From Concierge Medicine to Patient-Centered Medical Homes: International Lessons and the Search for a Better Way to Deliver Primary Health Care in the U.S

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From Concierge Medicine to Patient-Centered Medical Homes: 
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Gwendolyn Roberts Majette

I. INTRODUCTION

Primary care is crucial to the United States health care system. It is essential to the provision of high quality care; including the ability to reach health outcomes, ensure patient satisfaction, and facilitate efficient resource

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use. Primary care also places strong "emphasis on health promotion, disease prevention, and care of the chronically ill."

Physicians have introduced two business models in their attempts to improve the delivery of primary care: Concierge Medicine ("CM") and the Patient Centered Medical Home ("PCMH"). Both models provide personalized, comprehensive preventive care services.

CM is a private medical practice in which the physician charges patients an annual fee to be a patient in the practice. In exchange, the physician limits the number of patients in order to offer more personalized services and amenities such as: direct access through email or cell phone, same day or next day appointments, longer, more personalized appointments, house calls, and physician accompaniment to a specialist.

PCMH is defined by six characteristics: "(1) personal physician, (2) physician-directed medical practice, (3) whole-person orientation, (4) coordinated care, (5) quality and safety, and (6) enhanced access." In the PCMH model, the personal physician ensures that patients have access to coordinated and managed care that is continuous, comprehensive, preventive, and evidence-based.

For a significant portion of the U.S. population access to primary care services is provided through government programs. The United States Congress is responsible for designing, implementing, and overseeing Medicare, Medicaid, and SCHIP - the governmental programs that pay for health care services for the elderly, disabled, poor, and children. Congress' chief goals in these programs are to ensure improved health and to control costs. Congress' response to CM and PCMH has been diverse. Several bills were introduced to prohibit the use of CM, while legislation has been enacted and proposed to begin demonstration projects in Medicare, Medicaid, and SCHIP using PCMH.

The congressional decision to test the ability of the PCMH to deliver quality, cost-effective care to the Medicare, Medicaid, and SCHIP populations through demonstration projects is the better health policy decision.

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1. Inst. of Med., Primary Care in America: America's Health in a New Era 18 (1996) [hereinafter Primary Care in America].
2. Id.
6. See infra notes 73, 76, and 90 and accompanying text.
Widespread adoption of the PCMH is better than CM as a model to deliver primary care in the U.S. from a quality, cost, and access perspective. This conclusion is based on the World Health Organization’s Health for All agenda and the experiences of the Netherlands, the United Kingdom, and Belgium.\(^7\)

This paper will proceed in eight parts. Part II explores why primary care is a critical component of a country’s health care delivery system. Part III describes patient and physician dissatisfaction with the current state of primary care delivery in the United States. Parts IV and V describe physician-designed solutions and Congress’ responses to them. Part VI describes the role of primary care in the delivery of health services in the international context by focusing on the World Health Organization’s Health for All policy and the policies supporting primary care in the United Kingdom, the Netherlands, and Belgium. Part VII identifies the international health policies that are consistent with those of the PCMH. Part VIII identifies and analyzes the lessons that can be learned from the international context that demonstrate that widespread promotion of the PCMH model is sound health policy. Finally, Part IX provides recommendations for future legislation to maximize the benefits that will result from using the PCMH to improve beneficiary health outcomes and provide cost-effective health care.

II. PRIMARY CARE, ITS MEANING AND ITS BENEFITS TO THE HEALTH CARE SYSTEM

The term primary care was first introduced in 1961.\(^8\) Primary care is “the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.”\(^9\) The four main features of primary care are “(1) first-contact access for . . . new [health care] need[s]; (2) long-term person focused care (not disease focused); (3) comprehensive care for most health needs; and (4) coordinated care when it must be sought elsewhere.”\(^10\)

Empirical evidence shows that primary care improves “the overall performance of a health care system” by making it more efficient, effective, and accessible.\(^11\) Primary care improves the population’s health through:

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\(^7\) See discussion infra Part VIII.

\(^8\) Primary Care in America, supra note 1, at 27.

\(^9\) Id. at 31. Primary care is less complex and specialized than secondary care and tertiary care. “Secondary care is medical care provided by a specialist or facility upon referral by a primary care physician that requires more specialized knowledge [sic], skill, or equipment than primary care . . . .” Dictionary.com, primary care, http://dictionary.reference.com/browse/secondary care (last visited Nov. 08, 2009) (citing Merriam-Webster’s Medical Dictionary (2002)). It is the level of care normally provided by a community hospital. Primary Care in America, supra note 1, at 27. Tertiary care is “highly specialized medical care usually provided over an extended period of time that involves advanced and complex procedures and [sic] treatments performed by medical specialists in state-of-the-art facilities” such as medical centers and teaching hospitals. Dictionary.com, tertiary care, http://dictionary.reference.com/browse/tertiary care (last visited Nov. 08, 2009) (citing Merriam-Webster’s Medical Dictionary (2002); Primary Care in America, supra note 1, at 27.


\(^11\) Primary Care in America, supra note 1, at 72.
increasing access, especially among the disadvantaged; improving quality; emphasizing preventive services; identifying and beginning early health management to prevent hospitalization or use of emergency services; and decreasing the need for specialist care. Primary care lowers disparities in the population's health and generally reduces aggregate health expenditures. However, expanding primary care does not necessarily lead to lower costs because previously unmet needs are identified and expanded access can lead to increased utilization of services.

With respect to individuals, primary care is valuable because it provides a place where patients can bring a wide range of health problems for appropriate [care]...; it guides [the] patients through the health system; ... it facilitates an ongoing relationship between patients and clinicians...; [and] it helps build bridges between personal health care services and patients' families and communities.

III. U.S. HEALTH CARE SYSTEM: DISSATISFIED PHYSICIANS & PATIENTS

The benefits of primary care are not being fully realized because of problems that exist within the United States health care system. Some chief concerns include fragmented delivery of services, high prevalence of medical errors, and high health care expenditures. For primary care physicians in particular, residual problems exist because of the unintended consequences of implementing managed care to control costs. Managed care was initially viewed as a means to "manage care and organize a fragmented and wasteful health care system." The system was intended to emphasize primary care and be structured around the family physician and other primary care providers.

