and waivers).

⁴⁴ INTERNAL REVENUE SERV., 2011-16 I.R.B. 652, NOTICE 2011-20 (2011); Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67026 (Oct. 28, 2011); Memorandum from the Medicare Shared Savings Program to Medicare Shared Savings Program Applicants (Mar. 16, 2012), available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Memo_Additional_Guidance_on_ACO_Participants.pdf.

⁴⁵ Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 3502, 124 Stat. 119, 513 (2010) (to be codified at 42 U.S.C. § 256a-1) (establishing community health teams to support the patient-centered medical home); Pub. L. No. 111-148 § 3021, 124 Stat. 389 (to be codified at 42 U.S.C. § 1315a) (testing new payment models), Pub. L. No. 111-148 § 5301, 124 Stat. 615 (to be codified at 42 U.S.C. § 293k) (primary care training and enhancement).

⁴⁶ Davis & Brillman, *supra* note 4, at 1.

⁴⁷ See John K. Iglehart, *No Place Like Home: Testing a New Model of Care Delivery*, 359 NEW ENG. J. MED. 1200, 1200 (2008).

⁴⁸ See AM. ACAD. OF PEDIATRICS, COUNCIL ON PEDIATRIC PRACTICE, *Pediatric Records and a “Medical Home”*, in STANDARDS OF CHILD CARE 77–79 (1967).

⁴⁹ *Id.*

⁵⁰ Dominic J. Cirincione, *The Medical Home Model: Is There Really No Place Like Home?*, 13 J. HEALTH CARE L. & POL’Y 139, 144 (2010) (citing *Prologue: The Medical Home*, 27 HEALTH AFF. 1218, 1218 (2008)).

Although the phrases “medical home” and “patient-centered medical care” are increasingly bandied about, firm definitions remain elusive. There is a lot of jargon. In some respects, these phrases have become policy shorthand for the reinvention and reinvigoration of primary care in the United States.⁵¹

In 2007, four physician organizations developed Joint Principles for the PCMH model.⁵² The principles capture many of the oft-repeated elements (and also reflect the fact that they were written by physician groups). These are the seven principles:

Personal physician—each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician directed medical practice—the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation—the personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life: acute care, chronic care, preventive services, and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system . . . and the patient’s community Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home: [practices advocate for their patients, use evidenced-based medicine; adopt performance measurement techniques, engage patients in decision-making, appropriately utilize information technology, seek recognition as a medical home by a non-governmental entity, involve patients and families in quality improvement activities.]

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician,

⁵¹ See Landon, *supra* note 2 at 827.

⁵² AM. ACAD. OF FAMILY PHYSICIANS, AM. ACAD. OF PEDIATRICS, AM. COLL. OF PHYSICIANS & AM. OSTEOPATHIC ASS’N, JOINT PRINCIPLES OF THE PATIENT-CENTERED MEDICAL HOME (2007), available at <http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home>.

and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should . . . : [reflect the value of care management; pay for care coordination; support the use of information technology; support email and telephone consultation; recognize the value of remote monitoring; allow separate FFS payments for face-to-face visits; recognize case mix differences; allow physicians to share in savings from reduced hospitalizations; allow for additional payments for quality improvements.]⁵³

These Joint Principles contemplate recognition of a medical home by “an appropriate non-governmental entity.”⁵⁴ The National Committee for Quality Assurance (NCQA) now offers a PCMH “recognized practice” designation.⁵⁵ The NCQA accredits, certifies and recognizes a range of health care organizations, and its imprimatur holds weight among insurers and others.⁵⁶ Its criteria for PCMH recognition square with the Joint Principles, and set out specifics for different levels of attainment towards full recognition.

PCMH pilots abound in both the public and private sectors.⁵⁷ Some of the earliest pilots developed in integrated systems, such as Geisinger Health System in Pennsylvania and Group Health Cooperative (“Group Health”) in Washington State.⁵⁸ Group Health is a non-profit, integrated health insurance and delivery system that employs most of its physicians. In 2006, it piloted a medical home demonstration at one of its clinics near Seattle.⁵⁹ The redesign included increased patient engagement through the EHR and care

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ *Patient-Centered Medical Home*, NAT’L COMM. FOR QUALITY ASSURANCE, <http://www.ncqa.org/tabid/631/default.aspx> (last visited April 10, 2012).

⁵⁶ As of November 2011, the NCQA also accredits ACOs. *Accountable Care Organizations (ACO)*, NAT’L COMM. FOR QUALITY ASSURANCE, <http://www.ncqa.org/tabid/1312/default.aspx> (last visited Apr. 13, 2012).

⁵⁷ See, e.g., AM. HOSP. ASS’N, PATIENT-CENTERED MEDICAL HOME 5–6 (2010), available at <http://www.aha.org/research/cor/content/patient-centered-medical-home.pdf>; see also Nat’l Acad. for State Health Pol’y, *Medical Home & Patient-Centered Care*, <http://www.nashp.org/med-home-map> (last visited Sept. 12, 2011).

⁵⁸ See Ronald A. Paulus et al., *Continuous Innovation in Health Care: Implications of the Geisinger Experience*, 27 HEALTH AFF. 1235, 1235 (2008); Robert J. Reid et al., *The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers*, 29 HEALTH AFF. 835, 835 (2010).

