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

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

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

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Building a Medical Neighborhood for the Medical Home

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

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

Table 1. Eligibility Criteria for Participation in Medical-Home Programs.*

Medical-Home Capacities	How Capacities Are Measured in Most Current Medical-Home Certification Programs
Improved access and communication	Have written standards for key components of access and communication (4 points) and use data to document how standards are met (5). Assess language preference and communication barriers (2). (Total: 11 points)
Use of data systems to enhance safety and reliability	Use data system for nonclinical (2) and clinical (6) information to track patients' diagnoses (4) and clinical status (6) and to generate reminders (3). Track referrals (4) and laboratory results systematically (7). Use electronic system to order, retrieve, and flag tests (6); write prescriptions (3) and check their safety (3) and cost (2); and improve safety and communication (4). (Total: 50 points)
Care management and coordination	Adopt and implement evidence-based guidelines (3) and use reminders for preventive services (4). Coordinate care with other providers (5) and use nonphysician staff to manage patient care (3). (Total: 15 points)
Support for patient self-care	Develop individualized patient care plans, which assess progress and address barriers to achieving plan goals (5). Actively support patient self-care (4). (Total: 9 points)
Performance reporting and improvement	Measure (3) and report performance to physicians in the practice (3) using standardized measures (2). Report performance externally (1). Survey patients about their experience (3). Set goals and take action to improve (3). (Total: 15 points)

* Qualification requirements for receiving extra payments under current medical-home demonstration programs generally rely on qualification as a patient-centered medical home by the National Committee for Quality Assurance, with greater payments generally granted to practices achieving higher scores (points are shown in parentheses). Practices are expected to perform the core functions of primary care, which include first contact and comprehensive care. Primary care physicians (in family medicine, general internal medicine, pediatrics, or osteopathic medicine) are generally the focus of these programs. Whether specialty practices should be eligible to participate is controversial.

quately reimbursed in current fee-for-service practice, such as care coordination outside the context of a specific office visit, the adoption of health information technology, and interaction with patients by telephone or e-mail. The payment reforms currently being tested generally involve an additional per-patient monthly payment to practices that meet the qualification requirements developed under the auspices of the National Committee on Quality Assurance (see Table 1). Although one recently announced demonstration program focuses on practices in a single integrated delivery system,[2] most current or planned projects simply select qualified practices in a region or state.

Expectations are high. States, health plans, and the Medicare program are making substantial financial bets that implementation of the medical home will lead not only to improved care but also to long-term savings, largely by reducing the number of avoidable emergency room visits and hospitalizations for patients with serious chronic illness. Some see the medical-home model as a means of reversing the decline in interest in primary care among medical students and residents, and others argue that broad implementation would reduce health care spending overall.[3]

But there are several barriers that require attention if the medical home is to live up to its promise. First, effective care coordination for patients with either acute or chronic conditions requires not only full access to all the necessary clinical information obtained at multiple sites (physicians' offices, laboratories, hospitals, and nursing homes) but also a willingness by all the physicians involved in a patient's care to participate in collaborative decision making. The current medical-home model rewards practices for establishing electronic health records, regardless of how well they are integrated with other providers' systems, and leaves coordination entirely up to the primary care physician. There are no incentives for other physicians or hospitals to share information, improve coordination, or support shared decision making for patients who are in the medical home.

Second, it is still unclear how the public and other providers will respond to the model. Early reports from focus groups suggest that the term "medical home" makes many consumers think of nursing homes, with all the unfortunate connotations. Although the approach may be most likely to succeed when patients are required to choose a medical home, the public's enthusiasm for gatekeepers was sorely tested in the 1990s. Whether other physician groups support the strategy will depend on how it is implemented. To the extent that

Table 2. Strengthening Medical-Home Models.