But instead, managed care has brought an erosion of trust between the physician and the patient. The envisioned role of primary care provider as gatekeeper eroded trust because the physician was not seen as acting in the best interest of the patient and as being a gateway to appropriate care, but instead viewed as the managed care organization's agent charged with limiting care to control costs. A second consequence was disruption of

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12 Starfield, supra note 10, at 474.
14 Primary Care in America, supra note 1, at 53.
15 Comm. on Quality of Health Care in Amer., Inst. of Med., Crossing the Quality Chasm, A New Health System for the 21st Century 44-46 (2001) [hereinafter Crossing the Quality Chasm].
17 Kahn, supra note 16, at S5.
18 Id.
19 Id.
sustained physician-patient relationships. Here low managed care prices and employer decisions to change benefit plans encouraged patients to switch from health plan to health plan, and from provider to provider. Third, the low reimbursement rates generally paid to primary care physicians, the discounted rates imposed during the managed care era, and "flat or declining fees from public and private payers" required physicians to seek higher volumes of patients in order to maintain profitability. \(^{20}\) Higher volumes led to rushed appointments and more focus on disease treatment instead of prevention. \(^{21}\) With the exception of the gatekeeper issue, primary care physicians still encounter many of these problems.

In the managed care environment, primary care physicians could not deliver health care in a manner that was professionally or financially \(^{22}\) rewarding. Many physicians became dissatisfied and physicians reported being "frustrated, angry, and overwhelmed." \(^{23}\) A survey published by the Kaiser Family Foundation in 2006 noted that forty-seven percent of physicians reported that their enthusiasm for practicing medicine had lessened over the last five years and eighty percent noted that the overall morale of physicians had decreased. \(^{24}\) Another thirty-eight percent would not recommend the practice of medicine to a young person. \(^{25}\) Dissatisfaction also affected medical students' residency selections. From 1998 to 2002 there was a decline in the enrollment of family practice residency programs. Additionally, a significant number of physicians over 50 years of age left the practice of medicine or retired early. \(^{26}\) This decreased physician satisfaction, the decision by medical students to reject primary care as a specialty, and the early retirement of many physicians over 50 has created primary care physician shortages that are likely to persist in the future.


\(^{22}\) Physicians across the United States are experiencing financial pressures. The Center for Studying Health System Change (CSHSC) in its report, Losing Ground: Physician Income, 1995-2003, notes that physicians overall saw a 7.1% decline in real income between 1995 and 2003. "Primary care physicians fared the worst with a 10.2% decline." The report cites "flat or declining fees from both public and private payers [as] a major factor underlying declining or stagnating real incomes for physicians," Tu & Ginsburg, supra note 20, at 1, 3.

\(^{23}\) "House Calls are Back - For a Price: Plush Practices on the Rise, Med. Ethics Advisor, Feb. 1, 2002 [hereinafter House Calls are Back].

\(^{24}\) KAISER FAMILY FOUND., NATIONAL SURVEY OF PHYSICIANS 2 (2006) [hereinafter 2006 PHYSICIAN SURVEY]. In 2002, fifty-eight percent of physicians reported that their enthusiasm for practicing medicine lessened over the last five years, and eighty-seven percent responded that physician morale had gone down. Kaiser Family Found., National Survey of Physicians 2 (2002) [hereinafter 2002 PHYSICIAN SURVEY].

\(^{25}\) 2006 PHYSICIAN SURVEY, supra note 24, at 2. In 2002, 48% of physicians would not recommend the practice of medicine to a young person. The primary reasons that physicians would not recommend the practice of medicine to a young person reflect the primary negative impact that managed care has on medicine: Paperwork/red tape/administrative hassles (57%), Loss of autonomy (45%), Inadequate financial rewards (31%). 2002 Physician Survey, supra note 24, at 2.

Dissatisfaction with the current state of health care delivery extends to patients as well. Typical patients want "easy, quick, reliable access to a source of care seven days a week, twenty-four hours a day." They also want the health care provider to "know [them], have [their] records, care about [them], take continuing responsibility for [them], and guide [them] through the labyrinth" of the healthcare maze. This type of access is rare in our present system.

Patients' chief complaints include long waits to schedule appointments, long stays in the waiting room, and rushed appointments. In 2006, a survey of United States residents found that fifty-one percent of respondents were dissatisfied with their healthcare. Based on an earlier survey, forty percent agreed that the quality of care had worsened in the previous five years.

IV. PHYSICIANS PROPOSE TWO SOLUTIONS: CONCIERGE MEDICINE AND THE PATIENT-CENTERED MEDICAL HOME

Physician frustration led to the creation of a new business model: concierge medicine ("CM"), and revitalization of an old model: the patient-centered medical home ("PCMH"). Both models focus on providing personalized primary care that is comprehensive and emphasizes preventive care. Both models feature enhanced and convenient access to health care services.

A. CONCIERGE MEDICINE (CM)

Concierge medicine is a private medical practice in which the physician charges patients an annual fee to be a patient in the practice. In exchange, the physician limits the number of patients he or she accepts in order to offer more personalized services and amenities. In concierge practices, physicians focus on addressing patients' chronic and acute health care issues while providing preventive health care services and working to change patient behavior to facilitate better health. Given the comprehensive focus of concierge medicine, a wide range of patients benefit from use of this delivery model, including health conscious individuals, urban professionals, those with

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28 Fuchs, supra note 27, at 69.
29 Id.
33 CAO Concierge Report, supra note 3, at 1.
complicated medical conditions, the wealthy, and those that choose to allocate their resources to focus attention on health issues. 34

Dr. Howard Maron started the first concierge practice, MD2, in 1996. Dr. Maron was the former physician of the Seattle Supersonics basketball team and was in charge of VIP medicine at the 1990 Seattle Goodwill Games. 35 Dr. Maron's business model for MD2 was to provide custom medical care in which the doctor, equipment, pharmaceuticals, and staff are brought to the patient to meet the patients' unique needs. 36