⁵⁹ Reid, *supra* note 58, at 835. See also Eric B. Larson, *Group Health Cooperative—One Coverage-and-Delivery Model for Accountable Care*, 361 NEW ENG. J. MED. 1620, 1621 (2009) (summarizing results of study).

plans for those with chronic illnesses.⁶⁰ It also included practice changes such as longer physician visits, routine care-team “huddles” to review patient needs, and greater involvement by nurses, pharmacists, and medical assistants in coordinating patient care.⁶¹

All this required more staff, the greatest source of the additional costs directly attributable to the pilot (EHR improvements were costly but system-wide).⁶² Early results showed that the added costs were more than recouped by, among other results, significant reductions in ER visits and hospitalizations (29 percent and 6 percent, respectively).⁶³ The study results also showed improvements in clinical quality, patient experiences (including self-reports of health status), and staff burnout compared to control clinics.⁶⁴ Based on this experience, Group Health is now expanding the model to its other clinics.⁶⁵ The applicability of its experience elsewhere has limitations. Group Health is a relatively closed system, serving as both insurer and provider; moreover, it has a robust EHR and has long had a primary-care focus.⁶⁶

A different medical home project in Camden, New Jersey targeted the highest utilizers of emergency medical services in that community.⁶⁷ Most were uninsured or covered by a public program.⁶⁸ These “frequent flyers” typically had a constellation of poorly managed chronic conditions, often including mental health issues and substance abuse disorders, as well as complicating social circumstances.⁶⁹ As initially developed by Jeffrey Brenner, M.D., the Camden medical home model relied on extensive patient outreach, house calls (including by physicians), medical team meetings, and flexible telephone and after-hours access.⁷⁰

⁶⁰ Reid, *supra* note 58, at 837.

⁶¹ *Id.* at 836.

⁶² *Id.* at 841.

⁶³ *Id.* at 840.

⁶⁴ *Id.* at 842.

⁶⁵ Clarissa Hsu et al., *Spreading a Patient-Centered Medical Home Redesign: A Case Study*, 35 J. AMBULATORY CARE MGMT. 99, 102 (2012).

⁶⁶ Reid, *supra* note 58, at 835.

⁶⁷ John V. Jacobi, *High Utilizers of ED Services: Lessons for System Reform*, 21 ANNALS HEALTH L. 35, 35 (2012); see also Atul Gawande, *The Hot Spotters: Can We Lower Medical Costs by Giving the Neediest Patients Better Care?*, THE NEW YORKER, Jan. 24, 2011, at 41, available at http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande.

⁶⁸ Jacobi, *supra* note 67, at 36.

⁶⁹ *Id.* at 35.

⁷⁰ Gawande, *supra* note 67, at 41.

The patients' health indicators improved, and their ER usage declined.⁷¹ The project is now working to expand its population focus and transition from grant-based support to sustainable funding that leverages the down-stream savings.⁷² This is an impetus for New Jersey's newly authorized Medicaid ACO program.⁷³ One of the many interesting elements of this program is the possibility that community organizations could share in any savings. This general possibility is discussed by Bruce Landon and his co-authors who note that there is an "unsettled policy conundrum" about whether these types of payments "should be shared with a community-based organization that works with multiple practices."⁷⁴ Apart from this novel Medicaid ACO program, a number of states have Medicaid PCMH pilots under construction or underway.⁷⁵

Employers have also initiated pilots. One example is the "Boeing Intensive Outpatient Care Program," which involved 750 employees with significant health issues.⁷⁶ Boeing is a self-insured airplane manufacturer and Washington State's largest employer.⁷⁷ The employees were matched with a team of providers who offered health services in a medical home model in exchange for their usual fees plus a care management fee (the amount of which was not made public).⁷⁸ Boeing reported in 2010 that overall costs for those employees were twenty percent less than those of a control group, mostly due to reduced hospitalizations and ER visits; other health and satisfaction indicators also reportedly improved.⁷⁹ Working with an insurer that administers the health claims of its employees, Boeing announced that it intends to scale up the program.⁸⁰

In addition, insurers across the country are rolling out reimbursement systems that support the PCMH. Following a

⁷¹ *Id.* at 44.

⁷² *Id.* at 42.

⁷³ *Id.* 44.

⁷⁴ Landon, *supra* note 2, at 830.

⁷⁵ AM. HOSPITAL ASS'N, PATIENT-CENTERED MEDICAL HOME 6 (2010), available at <http://www.aha.org/research/cor/content/patient-centered-medical-home.pdf>; Mary Takach, *Reinventing Medicaid: State Innovations to Qualify and Pay for Patient-Centered Medical Homes Show Promising Results*, 30 HEALTH AFF. 1325, 1325 (2011).

⁷⁶ Peter Neurath, *Boeing Health Care Pilot Cut Costs 20 percent—and Improved Care*, PUGET SOUND BUS. J., Apr. 25, 2010, <http://www.bizjournals.com/seattle/stories/2010/04/26/story4.html?page=all>.

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ *Id.*

successful pilot project in Colorado, Wellpoint Inc., the nation's second-largest health insurer, announced a revised primary care payment program to begin in the summer of 2012.⁸¹ Physicians whose practices qualify under PCMH criteria are eligible for fee increases; they might also receive care management fees and shared savings.⁸² Because Wellpoint insures 34 million Americans and has a network of about 100 thousand primary care doctors, its system could be quite influential.⁸³ Another for-profit insurer, Aetna Inc., has plans to pay the 55 thousand primary care physicians in its network an extra fee of \$2–\$3 a month per patient “if their practices are certified as meeting certain standards for providing access for patients and coordinating their care.”⁸⁴

The hope, of course, is that the short-term savings and quality improvements demonstrated in small, targeted pilots will translate into gains for large, generally applicable programs. One question is whether higher payments from any one insurer will truly incentivize practice investment and change primary care delivery. As the medical director of an influential physician organization stated, “[I]f you only have 10% of your practice that you’re getting paid extra for, that’s not enough to get your attention.”⁸⁵

V. TESTING ONE MODEL HOME DESIGN AND FINANCE OPTION

Getting the attention of practice groups by involving most of their payers is a key design aspect of Washington's multi-payer, multi-site pilot. In 2009, Washington's legislature passed, and the governor signed, a bill to “identify appropriate reimbursement methods to align incentives in support of primary care medical homes” through a multi-payer pilot project.⁸⁶ The focus is on practice transformation, not short-term financial savings. By its nature, the project requires cooperation between payers, providers, and purchasers of health care.

One of the reasons for the state's establishment and oversight explicitly is “to exempt [project activities] from state antitrust laws, and to provide immunity from federal antitrust laws through the state

⁸¹ Christopher Weaver & Anna Wilde Mathews, *An Rx? Pay More to Family Doctors*, WALL ST. J., Jan. 27, 2012, at B1.