Barrier to Success of Medical Home	Approaches to Overcoming Barrier
Resistance to collaboration	**Share information among providers**
There are few incentives for hospitals and specialists to collaborate with primary care physicians	Require medical homes to specify practice network for performance measurement and information sharing
Single-practice data systems are insufficient	Require providers to meet connectivity standards
Lack or uncertainty of public and political support	**Establish performance measurements and rewards**
Acceptability to patients is unknown; fear of gatekeeping could undermine	Institute transparent performance measurement across continuum of care
Specialists will probably oppose if their incomes are threatened	Reward collaboration through payment updates, pay for performance, or shared savings
Difficulty controlling costs	**Institute broad accountability for population-based costs**
There are outside influences on costs	Foster integrated delivery systems that share savings from improved quality of care and lower costs for all patients
Savings in a subpopulation are probably offset by increased spending in others	

Medicare or other payers strive to keep the overall pool of physician-payment funds constant, any increase in total payments to primary care physicians would have to come at the expense of payments to other physicians — surely a nonstarter.

Finally, it is far from clear how spending more on medical homes will lead to lower overall spending. Most of us believe that improved care coordination and more effective disease management will result in better quality and lower utilization rates among patients in medical homes. But whether these savings will more than offset the increased payment to those medical homes is doubtful. Moreover, several countervailing forces may limit the effect of the medical home on spending. In current medical-home models, primary care physicians have no real leverage to persuade specialists to change their practices in keeping with the goals of the program. To the extent that the income of other providers continues to depend on service volume, it is unlikely that either specialists or hospitals will respond to fewer visits and stays from medical-home patients by allowing their incomes to fall. Given the discretionary nature of most clinical decisions — for instance, choices about how frequently to see patients with chronic illnesses or to order diagnostic tests — the response of these providers will probably be to increase the volume (or intensity) of the services they provide to other patients to maintain their current incomes. The gains in quality may be valuable in their own right, but advocates need to recognize the underlying determinants of health care spending.

These barriers all point to the importance of context: patients and other health care providers have key roles to play in the success of the model. Success will be more likely if primary care reforms such as the medical-home model are aligned with reform strategies that foster shared accountability among all providers for measurably and transparently improving the quality of care and reducing its cost.[4] Several approaches to overcoming these barriers should be considered (see Table 2).

The first is to make sure that steps toward implementation of medical-home models are aligned with the more general long-term goals of effective communication and care coordination among all providers. Most physicians already practice in coherent and stable local referral networks.[5] Continued (or increased) payments to the medical home could be based on stepwise progress toward shared electronic health records and communication standards in an explicitly delineated local practice network.

Second, performance measures should be broadened to include comprehensive evaluations of patients' experiences with care (including the effectiveness of care coordination), routine assessment of functional outcomes (that is, whether patients' health and quality of life are actually improved as a result of care), and the total costs for all patients in these defined networks. Advances in measurement have made the adoption of reliable performance measures in these domains feasible; transparency would not only be reassuring to the public but would also augment the effectiveness of professional norms, giving primary care physicians, specialists, and hospitals an incentive to collaborate effectively to improve

the coordination of care and mend the current fragmentation of the delivery system.

The third step would be to explore ways of integrating medical-home payments with other approaches to payment reform that foster shared accountability and shared rewards among all providers across the continuum of care. Medicare's Physician Group Practice demonstration, for example, offers each participating group of physicians (and its affiliated hospitals) a share of any savings achieved from providing better and more cost-efficient care to the Medicare beneficiaries who receive the preponderance of their care from that group. Such an approach would provide an incentive for all providers in the group to work together to improve coordination and reduce costs. And the opportunity for shared savings could allow physicians' net incomes to be preserved even while their total billings declined.

The medical home has great potential to improve the provision of primary care and the financial stability of primary care practice. What has been missing so far has been an effort to implement this model in concert with other reforms that more effectively align the interests of all physicians and hospitals toward the improvement of patient care. To deliver on its promise, the medical home needs a hospitable and high-performing medical neighborhood.

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