In 2001, a Florida company, MDVIP, expanded the availability of concierge medicine by providing custom medical care at a significantly reduced rate. 37 As of 2004 there were at least 145 concierge physicians in the United States. 38

Concierge Medicine is an urban phenomenon, occurring mostly on the east and west coasts. Practices are in 25 states and concentrated in California, Florida, Washington, and Massachusetts. 39

Concierge physicians are largely primary care physicians, most commonly from disciplines like internal medicine and family practice. The physicians are also generally seasoned, averaging about 19 years of practice. 40

While the traditional primary care practice has 2,500 to 5,000 patients, 41 the typical concierge practice averaged 491 patients in 2004. 42 The cost of concierge services varies from $60 to $15,000 per year, and the most frequently reported annual fee was $1,500.43

Concierge practices offer a variety of services which can be grouped in three categories: (1) services not covered by insurance or services subject to coverage limitations; (2) access to the physician and patient convenience; and (3) amenities. Services included in concierge practices that are not covered by insurance or subject to coverage limitations typically include periodic preventive care physical examinations, wellness planning, exercise management, nutrition, weight loss programs, smoking cessation, and stress reduction counseling. 44 Patient convenience and access services include:

35 Brubaker, supra note 30, at 78.
37 Id.
38 Id. at 9.
39 Id. at 12.
40 Id.
41 Max P. Rosen, et. al., American Medical Association Teleconference: Physician Entrepreneurs: On the Cutting Edge of Technology and Care, Feb. 15, 2003, (on file with the author); Wagner, supra note 36, at 32.
43 Eighty percent of the concierge physicians that responded to the GAO questionnaire "reported annual fees from $500 to $3,999." GAO Concierge Report, supra note 3, at 12. A small percent of physicians "waived the membership fee for some of their concierge patients." Id.; Council Report, supra note 36, at 2.
44 GAO Concierge Report, supra note 3, at 16; Guglielmo, supra note 30, at 67; Rosen, supra note 41; Wagner, supra note 36, at 1, 3; Ronni Sayewitz, Retainers for Doctors Under Attack, S. Fla. Bus. J, April 12, 2002; House Calls are Back, supra note 22. If health insurance policies cover these services they are generally limited. For example, since passage
telephone and email consultations; priority, same-day, or next day appointments for non-urgent matters; longer, more personalized appointments that allow the physician to interact more fully with the patient; house calls or workplace consultation; accompaniment to specialist appointments; transportation to and from the office; and prescription delivery. Amenities can include a waiting area that provides coffee, cake, and fruit for the patients, or they can be upscale and include private waiting areas, monogrammed bath robes, and marble hallways.

B. PATIENT-CENTERED MEDICAL HOME (PCMH)

A PCMH provides a "continuous relationship with a personal physician" who cares for the whole person. There are six characteristics to the PCMH model of delivery: [1] a personal physician, [2] physician-directed care for the whole person.

of the Medicare Improvement and Modernization Act in 2003, Medicare provides a one-time "Welcome to Medicare" exam which is a preventive evaluation and management service. To be covered the benefit must be taken advantage of within 12 months of joining the Medicare program. Centers for Medicare and Medicaid Services, Overview: Welcome to Medicare Visit, http://www.cms.hhs.gov/pdf/printpage.asp?ref=http://www.cms.hhs.gov/WelcometoMedicareExam/Overview.asp. However, the Medicare program does not cover a routine physical exam or check-up physical that some physicians provide annually or biannually. CMS. FOR MEDICARE & MEDICAID SERV., THE GUIDE TO MEDICARE PREVENTIVE SERVICES FOR PHYSICIANS, PROVIDERS, SUPPLIERS AND OTHER HEALTH CARE PROFESSIONALS 19 (3d ed. 2009), available at http://www.cms.hhs.gov/MINProducts/downloads/mps_guide_web-061305.pdf [hereinafter, MEDICARE PREVENTIVE SERVICE GUIDE]. In order for a beneficiary to receive counseling on his/her diet, he/she must generally have a condition or disease, such as being overweight or having diabetes or high cholesterol. MEDICARE PREVENTIVE SERVICE GUIDE, supra at 21, 43, and 53.

This can include 24 hour pager or cell phone access to the physicians.

The ability to provide longer appointments is an important feature because it facilitates the practice of medicine in ways consistent with the recommendations of physicians from five countries on means that can improve the quality of care. Those means include spending more time with patients, improving access to preventive care, and providing better patient education. Robert J. Blendon, et al., Physicians' Views on Quality of Care: A Five-Country Comparison, 20 HEALTH AFF. 233, 238 (2001) (surveying physicians from Australia, Canada, New Zealand, England, and the United States). By spending more time with patients, physicians have the ability to incorporate treatment methods that help patients change behavior and adhere to treatment protocols. Gretchen L. Zimmerman, et al., A "Stages of Change" Approach to Helping Patients Change Behavior, 61 AM. FAMILY PHYSICIAN 1409, 1411-12 (2000). This model has 6 stages: Precontemplation, contemplation, preparation, action, maintenance, and relapse. A physician must first assess where a patient is with respect to changing behavior that affects health. Once that is done the physician can adjust their medical advice accordingly. The physician can implement the model in longer visits or brief counseling sessions lasting 5 - 15 minutes. Id. at 1409-10.

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The American Academy of Pediatrics (“AAP”) introduced the [first] medical home [model] in 1967” to improve the care provided to children with special needs.53 In 2004, the Future of Family Medicine Project expanded the model to create the patient-centered medical home and “called for every American to have a ‘personal medical home.”54 Today, four primary care physician organizations encourage use of the PCMH: (1) the American Academy of Family Physicians, (2) the American Academy of Pediatrics, (3) the American College of Physicians, and (4) the American Osteopathic Association.55

In a PCMH, each patient in the practice is assigned to a team of health care professionals who are responsible for that patient’s ongoing care.56 The team is directed by a personal physician. The personal physician provides acute, chronic, and preventive care, as well as care for all stages of life, including end-of-life.57 The personal physician coordinates care across providers and in the patient’s community.58 To ensure clinical quality, physician decision-making is evidence-based.59 In addition, patients are involved in their treatment decisions and trained to manage their health conditions.60

Current fee-for-service payment systems create barriers to use of the PCMH model by paying each provider separately and emphasizing treatment for acute conditions and face-to-face care.61 In fact, the current reimbursement system in the United States does not reimburse physicians for the time that they or their staff provide coordinating care between the practice, specialists, ancillary health care providers and community.