⁸² *Id.*

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ *Id.*

⁸⁶ 2009 Wash. Legis. Serv. Ch. 305 (S.S.B 5891) (West).

action doctrine.”⁸⁷ The state action doctrine, which is generally disfavored, provides that state-mandated or state-directed restraints be exempt from antitrust liability.⁸⁸ For the doctrine to apply, the state must act as a sovereign, rather than as a “participant in a private agreement or combination by others for restraint of trade.”⁸⁹ As has happened in Pennsylvania, Vermont, Maine, and other states under this type of framework, a health care agency brings together payers to agree upon a different reimbursement model for a pilot.⁹⁰

In May 2011, Washington launched its multi-payer, multi-site pilot.⁹¹ As explained in more detail below, the thirty-two-month pilot involves seven health plans and eight primary care practices.⁹² The practice sites receive from their insurers their usual FFS payments plus a monthly care management fee (“CMF”) to support enhanced primary care services and coordination.⁹³ As evaluated at the end of each year, if quality metrics are maintained and avoidable ER visits or hospitalizations are reduced beyond the break-even targets, the practice sites will share the financial savings with the insurers.⁹⁴ If quality is not maintained and/or usage not sufficiently reduced, the practice sites face financial risk in the form of reductions in their CMF going forward (and no shared savings).⁹⁵ They also face the financial risk that they will not recoup their outlays to provide the added services.

One goal of the project was to involve most of the state’s

⁸⁷ *Id.*; see Tara Adams Ragone, *Structuring Medicaid Accountable Care Organizations to Avoid Antitrust Challenges*, 42 SETON HALL L. REV. 1443, 1460–69 (2012) (explaining applicability of state action doctrine to projects of this type).

⁸⁸ *Parker v. Brown*, 317 U.S. 341, 350–52 (1943); see also Ragone, *supra* note 87.

⁸⁹ *Parker*, 317 U.S. at 351–52; see also Ragone, *supra* note 87.

⁹⁰ JASON BUXBAUM & MARY TAKACH, STATE MULTI-PAYER MEDICAL HOME INITIATIVES AND MEDICARE’S PRIMARY ADVANCED PRIMARY CARE DEMONSTRATION 2 (2010), available at <http://nashp.org/sites/default/files/MedHomesWebinar.pdf>.

⁹¹ Richard Onizuka, Assistant Dir., Wash. St. Health Care Auth. Washington State Health Benefit Exchange, Presentation at Washington Healthcare Policy Conference: State of Reform (Jan. 4, 2012) (notes on file with author) (slides available at http://depts.washington.edu/rchpol/docs/2012_State_of_Reform-WA-Insurance_Exchange_Panel.pdf).

⁹² *Multi-Payer Medical Home Pilot Launches*, WEEKLY REPORT, (Wash. State Hosp. Ass’n, Seattle, WA) (July 17, 2011), available at <http://www.wsha.org/weeklyReportDetails.cfm?EID=2011-06-17%2000%3A00%3A00%2E0>.

⁹³ *Id.*

⁹⁴ WASH. ST. HEALTH CARE AUTH., MULTIPAYER REIMBURSEMENT MODEL PILOT: PILOT DESIGN 1 (2010), available at http://www.hca.wa.gov/documents/medical_homes/pilot_design.pdf.

⁹⁵ *Id.*

insurers.⁹⁶ All of the state's large commercial health plans—Aetna, Cigna, Group Health, Regence, Premera, Molina, and Community Health Plan of Washington—are participating.⁹⁷ Collectively, they comprise more than half of the health insurance market in Washington State.⁹⁸ This group includes not only the commercially insured, but also patients covered by self-insured plans, Medicare Advantage, Medicaid Healthy Options, and Washington's Basic Health Program (state-subsidized insurance for low-income people who are ineligible for Medicaid).⁹⁹ Medicare FFS declined to participate, a disappointment for the planners.¹⁰⁰

Medicare is, as authorized by the ACA, participating in PCMH demonstration projects in several other states.¹⁰¹ The agency apparently preferred projects that had more of a focus on quality measures, did not preclude participation by small groups of providers, and were already implemented or soon to be implemented.¹⁰²

Having so many insurers involved was critical to this pilot's design. The practice changes are meant to apply—indeed under the pilot's rules *have* to apply—to all of a practice's patients.¹⁰³ If additional money is linked to only a fraction of the patients, there simply will not be, the argument goes, financing or incentives for broad-based transformation.

Single-payer pilots, as described above, have been significant in shaping the PCMH model. They have, though, tended to apply to relatively closed insurer-provider systems (as in the Group Health pilot) or to a limited high-needs population (as in the Boeing pilot). The new federal ACO program is a single-payer model (Medicare), but the expectation has always been that commercial payers would enter into similar agreements with the authorized ACOs.¹⁰⁴ Indeed,

⁹⁶ Telephone Interview with Richard Onizuka, PhD Health Care Policy Director, Washington State Health Care Authority (Nov. 23, 2010) (on file with author).

⁹⁷ *Multi-Payer Medical Home Pilot Launches*, *supra* note 92.

⁹⁸ Telephone Interview with Richard Onizuka, *supra* note 96.

⁹⁹ *Id.*

¹⁰⁰ *Id.*

¹⁰¹ *Id.*; see also *Multi-Payer Advanced Primary Care Practice Demonstration Fact Sheet*, CTRS. FOR MEDICARE & MEDICAID SERVS. (2012), available at http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/mapcpdemo_Factsheet.pdf.

¹⁰² Telephone Interview with Richard Onizuka, *supra* note 96.

¹⁰³ WASH. STATE HEALTH CARE AUTH., *supra* note 7, at 5.