57 Coordinated care manages referrals, connects patients to care outside the competence of the physicians. “Primary care physicians are central to efforts to improve care coordination by managing referrals and connecting care and medical information over time and across settings.” Robert J. Blendon, et al., On the Front Lines of Care: Primary Care Doctors’ Office Systems, Experiences, and Views in Seven Countries, 25 HEALTH AFF.-WEB EXCLUSIVE w555, w560 (2006) [hereinafter PCP Office Systems].


59 Id. at 38.

60 Id.

61 Id. at 38.


63 Id.

64 Id.

65 Id.

66 Id. The traditional health care system is designed for passive patients who do not get involved in self-management of their care because it is assumed that their illness or injury is acute and will resolve itself in days or weeks through the use of short-term treatment. Thus, the traditional health care system is not designed to adequately treat or support patients with chronic disease. MedPac, Report to the Congress: Increasing the Value of Medicare 35 (2006) [hereinafter MedPac Report: Increasing the Value of Medicare].

In this environment, many patients do not receive recommended care and suffer harmful consequences such as unnecessary hospitalization. Studies show that coordination of care across clinicians and settings improves efficiency and produces better clinical outcomes. Accordingly, efforts are being made to amend Medicare reimbursement legislation to compensate physicians for care coordination and care management. Additionally, private insurers are launching pilot projects that "pay participating physicians a per-member-per-month care management fee in addition to fee-for-service payments."

V. CONGRESS RESPONDS DIFFERENTLY TO THE PRIMARY CARE DELIVERY MODELS

The congressional response to these two primary care models has been diametrically opposed. Several bills were introduced to prohibit the use of concierge medicine with Medicare beneficiaries while legislation has been enacted and proposed to begin demonstration projects in Medicare, Medicaid, and SCHIP using the PCMH.

A. CONGRESSIONAL RESPONSE TO CONCIERGE MEDICINE

Several congressmen were concerned about the use of the concierge business model to treat Medicare beneficiaries because of the potential financial burden imposed on elderly patients and the possibility that the model would limit access to care.

Third-party payers use charge limitations to help control the cost of health care services paid by insured patients. Charge limitations are designed to control the reimbursement rate that physicians receive from third-party payers. Charge limits also can prevent balance billing. Balance billing occurs when a physician contractually agrees with a third-party payer to be

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62 Backer, supra note 52, at 39; Medicare Physicians Hearings, supra note 56 (testimony of Rick Kellerman, M.D., President, American Academy of Family Physicians).
63 MEDPAC REPORT: INCREASING THE VALUE OF MEDICARE, supra note 61, at 15; see also Elizabeth A. McGlynn, et al., The Quality of Health Care Delivered to Adults in the United States, 348 NEW. ENG. J. MED. 2633, 2643 (2003) (noting that on average, adult Americans receive about half of the recommended medical care for acute and chronic conditions as well as preventive care).
65 The American Academy of Family Physicians has recommended to Congress that it adopt the "Patient-centered Medical Home as an interim component of [the] physician payment while awaiting ... [the] results of the [medical home] demonstration" authorized under the Tax Reform and Health Care Act 2006. Medicare Physicians Hearings, supra note 56 (testimony of Rick Kellerman, M.D., President, American Academy of Family Physicians). Staff at the Centers for Medicare and Medicaid Services has already begun working on defining a CPT code for care management. Backer, supra note 52, at 39.
66 Backer, supra note 52, at 39.
reimbursed at a certain rate for providing a medical service and then attempts to collect the balance of the amount charged from the patient.\textsuperscript{68}

For example, in the Medicare program the two primary methods of reimbursement for physicians place limits on what physicians may charge Medicare beneficiaries. Physicians can agree to an accepted fee as a participating provider. Alternatively, the physician can choose to be a nonparticipating physician and be limited to charging a percentage of the Medicare fee schedule.\textsuperscript{69} The only way physicians are not limited in what they charge the beneficiary is by not participating or opting out of the Medicare program.\textsuperscript{70}

Given the Medicare reimbursement limits, concerns about concierge medicine and its use with Medicare beneficiaries were raised explicitly in a letter from several congressmen to then Secretary of Health and Human Services, Tommy Thompson. This letter alleged that physicians who established concierge practices and treated elderly patients were unlawfully billing Medicare in excess of Medicare allowable rates.\textsuperscript{71}

Secretary Thompson replied to the congressmen by letter that it was not clear that concierge practices, which offer patients a package of non-covered services for an annual fee, violate the law. The Secretary reasoned that the Medicare limits on physician charges only govern Medicare-covered services. To the extent that the concierge fees are for non-covered services, there is no violation of Medicare law.\textsuperscript{72}

In response to Secretary Thompson's letter, several congressmen proposed legislation that would bar physicians from charging Medicare beneficiaries a concierge fee unless the physicians totally opted out of the Medicare system.\textsuperscript{73} This proposed legislation, however, was never enacted.

\textsuperscript{68} Massachusetts Med. Soc'y v. Dukakis, 815 F.2d 790, 799 (1st Cir. 1987).

\textsuperscript{69} Non-participating providers are limited to charging 115\% of the Medicare physician fee schedule. 42 U.S.C. § 1395w-4(g)(2) (2006).

\textsuperscript{70} When physicians opt out of Medicare and serve Medicare patients, this is called private contracting. There are specific procedures that a physician must follow to opt out of Medicare. The physician must secure a written contract with the patient that explains that he/she is not accepting Medicare. Neither the patient nor the doctor can bill Medicare for the medical services that are provided. The physician must explain to the patient that the patient is solely responsible for paying the medical bill. The doctor must agree to opt out of the Medicare system for two years. This means the physician can not bill Medicare for any services for two years. 42 U.S.C. § 1395(a)(b) (2006).


\textsuperscript{73} In 2001, Senator Nelson introduced Senate Bill 1592. In 2002, Congressman Cardin introduced House Bill 4752. This bill was co-sponsored by Congressmen Waxman, Stark and Brown. Additionally in 2002, Senator Bill Nelson from Florida introduced Senate Bill 1606. In 2003, Medicare Equal Access to Care Act 2003 was introduced in the House of Representative by Congressman Cardin as House Bill 2423 and in the Senate by Senator
Subsequently, in 2003 Congress required the Government Accounting Office (GAO) to study concierge medicine and its impact on Medicare beneficiaries. In 2005, the GAO concluded that "the small number of concierge physicians makes it unlikely that the approach has contributed to widespread access problems."

B. CONGRESSIONAL RESPONSE TO THE PATIENT-CENTERED MEDICAL HOME

In contrast, the Congressional response to PCMH has been positive. Congress has enacted legislation authorizing demonstration projects using the PCMH model under Medicare and introduced a bill to conduct demonstration projects under Medicaid and SCHIP.

1. Tax Relief and Health Care Act of 2006

Section 204 of the Tax Relief and Health Care Act of 2006 (TRHCA) requires the Secretary of Health and Human Services to conduct medical home demonstrations in the Medicare program for 3 years in up to 8 states. The Medicare medical home demonstration was originally scheduled to begin in September 2008, but will not begin until the Office of Management and Budget approves the design of the demonstration.

The medical home is a physician practice that provides "targeted, accessible, continuous and coordinated, family-centered care to high-need populations." High-need populations are defined as "individuals with multiple chronic illnesses that require regular medical monitoring, advising, or treatment." The personal physician must be "board certified," provide "first contact and continuous care," and have "staff and resources to manage the comprehensive and coordinated health care" of patients. The personal physician is responsible for advocating, supporting, and guiding a plan of care.

Nelson as Senate Bill 345. Congressman Cardin's bill was co-sponsored by Congressmen Waxman, Brown of Ohio, Congressman Stark, and Congressman Kleczka. Senator Nelson's bill was co-sponsored by Senators Kennedy, Graham, Edwards, and Sarbanes. 

75 GAO CONCierge REPORT, supra note 3, at 4.
76 Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, § 204(a)-(b), 120 Stat. 2922, 2987. The duration and scope of the demonstration may be expanded as the Secretary deems appropriate if "the expansion of the project is expected to improve the quality of patient care without increasing spending" or will "reduce spending under the Medicare program without reducing . . . quality." Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No. 110-275, § 183, 122 Stat. 2494, 2531. The Secretary must file an annual evaluation and final report to Congress. Tax Relief and Health Care Act § 204(f).
78 The medical home must target individuals for participation in the demonstration, provide "safe and secure technology to promote patient access to personal health information," and develop "a health assessment tool for the individuals targeted." The medical home must also train the personnel that are involved in the coordination of care. Tax Relief and Health Care Act § 204(d).
79 Id. § 204(a)
80 Id.
81 Id. § 204(c)(2).
for the patient that is integrated, coherent and cross-disciplined in nature. The plan of care should be "developed in partnership with the patient . . . and other appropriate medical personnel or agencies." The personal physician must "use[] evidence-based medicine and clinical decision support tools to guide decision-making", "use[] health information technology to . . . monitor and track health status," and "provide . . . enhanced and convenient access to services." The physician also should "encourage[] patients to participate in the management of their own health through education and support systems."

Currently, the Medicare statute does not provide reimbursement for physician services to coordinate care. TRHCA eliminates this deficiency in the demonstration project by paying the personal physician a care management fee to coordinate care. The medical home is compensated by sharing 80% of the reductions in Medicare spending that are attributable to the efforts of the medical home. The reduction in Medicare spending is based on an assumption that there will be "reductions . . . of health complications, hospitalization rates, medical errors, and adverse drug reactions." Monies from the Federal Supplementary Medical Insurance Trust Fund will fund the reimbursement paid to the personal physician and the medical home.

2. The Medical Homes Act of 2007

Several Congresspersons also have proposed use of the PCMH in Medicaid and the State Children's Health Insurance Program (SCHIP). Senators Durbin of Illinois (D) and Burr of North Carolina (R) introduced a bipartisan bill, the Medical Homes Act of 2007, to conduct a 3-year demonstration project. The medical homes are expected to "improve the effectiveness and efficiency in providing medical assistance." The core

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82 Id. § 204(e)(3).
83 Id.
84 Id. § 204(e)(3).
85 Id.
86 Id. § 204(e)(1).
87 Id. § 204(e)(2).
88 Id.
89 Id. § 204(e)(3). Funding from the SMIF Trust is limited to $100,000,000. Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No. 110-275, § 133(g), 122 Stat. 2494, 2532.
91 S. 2376. According to the Congressional findings, use of the medical home will achieve the following: (a) improve health outcomes, (b) result in greater patient satisfaction, (c) satisfy the need to involve patients "in their health care decisions, better inform them of treatment options, and improve their access to information," (d) result in better management of chronic conditions, (e) reduce disparities in access generally and among minorities, (e) "reduce duplicative health services and inappropriate" use of the emergency room, and (f) encourage the use of health information technology in the provision of health care. Id. § 2. The Secretary must "evaluate the project to determine the effectiveness of the PCMH in terms of quality improvement, patient and provider satisfaction, the improvements of health outcomes," and estimates of cost savings from the program. Id. § 3(e).
components of the medical home include a personal primary care provider who uses health information technology to manage and coordinate care that is continuous, comprehensive, preventive, evidence-based, and emphasizes patient self-management. Accordingly, the PCMH demonstration must be designed to increase: [a] cost efficiencies of health care delivery,” (b) convenient access to care including wellness and prevention, (c) “patient satisfaction,” (d) communication among health care providers (primary care, hospital, etc), (e) “school attendance,” and (f) quality of care. 

The PCMH must also be designed to reduce inappropriate uses of the emergency room, avoidable hospitalizations, and duplication of health care services. 

The medical home must comply with the standards and measures established by the medical management committee. The medical management committee will review “evidence-based practice guidelines,” select “targeted diseases and care processes that address the health conditions of the community as identified in national or state health assessments or reports like Healthy People 2010,” and evaluate the care provided by the medical home. 