¹⁰⁴ See Berwick, *supra* note 11, at 1753 (stating that new CMS programs are intended to work "in synergy with the private sector").

that has proven to be the case with the first group of organizations accepted into the program in April 2012.¹⁰⁵

The Washington pilot involves eight primary care practices at twelve clinic sites.¹⁰⁶ As specified in the Invitation to Apply, all are relatively advanced in their ability to provide comprehensive, coordinated care.¹⁰⁷ The sites do not need to be formally recognized as a PCMH or seeking that recognition.¹⁰⁸ They are expected to commit to key principles of the model and to “mak[ing] changes that *impact their entire practice population.*”¹⁰⁹ As is true of the Medicare ACO program, changes (such as care coordination and follow-up) cannot apply only to the population covered by the participating insurers. All of the chosen sites had been involved in the state’s earlier Medical Home Collaborative.¹¹⁰ State law authorized this two-year collaborative.¹¹¹ It was directed by the Health Care Authority and involved thirty-three clinics in a variety of information and learning activities.¹¹²

¹⁰⁵ Jenny Gold & Christian Torres, *ACOs Multiply as Medicare Announces 27 New Ones*, KAISER HEALTH NEWS (Apr. 10, 2012), [http://www.kaiserhealthnews.org/Stories/2012/April/10/ACO-Medicare-Shared-Savings-Program.aspx?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+khn%2Fheadlinesonly+\(All+Kaiser+Health+News+\(Headlines\)\)](http://www.kaiserhealthnews.org/Stories/2012/April/10/ACO-Medicare-Shared-Savings-Program.aspx?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+khn%2Fheadlinesonly+(All+Kaiser+Health+News+(Headlines))) (“[A CMS administrator] said many of the organizations are working with private health insurers to serve patients not in the Medicare program.”); CTRS. FOR MEDICARE & MEDICAID SERVS., FIRST ACCOUNTABLE CARE ORGANIZATIONS UNDER THE MEDICARE SHARED SAVINGS PROGRAM (Apr. 10, 2012), *available at* <http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4334&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&boOrder=date>.

¹⁰⁶ *Multi-Payer Medical Home Pilot Launches*, *supra* note 92. One of these clinics, I learned while doing this research, is where my own family practice physician practices. Since the pilot launched and as of this writing, I have not been to the clinic and have never spoken to her about it. As noted above, my husband’s family practice clinic is not involved in this pilot, but another within the University of Washington Neighborhood Clinics is.

¹⁰⁷ All participated in a prior, state-sponsored medical home collaborative that was intended to facilitate sharing of ideas for how to transform primary care practices. WASH. REV. CODE § 43.70.533 (2010) (authorization for collaborative).

¹⁰⁸ Telephone Interview with Richard Onizuka, *supra* note 96.

¹⁰⁹ WASH. STATE HEALTH CARE AUTH., *supra* note 7, at 5 (emphasis in original).

¹¹⁰ Telephone Interview with Richard Onizuka, *supra* note 96.

¹¹¹ WASH. REV. CODE § 70.54.380 (2010); *see also Patient-Centered Medical Home Collaborative*, WASH. ST. DEP’T OF HEALTH, http://www.medicalhome.org/physicians/learning_collab.cfm (last visited Oct. 2, 2012).

¹¹² WASH. STATE HEALTH CARE AUTH., *Medical Homes*, http://www.hca.wa.gov/medical_homes.html (last visited Oct. 2, 2012); *see also*

The Invitation to Apply provides some specifics. Eligible practices had to have at least 8,000 active patients, four or more full-time providers, and a focus on primary care.¹¹³ They also had to be paid mostly on a FFS basis, have at least a plan for a specific care coordination system, and use a patient registry for those with one or more chronic conditions or have an established EHR.¹¹⁴

The Invitation to Apply lists several factors, which, while not required, are desirable and considered likely for success. These include extended hours (e.g., weekday evenings and Saturdays), flexible access (e.g., email), and “a significant percentage of their [patients] covered by the participating health plans.”¹¹⁵ Additionally, the Invitation to Apply stresses that it is important to have, or be developing, a “system of communication with the hospital” utilized by most of the clinic’s patients.¹¹⁶ How will the clinic be notified that a patient was seen in the ER? How will discharge planning be coordinated?

One key issue with any type of enhanced primary care is figuring out the sweet spot for additional payments. Bruce Landon and others note that although the PCMH Joint Principles¹¹⁷ do not specify a particular reimbursement strategy, the PCMH model suggests a need for up-front funding.¹¹⁸ “The overriding policy concern related to the medical home model in the short term is determining the optimal way to finance its implementation.”¹¹⁹

What amount is enough to incentivize real practice transformation without consuming all downstream savings, assuming there are any? As Princeton health economist Uwe Reinhardt has noted, health care can legitimately absorb any dollar it is allocated.¹²⁰ Care coordination—with its phone calls, emails, and team meetings—can be extremely labor-intensive. The labor of nurses, physicians’ assistants, and doctors is not cheap. Neither is the cost of EHRs or extended office hours.

WASH. ST. DEP’T OF HEALTH, *supra* note 111.

¹¹³ WASH. STATE HEALTH CARE AUTH., *supra* note 7, at 5.

¹¹⁴ *Id.*

¹¹⁵ *Id.* at 6.

¹¹⁶ *Id.*

¹¹⁷ See AM. ACAD. OF FAMILY PHYSICIANS, *supra* note 52.

¹¹⁸ Landon et al., *supra* note 3, at 827.

¹¹⁹ *Id.* at 832.

¹²⁰ See *Healthcare Crisis: Who’s at Risk* (PBS television broadcast Nov. 3, 2000) (transcript available at <http://www.pbs.org/healthcarecrisis/transcript.html>) (paraphrasing Dr. Reinhardt’s comments).

The payment model for this pilot is a hybrid one, with FFS, CMF, and possible shared savings. After much negotiation, the pilot determined that the CMF will be \$2.50 per patient per month in the first year and, assuming no reduction for poor outcomes, \$2.00 per patient per month in the second and third years of the pilot.¹²¹ According to pilot director Richard K. Onizuka, PhD, arriving at these amounts was one of the challenging aspects of the project's design.¹²² The CMF amount is calculated to be the point at which the health plans' investment is equal to the estimated savings from expected reductions in hospital-based care.¹²³ The practices choose whether their metric will be preventable ER visits or preventable hospitalizations.¹²⁴

These new payments to the practices are in addition to fees received from the participating insurers. The regular FFS payments for office visits and other services do not change under this pilot. Medicare will continue to pay for its enrollees within these practices under its usual FFS reimbursement method. As a non-participant in the pilot, Medicare will not contribute a CMF, and neither will Medicaid FFS, non-participating commercial insurers, or self-pay patients.¹²⁵

The proposed Medicare ACO rules did not include the possibility of any upfront payments.¹²⁶ This was one of the many criticized aspects of the proposal. The final rules released in October 2011 do allow upfront payments from Medicare to those ACOs that are sponsored by physicians or by rural providers.¹²⁷ This change recognized that physician groups and rural hospitals in particular might lack the ready cash reserves needed to develop the infrastructure necessary for coordinated care.