The medical home must also seek guidance from the steering committee. The steering committee is a collaborative organization that is composed of representatives from the community’s health care delivery system. The steering committee is tasked with “implement[ing] State-level initiatives [and] develop[ing] local improvement initiatives” for primary care. 

The steering committee will also “investigate questions related to community-based practice.” 

Selected states will receive funding for the demonstration project from Federal matching payments and development grants awarded by the Secretary of Health and Human Services. Federal matching payments shall be used to pay primary care providers a per-member, per month care management fee that is not less than $2.50. The exact amount is determined by assessing the care needs of the targeted patient population. Similarly, the Federal matching payments will be used to pay the “steering committee no[ ] less than $2.50 per targeted beneficiary per month.” The steering committee must use the funds “to purchase health information technology, pay primary care case managers, [and] support network initiatives.” The States shall also
receive development grants to develop "steering committees, medical management committees, and local networks of health care providers and [to] facilitate coordination with local communities." 

VI. PRIMARY CARE IN THE INTERNATIONAL CONTEXT

A. Generally – WHO – HEALTH FOR ALL

In 1978 the World Health Organization (WHO) \(^{106}\) sponsored a conference on primary care as a means "to protect and promote the health of all the people of the world." \(^{108}\) Consistent with the WHO constitution, the conference defined health broadly to be a "state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity." \(^{109}\) The conference called for "national and international action to develop and implement primary health care throughout the world." \(^{110}\)

The Member-States attending the Alma-Ata conference agreed that governments should eliminate health inequality and focus on providing primary health care to ensure that all citizens are healthy enough to lead socially and economically productive lives by the year 2000. \(^{111}\) Governments also were encouraged to formulate, launch, and sustain a primary care system "as part of a comprehensive national health system." \(^{112}\) Costs were recognized as a relevant consideration in determining the type of care that is provided as part of the national health system.\(^{113}\) In particular, Member-States agreed that the services offered in the national health system should reflect the costs that the "community and country can afford to maintain." \(^{114}\)

In 2003, twenty-five years after Alma-Ata, the WHO Secretariat issued a report on the status and future of primary health care in the twenty-first century. \(^{115}\) According to the report, government health care policies are changing to focus on "population health and the organization and delivery of health care." Some trends among the countries focus on "integrated models of care . . . and organizing health systems." \(^{116}\)
According to the report, all Member-States have made a genuine commitment to the principles of primary health care. Some countries have implemented the commitment by adopting a specific policy on primary health care and by ensuring that local and national leadership adopt that policy with appropriate resources to support its implementation. In developed countries, including the United States, the focus is to ensure that the right service is received in the most appropriate setting. The report further identifies the characteristics of successful primary care systems in the future. Future primary care systems will be able to (a) "adapt to rapidly changing circumstances, [(b)] respond to locally defined needs, and [(c) have] "sufficient and stable resources." The report also summarizes the status of primary health care by WHO region. The two most relevant to this paper are the Region of the Americas (which includes the United States) and the European Region (which includes the United Kingdom, the Netherlands, and Belgium). The European Region is further advanced in its use of primary health care in comparison to the Region of the Americas. "The [European] Region clearly has position[ed] primary health care as the most important tool to reach the target of health for all." The challenge for the European Region is the impact of chronic diseases and the ability to effectively treat them given the need for increased access to drugs and provision of comprehensive care.

In contrast, in the Region of the Americas, while most countries embraced the goal of Health for All through primary health care, there is room to expand and improve primary health care. For countries that have not achieved universal coverage with essential services, to do so requires "[(a)] strong political commitment, [(b)] allocation of sufficient resources, [(c)] creation of adequate incentives, and [(d)] prioritiza[on] and targeting services to the most vulnerable groups." Despite the existence of the Health for All policy, lack of access by poor and marginalized groups to essential health care services is still a problem worldwide. Both the 11th General Programme of Work -A Global Health Agenda have

117 Id. at ¶ 5.
118 Four years later the United States has the same goal. An Administrator at the Center for Medicare and Medicaid Services (CMS) recently testified at a congressional hearing that the "Medicare payment systems should encourage physicians to provide the right care at the right time and in the right setting." The payment policy should also "encourage prevention and ongoing care for the chronically ill." Medicare Physicians Hearings, supra note 56 (testimony of Herb Kuhn, Acting Deputy Administrator, Centers for Medicare and Medicaid Services).
119 Id. at ¶ 9.
120 Id. at ¶ 15 (emphasis added).
121 Id. at ¶ 16.
122 Id. at ¶ 12.
123 Id.
Agenda adopted by the World Health Assembly in 2006 – and the 2008 World Health Report propose universal coverage as the solution.125

Finally, in 2008, during the 30th anniversary year of the Alma-Ata Declaration, WHO issued its latest pronouncement on the role that primary health care should play in national health systems. The 2008 World Health Report entitled Primary Health Care - Now More than Ever, reiterates the importance of primary health care as a tool to reorient national health care systems toward delivering care that is fair, efficient, and effective.126

B. PRIMARY CARE IN SPECIFIC COUNTRIES

As noted previously, the WHO 2003 Health for All report concludes that primary care services are highly developed in the middle income and developed countries of the European Region which includes the United Kingdom, the Netherlands, and Belgium.

1. The United Kingdom

The United Kingdom ("UK")127 has a highly developed primary care system delivered by general medical practitioners (GPs) and staff. Most of the population is registered with a GP who provides a wide range of "preventive, diagnostic, and curative services."128 Patients chose their GP and most people have long-standing relationships with their GP.129 On average, a GP has a registered patient list of 1,800 patients.130 GPs serve as gatekeepers to hospital specialist services.131

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125 Engaging for Health, supra note 124, at 16; World Health Organization, World Health Report 2008: Primary Health Care - Now More than Ever ix, 25, 33 (2008) (hereinafter World Health Report 2008: PHC - Now More than Ever). 126 World Health Report 2008: PHC Now More than Ever, supra note 125, at ix, 25, 33. Member-States can refocus their health care systems by focusing on four reform initiatives: (1) Universal coverage ensures that all people have access to health care regardless of ability to pay; (2) Patient-centered services focuses on reforming delivery of health services to be more responsible to the needs of individuals while producing better outcomes; (3) Healthy public policies promote the protection of public health by engaging other sectors that impact health such as trade, environment, and education; and (4) Leadership addresses the need for leaders in the government, private, business, and civil society to negotiate and steer health systems to become more fair and effective instead of relying disproportionately on command and control or laissez-faire principles. Id. at ix, xvi-xviii.

127 The United Kingdom is composed of four countries England, Northern Ireland, Scotland, and Wales. Each country is responsible for the health care of its citizens. The UK has a national health insurance system that is primarily funded "through national taxation; deliver[s] services through public providers; and [has] devolved purchasing responsibilities to local bodies [like the] primary care trusts in England." World Health Organization Regional Office for Europe, Sarah Allin et al., European Observatory on Health Systems and Policies, Snapshots of Health Systems 49 (Susanne Grosse-Tebbe & Joseph Figueras eds.) (2005), available at http://www.euro.who.int/document/c87303.pdf (hereinafter WHO-Europe, UK Health System).


129 Id.

130 Peter P. Goenewegen et al., The Regulatory Environment of General Practice: and International Perspective, in Regulating Entrepreneurial Behavior in European
While GPs are independent providers that contract with the National Health Service (NHS), regulations exist with respect to the number of GPs, the location of their practices, the extent of private fee payments, and how the NHS pays for their services. With respect to GPs, the system has been moving toward managed care and entrepreneurship.

The United Kingdom has increased its role in shaping and monitoring standards of clinical care. First, the UK specifies the types of services that should be provided by primary care physicians in a national contract with general practitioners. Second, it focuses on governance of clinical care by establishing a national quality strategy to establish best practices.

The General Medical Services Contract (GMS Contract), introduced in 2004, was negotiated closely with physicians who "sought to apply evidence-based principles to the selection of performance indicators that were consistent with national clinical guidelines." A provision of the contract "provides bonuses . . . [to GPs] for reaching quality targets.

To implement the GMS Contract, GPs "employed more nurses and administrative staff, established chronic-disease clinics, and increased the use of electronic medical records." Accordingly, in 2006, a survey of primary care physicians in the UK showed that a significant majority of the practices use electronic medical records. This same survey showed that 81% of practices use multidisciplinary teams to deliver care and over half "use nonphysicians routinely to deliver chronic and primary care."
Quality also is enhanced by the UK's implementation of a national quality strategy. The National Institute for Clinical Excellence (NICE) is an essential organization that implements the United Kingdom's quality strategy. NICE provides guidance to the NHS on which health care services are effective and cost-effective. Part of NICE's guidance includes publication of treatment guidelines.

Patients have access to after-hours care through Primary Care Organizations. The UK requires practices to arrange coverage and has set up a 24 hour nurse-led help line and NHS walk-in centers.

The UK provides comprehensive health insurance coverage to its populations with little or no patient costs. The coverage is provided under the United Kingdom National Health Service.

2. The Netherlands

Like the UK, primary care is well-developed in the Netherlands and is central to the country's ability to achieve desired health outcomes and limit costs. Primary care is largely delivered by family physicians and most patients have a regular family physician. While patients have the freedom to choose their family physician, [as of 2006, patients must register with a specific primary care practice.]

Most family physicians in the Netherlands have an average of 2,300 patients.

Family physicians serve as the gatekeepers to health care in the Netherlands and their approval is required before a patient can access...
hospital and specialist care. In the Netherlands, patients are satisfied with the delivery of primary health care and value their long-standing relationships with family physicians. Family physicians speak extensively with patients, and, "[i]n addition to giving advice, [physicians] take the time to explain the nature of the medical problems and to discuss various psychological aspects."

A primary care provider and hospital specialists treat and monitor patients with chronic diseases. One-third of practices use nurse practitioners to manage care and usage is increasing. "Nearly all [physicians] use electronic medical records . . . and computer software to identify and track patients with chronic conditions or those at risk of developing chronic conditions."

Physicians use clinical guidelines to provide care. The Dutch College of Family Physicians offers voluntary accreditation of primary care practices to ensure quality provision of care.

Patients in the Netherlands also have enhanced access to after-hours and emergency care. Patients are assigned to a primary care cooperative, a large-scale after-hours organization. Trained nurses triage the patients and give advice. When necessary, family physicians follow up by telephone, in person, or through home visits.

The Netherlands is a social health insurance country where basic coverage pays for primary and secondary care. Health insurance coverage is universal.

The Netherlands has a private health care system where the health care providers negotiate contracts and budgets with various health insurers. In 2006, the health insurers introduced a new payment system to reimburse primary care physicians. Under the new system, physicians receive "capitation per patient and a fee per consultation, plus a negotiable [reward based] on . . . quality and efficiency indicators." The Netherlands has an effective and efficient health care system because "when care is needed, the doctor who is best equipped to deal with the specific health problem provides it."
3. Belgium

In Belgium, primary care is delivered by general practitioners and specialists. There are a large number of general practitioners in Belgium—"approximately [1] ... for every 600 inhabitants." Thus, there are no significant barriers to accessing GPs. About 95% of the population has a regular GP. Additionally, Belgium probably has the highest number of home visits in the world.

In Belgium, patients can choose their first point of contact with the health care system. This free choice is believed to result in over consumption of medical care which led to higher health care expenditures. As a result, since 1999, efforts have been made to strengthen primary care and the role of GPs. The government introduced ... a global medical file (GMD-DGM) to increase access to and availability of patient information and to develop patient loyalty towards a GP. Patients with a GMD-DMG receive a 30% reduction in their out-of-pocket payments for visits to the GP who holds their file. At least until 2002, elderly patients who signed up with a GP were exempt from co-payments that exist for other groups.

GP Circles are another effort to strengthen primary care. The GP Circle is a local group of GPs working with each other and the local authorities to organize after hours care, provide emergency care, coordinate care with domiciliary care providers, and provide patient education and other preventive medicine programs.