The Washington pilot also has a shared savings component, much like the ACA's Medicare ACO program. If there are further reductions in preventable hospital-based care beyond the practice-specific targets, the practices that achieve these reductions will share

¹²¹ WASH. STATE HEALTH CARE AUTH., *supra* note 7, at 3.

¹²² Telephone Interview with Richard Onizuka, *supra* note 96.

¹²³ WASH. STATE HEALTH CARE AUTH., *supra* note 7, at 3.

¹²⁴ *Id.*

¹²⁵ See Telephone Interview with Richard Onizuka, *supra* note 96.

¹²⁶ Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 19528-01 (Apr. 7, 2011) (to be codified at 42 C.F.R. pt. 425).

¹²⁷ *Id.* at 67802.

with the relevant insurers in any savings.¹²⁸ The calculations as to usage and savings are to be done at the end of each pilot year.¹²⁹ As the pilot is still in its first year, there is no data yet.

The initial savings go first to the health insurers to recoup their CMFs.¹³⁰ Beyond that, the practice and the plans share additional savings equally.¹³¹ For example, in initial modeling, the break-even target for avoidable ER use is 17 percent (which would correlate with reduced overall ER use of about 10 percent) and 2 percent for avoidable hospitalization. Within the pilot, if a practice's patients reduce their avoidable ER use by more than 17 percent or avoidable hospitalization by more than 2 percent, the practice and the relevant insurers share in savings attributable to that further reduction. Each insurer reaps benefits proportionate to its share of the practice's population.¹³²

The practices have to maintain their own baseline quality measures.¹³³ The pilot defined 7 quality measures, and the practices must maintain a composite score across all indicators (within a 5 point corridor) on 7 out of 10.¹³⁴ As with the Medicare ACO, the quality measures relate to performance of recommended screenings (e.g., mammograms), management of chronic conditions (e.g., heart disease), and experience measures (as to both patients and physicians/staff).¹³⁵ The Medicare ACO program has a couple of key differences in this regard. First, it includes many more quality metrics—33, down from the 65 included in the proposed rules. Second, in a more classic pay-for-performance arrangement, successful ACOs will ultimately have to meet or exceed a uniformly applicable, standard quality level on the reported measures.¹³⁶

¹²⁸ WASH. STATE HEALTH CARE AUTH., *supra* note 7, at 3–4.

¹²⁹ *Id.*

¹³⁰ *Id.*

¹³¹ *Id.*

¹³² Medical Home Pilots: Washington State Plan for Implementation, webcast Aug. 5, 2010, available at <http://www.wsha.org/files/Medical%20Homes%20Pilot.pdf>.

¹³³ WASH. STATE HEALTH CARE AUTH., *supra* note 7, at 3–4.

¹³⁴ The Invitation to Apply specified 10 quality measures, *see* WASH. STATE HEALTH CARE AUTH., *supra* note 7, at 3–4; but the project ultimately settled on 7 for practical reasons. E-mail from Steve Lewis, Senior Health Policy Analyst, Wash. Health Care Auth., to author (Sept. 21, 2012, 16:10 PST) (on file with author).

¹³⁵ L. Gordon Moore, *Multi-Payer Reimbursement Pilot*, WASH. STATE HEALTH CARE AUTH. (2010), available at http://www.hca.wa.gov/medical_homes.html.

¹³⁶ Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. at 67872.

Unlike the Medicare ACO program, the practices in this pilot do face specific downside financial risk. Those practices that do not meet their quality or usage targets will see a reduction in the following year's CMF.¹³⁷ Rather than \$2.00 per member per month, it could go as low as \$1.00 per member per month.¹³⁸ Losing that much of the CMF is unlikely, however, as it is a staggered adjustment, not an all-or-nothing proposition.¹³⁹ In addition, as with any pilot of this nature, there is the general financial risk that the added payments will not cover the added expenses and that a shared savings expectation might be dashed.

VI. IS THERE NO PLACE LIKE HOME?

Washington's pilot should help identify a sweet spot for additional primary care reimbursement in a transforming health care system. Likewise, it should help identify barriers to effective practice transformation. It might also provide preliminary answers to some of the other questions swirling around PCMHs and ACOs. Definitive, fully transferable answers are unlikely. As with most pilots of this nature, its time frame is short and its evaluative framework is limited.¹⁴⁰ If change happens at the margins, though, perhaps guidance emerges from the footnotes.

A. *Isn't There a Better Name?*

As others have noted¹⁴¹ “medical home” conjures up visions of a “nursing home.” “Patient-Centered Medical Home” does not really change the vision much, is a mouthful, and sounds jargony. Are other clinics really “staff-centered” or “insurer-oriented”? “PCMH” has other problems, including that it is difficult to say. At least in health care, the readily used acronyms are either short (e.g., ER) or include at least one vowel (e.g., EMTALA) so they can be spoken as a

¹³⁷ WASH. STATE HEALTH CARE AUTH., *supra* note 7, at 3–4.

¹³⁸ *Id.*

¹³⁹ Telephone Interview with Douglas A. Conrad, PhD, Prof., U. Wash. Sch. of Pub. Health (Nov. 26, 2011) (on file with author); Telephone Interview with Richard Onizuka, *supra* note 96.

¹⁴⁰ See Landon et al., *supra* note 2, at 833 (discussing reasons why “it is not likely that existing patient-centered medical home demonstration projects will provide definitive answers”).

¹⁴¹ Diane R. Rittenhouse & Stephen M. Shortell, *The Patient-Centered Medical Home: Will It Stand the Test of Health Reform?*, 301 JAMA 2038, 2040 (2009); Murray Ross et al., *From Our Lips to Whose Ears? Consumer Reaction to Our Current Health Care Dialect*, 13 PERMANENTE J. 8, 11 (2009).

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word.

It could be possible to poll the clinics involved in the pilot project as well as those involved in the pre-cursor Collaborative. What terminology do they use to distinguish themselves in their advertising? What words do staff members use to describe their clinics to patients or other non-medical people? “Enhanced primary care” is an option, though a bit tepid. “Health care club” or “personal medical team” are not quite right, but at least have positive connotations. Reasons for the prevalence of the “PCMH” nomenclature probably relate both to its historical development and its linkage with possible certification by the NCQA as such.

B. How Necessary is a Formal Recognition System?

The Washington pilot does not require that the participating clinics seek NCQA recognition as PCMHs.¹⁴² For insurers, this designation might serve as ready shorthand for technical ability to provide the type of care that would justify increased primary care reimbursements. For the public, recognition and its attendant logo might indicate a type of primary care it values. For individual health care providers, it might suggest a clinic environment to seek, or to avoid. Of course, there are attendant costs, including NCQA fees, reporting obligations, and required processes. How does the value stack up against the costs?

This pilot proceeds independent of formalized markers of a PCMH. While there are some required and suggested proficiencies, the participating clinics had to meet few set structural standards. Thus, their experience might bear on the value of formal recognition or measurable standards. Did the participating clinics obtain NCQA recognition or do they intend to? The participating insurers could also weigh in. Some of them have a national presence and likely have opinions as to the uses of PCMH standards in different locales. It might be that insurers that offer additional payments for enhanced primary care effectively require some sort of formal PCMH designation.

C. What do Patients Perceive?

Providing “the right care to the right patient at the right time”¹⁴³

¹⁴² WASH. STATE HEALTH CARE AUTH., *supra* note 7, at 6 (noting that certification is considered but not required as part of selection process).

¹⁴³ *Accountable Care Organizations (ACO)*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Medicare/Medicare-Fee-for-Service->

does mean that some patients will get more physician time and more medical treatment and others will get less of both. An email exchange with a nurse might do for a discreet issue in a generally healthy patient. A patient with complicated chronic conditions, on the other hand, might be best served by pre-visit team meetings, hour-long appointments, follow-up emails, nurse house calls, and extra testing. Of course, the generally healthy patient might like all that too.

A YouTube video with cartoon characters and computer-generated speech illustrates this point (and other health policy issues):

“Hello. I am your doctor. Welcome to your patient-centered medical home. How may I help you?”

“My back hurts and I want an MRI scan.”

...

“Well, I looked it up [in our electronic health record] and you do not need an MRI. You should go away, take some acetaminophen, and rest.”

“I don’t want pills or rest. I want the scan. I looked this up on the Internet and I could have cancer or a disc or need an operation or need to see a neurosurgeon.”

“Why don’t I have you see one of our nurses, who can ask you a lot of open-ended questions?”

...

“Hey, I know you are getting paid like nine dollars a month to take care of me. . . . Maybe you should send me to a real doctor that can get an MRI scan.”

“If I do that, we will not achieve patient-centeredness, whole-person orientation, integrated care, and coordination. I also will not get pay-for-performance and your health insurance company will lose money, national health care trends will skyrocket, electronic medical record companies will go bankrupt, and to fix the budget we will have to sell California to the Chinese government.”

“I want an MRI scan.”

“OK. . . .”¹⁴⁴

While the Washington pilot does not focus on improving quality,

Payment/ACO/index.html (last visited Oct. 2, 2012).

¹⁴⁴ DMCareBlog, *Patient Centered Medical Home*, YOUTUBE (Sept. 21, 2010), <http://www.youtube.com/watch?v=k7VH9ykZSB0>. A similarly clever video pokes fun at negotiations between a PCMH and hospital to link together and set up an ACO. DMCareBlog, *Setting Up An Accountable Care Organization*, YOUTUBE (Oct. 20, 2010), <http://www.youtube.com/watch?v=ULy5vjcGuDc&feature=relmfu>.

one of the quality markers to be assessed is patient satisfaction.¹⁴⁵ As the managed care backlash of the 1990s shows, patient satisfaction is no small matter. If people—patients, providers, and the population at large—believe care is being compromised to save money, they will push employers, legislators, and insurers to change the model.¹⁴⁶

Other pilots have targeted the chronically ill and their needs for additional services; this pilot does not.¹⁴⁷ The selected clinics had to be primary-care oriented, ideally with most patients covered by the participating insurers.¹⁴⁸ Thus the population is almost by definition somewhat average for the locale, with high- and low-need patients, many of whom could use their insurance to obtain care elsewhere. Satisfaction indicators thus might be more transferable to the general population.

D. Will it Actually Save Money?

Providing enhanced primary care to a general population might both improve health outcomes and also *raise* overall costs. Good preventative care may promote all sorts of values without actually saving money, as Jessica Mantel notes in her article for this Symposium.¹⁴⁹ For a variety of reasons, it is hard to reduce medical interventions of marginal value. And of course, patients diagnosed early with a chronic condition may then live long lives on expensive medication. Medical testing can be costly, particularly when factoring in follow-up tests and false positives. And even if patients are offered coordinated care and flexible scheduling, the ER might seem more convenient.

One purpose of this pilot was to address the hesitancy of insurers to pay the upfront costs needed to transform primary care. Presumably, their hesitancy is not entirely irrational. “Tension exists between payers and policy makers,”¹⁵⁰ with the former seeking evidence of significant cost savings and the latter focused on shoring up primary care. For the pilot, one of the many bedeviling details was figuring out an appropriate CMF to test. What amount of upfront payment linked to a majority of a clinic’s patients will result

¹⁴⁵ WASH. STATE HEALTH CARE AUTH., *supra* note 7, at 25.

¹⁴⁶ See, e.g., Shortell, *supra* note 2, at 408 (discussing importance of public perception in acceptance of new organizational models).

¹⁴⁷ WASH. STATE HEALTH CARE AUTH., *supra* note 7, at 3.

¹⁴⁸ *Id.* at 5–6.

¹⁴⁹ Jessica Mantel, *Accountable Care Organizations: Can We Have Our Cake and Eat It Too?*, 42 SETON HALL L. REV. 1393 (2012).

¹⁵⁰ Landon, *supra* note 2, at 833.

in enough downstream savings to make the arrangement financially worthwhile?

Is it possible to recoup additional costs, including administrative costs, under this model? The results of this and other studies over the next several years should help answer this question. They should also help clarify the role of shared savings, whether merely hoped for or actually obtained. Determining the attributable costs is itself no small matter. For example, information technology is central to the model and expensive, but a robust EHR has a variety of other important uses. A robust EHR can, for example, facilitate medical research, support accurate billing, and qualify a facility for federal money meant to encourage “meaningful use” of electronic medical records.¹⁵¹ As with analysis of the Medicare ACO program, it will be important to determine which costs should be considered part of that particular change, and which should not.

E. Where Will the Providers Come From?

Enhanced primary care needs primary care providers. The country currently faces a shortage of primary care physicians and nurse practitioners, particularly in rural and inner-city areas.¹⁵² If the Massachusetts experience and common sense are predictive, adding millions to the rolls of the insured will exacerbate the problem. Assuming the ACA goes forward and adds millions to the insured rolls, the law’s provisions to increase primary care reimbursement and training should help somewhat.¹⁵³ There are, though, practice-related reasons for the shortage. Some of these might be addressed by the PCMH.

One of the quality measures in this pilot is the experience of providers and staff in the clinics.¹⁵⁴ The Group Health medical home pilot noted a reduction in measures of workplace stress and physician

¹⁵¹ See, e.g., Bradford H. Gray et al., *Electronic Health Records: An International Perspective on “Meaningful Use,”* 28 THE COMMONWEALTH FUND 1, 1 (Nov. 2011), available at http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2011/Nov/1565_Gray_electronic_med_records_meaningful_use_intl_brief.pdf.

¹⁵² Esme Cullen et al., *Primary Care Shortage: Background Brief*, HENRY J. KAISER FAMILY FOUND (Apr. 2011), <http://www.kaiseredu.org/Issue-Modules/Primary-Care-Shortage/Background-Brief.aspx>.

¹⁵³ See, e.g., Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 3021, 124 Stat. 389 (to be codified at 42 U.S.C. § 1315a) (testing new payment models), Pub. L. No. 111-148 § 5301, 124 Stat. 615 (to be codified at 42 U.S.C. § 293k) (primary care training and enhancement).

¹⁵⁴ WASH. STATE HEALTH CARE AUTH., *supra* note 7, at 25.

burnout,¹⁵⁵ and also showed an increase in satisfaction with work assignments.¹⁵⁶ It is hoped, of course, that this is an inherent feature of the PCMH and not a selection bias unique to that particular study.

F. Is This a Repeat of Past Reforms?

The managed care revolution of the 1980s and 1990s promoted integration and capitation. Both feature in current reform efforts, including accountable care and medical homes. Will today's efforts be different, or more successful? Writes one skeptic of the capitation model within ACOs: "The problem with this movie is that we've actually seen it before and it was a colossal and expensive failure."¹⁵⁷

As with any PCMH pilot, real savings are likely to come from efforts targeted at those with complex medical problems and/or high usage of hospital-based services. These high-cost patients will need to be effectively managed, but in ways that do not trigger another "managed care backlash." Ideally, this multi-payer, multi-site pilot will produce some indicia as to these patients' experiences in particular.

G. Will We See True Coordination?

Coordinated care requires coordination. That is not a strength of the current system. And the United States lags other industrialized countries in the adoption of the EHRs that help facilitate coordination.¹⁵⁸ Private-sector initiatives, as well as the recent federal initiatives and stimulus funding, promote adoption of these expensive systems.¹⁵⁹ Having an EHR doesn't mean, however, that others involved in a patient's care can easily use it; technological incompatibility and privacy concerns can get in the way. Entirely apart from these challenges, the siloed FFS system has not historically provided much incentive for robust cooperation. The incentives are changing, though, and have been prior to the ACA's boost.

This is apparent in the nationwide frenzy of affiliations, joint ventures, alliances, acquisitions, and mergers involving hospitals and

¹⁵⁵ Reid, *supra* note 58, at 837, 842.

¹⁵⁶ *Id.*

¹⁵⁷ FURROW, *supra* note 3, at 205 (citing Jeff Goldsmith, *The Accountable Care Organization: Not Ready For Prime Time*, HEALTH AFFAIRS BLOG (Aug. 17, 2009, 3:22 PM), <http://healthaffairs.org/blog/>).

¹⁵⁸ Gray et al., *supra* note 151, at 1.

¹⁵⁹ See, e.g., Health Information Technology for Economic and Clinical Health Act (HITECH), Pub. L. No. 111-5, Div. A, Title XIII, Div. B, Title IV, 123 Stat. 226, 467 (2009) (codified as amended in scattered sections of 42 U.S.C.).

physician groups.¹⁶⁰ Part of this is driven by the expectation that not all will survive. One talk at the Seton Hall Symposium was entitled “The Prospect of Being Hanged: Focusing the Physician Mind on ACOs.”¹⁶¹ As to hospitals, they need to seriously consider getting on the accountable care train or risk getting run over by those that have adopted a coordinated model. If there is less hospitalization, not all hospitals will survive.

PCMHs in general and this pilot in particular share many features of the Medicare ACO program and its incentives for care coordination. This pilot does not, however, require the solid linkages with hospitals and specialists that are a hallmark of accountable care.¹⁶² Hospitals and specialists will not share directly (or even necessarily indirectly) in savings that result from reduced usage of their services by patients in the participating primary care clinics.

One breakeven point for this pilot is calculated to be roughly a 17 percent reduction in avoidable ER visits by those patients.¹⁶³ The hope is that there will be even greater reductions, and thus savings shared between the clinics and the insurers. Will hospitals and specialists find a way to increase their usage and make up for their lost revenues in other ways, thus negating any overall savings? Or will there be other integrative affiliations, as formal ACOs or otherwise, that appropriately sort out the financing? Elliott Fisher, who has written extensively about ACOs and PCMHs, cautions that, to succeed, the PCMH “needs a hospitable and high-performing medical neighborhood.”¹⁶⁴ It needs connections to, and support from, the hospitals and specialists whose revenues it is intended to reduce.

H. Will Success be Transformative?

Assume that this pilot is wildly successful in all key aspects. Quality measures are stable, avoidable ER use is reduced by more than 17 percent, savings are shared, patients and staff are happy. Will its success translate to changes elsewhere in the country? Not necessarily. The “field of health care is littered with the corpses of

¹⁶⁰ Thomas L. Greaney, *Accountable Care Organizations, A New New Thing With Some Old Problems*, 3 HEALTH L. OUTLOOK 6, 8–9 (2010).

¹⁶¹ Hal Teitelbaum, CEO and Managing Partner, Crystal Run Healthcare, *The Prospect of Being Hanged: Focusing the Physician Mind on ACOs* (Oct. 28, 2011).

¹⁶² See Fisher, *supra* note 32, at 220.

¹⁶³ See Moore, *supra* note 135.

¹⁶⁴ Fisher, *supra* note 5, at 1205.

good ideas” and successful pilots.¹⁶⁵ The system’s fragmentation, cost, complexity, and ingrained interests can hinder adoption of novel ideas. Local successes often remain local.

Now, however, there are significant national forces supporting fundamental transformation of the health care financing and delivery systems. There is, of course, the ACA, with its new Medicare ACO program, and initiatives supporting PCMHs, bundled payments, and other measures. It is not just the federal law, though. National initiatives by insurers and employers are supportive of a transformation that rewards value, not just volume. This wide range of support should ensure attention to lessons from pilots, and perhaps broad adoption of their successful aspects.

VII. BUILDING BEFORE THE DRAFTING INK DRIES

Efforts to construct new payment and delivery systems are sure to continue whether the Affordable Care Act is repealed or re-energized, replaced or refined. There is simply too much interest from all quarters, too much concern about rising costs and lackluster quality outcomes. Construction is proceeding although there is no agreement on the best designs or financing models. Writing about the PCMH, Rittenhouse and Shortell conclude that “[m]arketplace and political realities will necessitate action on delivery system reform before evidence is available to determine the optimal course of action.”¹⁶⁶

It might well be true that the multiplicity of pilots and programs and demonstrations is a strength¹⁶⁷ and that “not knowing the final design should not deter us from beginning.”¹⁶⁸ Arguably, this is a situation in which a “more ‘intuitive’ approach to health policy” makes sense and “interventions will evolve over time based on [emerging] data.”¹⁶⁹ This has parallels to fast-track construction in which work begins on foundational elements that have a long lead time, although the building’s final design is incomplete.

¹⁶⁵ Aaron Katz, *Gawande and the “Great Idea” Theory*, SEATTLEPI.COM (Feb. 14, 2011, 5:00 AM), <http://blog.seattlepi.com/thehealthretort/2011/02/14/gawande-and-the-%E2%80%9Cgreat-idea%E2%80%9D-theory/>.

¹⁶⁶ Rittenhouse & Shortell, *supra* note 141, at 2040.

¹⁶⁷ Atul Gawande, *Testing, Testing*, NEW YORKER, Dec. 14, 2009, at 34 (“Almost half of [the Senate health reform bill] is devoted to programs that would test various ways to curb costs and increase quality. The bill is a hodgepodge. And it should be.”).

¹⁶⁸ John K. Iglehart, *No Place Like Home—Testing a New Model of Care Delivery*, 359 NEW ENG. J. MED. 1200, 1202 (2008).

¹⁶⁹ Landon et al., *supra* note 2, at 833.

This sort of expedited construction should encourage attention to model homes and their early lessons. The Washington State “Multi-Payer Medical Home Reimbursement Pilot” is meant to be an early step in a larger transition.¹⁷⁰ This larger transition is supported by the complicated rezoning effort that is the Medicare ACO program, the substantial federal effort that got underway about a year after Washington’s pilot launched.¹⁷¹

Results from the Washington pilot might also help answer some of the questions swirling around accountable care in general and the PCMH model in particular. This pilot should provide preliminary answers about the value of its alternative payment approach for PCMHs: continued FFS payments at the usual rates; a CMF of \$2.50 the first year and up to \$2.00 for the following two years; and the prospect of savings shared between the clinics and the insurers. Does this payment approach support the practice changes needed to cost-effectively reduce unnecessary ER visits and hospital admissions? To what extent will the clinics see shared savings? Will there even be any savings?

In addition, perhaps the study will discover a better, more appropriately evocative name for this type of enhanced primary care. It might also provide evidence about the value of a formal PCMH recognition system, whether by the NCQA or other set criteria. More fundamentally, will patients buy into this new delivery system, or will we see a twenty-first century version of the managed care backlash of the last century? And what about physicians, primary care and otherwise? Will there be true coordination and cooperation or, in the face of real threats to hospital and specialist reimbursements, opposition and obstruction? Even if this pilot and others like it succeed, will that success impact the broader system?

The ultimate issue is how these redesigned homes will fit into the rezoned medical neighborhood. As with any rezone, assessment of its results awaits development and usage. Although construction is well under way, the drafting plans are still new. They are still subject to revision. The ongoing Washington State pilot project, and others

¹⁷⁰ See WASH. ST. HEALTH CARE AUTH., *supra* note 94; *Model Homes*, WASH. ST. HEALTH CARE AUTH., http://www.hca.wa.gov/medical_homes.html (discussing the various pilot projects underway) (last visited Oct. 1, 2012).

¹⁷¹ Washington’s pilot launched in May 2011. See WASH. ST. HEALTH CARE AUTH., *supra* note 94.

The Medicare ACO program announced the first group of “pioneer” ACOs in December 2011, and the first group of regular ACOs in April 2012. See Press Release, U.S. Dep’t of Health & Human Servs., *supra* note 36.

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like it, might suggest blueprint revisions to better design medical homes for the changing health care neighborhoods.