Belgium's government created the quality accreditation program to promote quality and cost conscious care, to facilitate efficient relationships.
between physicians, to encourage the “exchange of patient data to prevent duplication of effort,” and to encourage physicians to participate in ongoing training.\textsuperscript{75} Physicians whose medical practices are “quality accredited” receive financial rewards.\textsuperscript{76}

The cost of primary care services for patients is covered through compulsory health insurance. This insurance covers almost 99% of the population.\textsuperscript{177} Patients are generally responsible for 25% of the cost of health care, absent some discount.\textsuperscript{178}

Physicians are paid using a fee-for-service system. The cost of fees is fixed by a national agreement that is negotiated between the National Convention Committee of Sickness Funds and the association of doctors.\textsuperscript{179} Adherence is voluntary,\textsuperscript{180} but most physicians abide by the fee guidelines.\textsuperscript{181}

\section{VII. Policies That Promote PCMH – The International Experience}

The national health policies for the UK, Netherlands, and Belgium incorporate the three critical components of PCMH: physician reimbursement for coordinated care; health information technology; and quality control via clinical guidelines and practice accreditation. These characteristics are discussed in detail below.

\subsection{A. Adequate Reimbursement}

1. Characteristics of Effective Physician Payment Systems

An effective physician payment system includes adequate payment and a performance component. Adequate payment enables practices to pay salaries that are consistent with a robust, modern practice. The performance component ensures that physicians achieve the societal goals for efficient, safe,\textsuperscript{182} and accessible\textsuperscript{183} care.

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\textsuperscript{\textsuperscript{75} "Id. at 150.}\textsuperscript{\textsuperscript{76} "Id. at 150.}\textsuperscript{\textsuperscript{77} "Id. at 59. Insurance companies are known as “Sickness Funds” in Belgium. "Id.}\textsuperscript{\textsuperscript{78} NYS, supra note 166, at 35.}\textsuperscript{\textsuperscript{79} Corens, supra note 165, at 71.}\textsuperscript{\textsuperscript{80} NYS, supra note 166, at 23.}\textsuperscript{\textsuperscript{81} The government provides incentives to physicians to comply by making contributions to a fund that provides “additional old-age or disability pensions to providers who” adhere to the negotiated fee. Corens, supra note 165, at 71.}\textsuperscript{\textsuperscript{82} Two particular concerns to be avoided when primary care physicians are the first point of contact include underutilization of referrals and denial of necessary care.}\textsuperscript{\textsuperscript{83} Allan H. Goroll, et al., Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care, 22 Soc'y of Gen. Internal Med. 410 (2007).}
Performance incentives have two categories: quality improvement and reporting, and care coordination. In both the UK and Belgium, primary care physicians receive incentives to improve quality and to report quality data. The UK’s General Medical Services Contract of 2004 established criteria for physicians to receive financial rewards based on meeting clinical performance requirements, conducting patient surveys, and improving care in response to the surveys. That incentive program is considered well-designed because it pays the medical practice, not the physician. Teamwork and peer review are encouraged. The program includes mechanisms to verify performance. The first year of implementation showed that physicians met the targets for 83.4% of the population.

Belgium has implemented two performance incentives. It compensates physicians for maintaining a patient’s global medical file. The global medical file was created to ensure that a patient’s health information is complete and accessible. Only the physician designated by the patient to maintain the global medical file is entitled to reimbursement for those services. Another quality incentive is tied to accreditation of physician practices. Practices that are quality accredited receive two financial incentives. First, patients receive a fee supplement and the government steers patients to the practice by rewarding patients with lower out-of-pocket costs for using accredited practices.

The second performance incentive is compensation for care coordination. The Netherlands provides care coordination incentives for its chronic care patients. The government compensates physician practices for the costs associated with hiring a nurse practitioner to manage chronic care patients.
2. The U.S. Lacks a Primary Care Focused National Payment Policy

The United States does not have a national payment policy that focuses on primary care physicians. Additionally, payment for primary care services among both private and public payers (Medicare and Medicaid) is too low. In the U.S., specialist and procedure-based care is compensated at higher rates than cognitive-based care. Instead of a national payment policy focusing on primary care, private insurers, employers, and states are exploring initiatives to facilitate care coordination. As discussed previously, at the federal level a medical home demonstration project for Medicare has been enacted under the Tax Relief Health Care Act of 2006 (TRHCA) and proposed for Medicaid and SCHIP under the Medical Homes Act of 2007 (MHA). Under TRHCA, the Medicare program provides financial incentives to coordinate care and provide cost-effective care by paying physicians a care coordination fee and a percentage of the savings to the Medicare program that are attributable to the efforts of the medical home. Similarly, the MHA will compensate Medicaid and SCHIP providers by paying them a care management fee that is a minimum of $2.50 per patient. The exact amount will be determined by assessing the care needs of the target patient population.

B. ENCOURAGING HEALTH INFORMATION TECHNOLOGY

Health information technology ("HIT") is an important tool to transform the provision of direct patient medical care. It supports quality initiatives by tracking physician performance and validating patient health outcomes.

National policies to support primary care in the Netherlands and the UK have made widespread diffusion of information systems possible to even small group and solo practices. The UK made a national investment in health information technology and in the Netherlands partial funding was provided to GP practices to cover start-up costs.

A survey of primary care physicians in the Netherlands revealed that 98% of the physicians use electronic medical records in their practice. Similarly,
a survey of primary care physicians in the UK revealed that 89% of the physicians use electronic medical records (EMR) in their practice. In the Netherlands and UK electronically order tests, access patients' test results, prescribe medication, send reminder notices, "generate lists of patients by diagnosis or health risk," receive notification regarding patients' due dates for tests or preventive care, and send reminder notices to patients for preventive or follow-up care.

C. Quality Care - Treatment Guidelines & Accreditation

The development and implementation of national quality initiatives, such as the use of treatment guidelines and accreditation, is consistent with the features of the PCMH. In both the UK and the Netherlands physicians widely use primary care clinical guidelines. Additionally, the Netherlands and Belgium have implemented accreditation programs for primary care practices to ensure the provision of quality services. Further analysis of the role of quality in the delivery of primary care services follows in the next section.

VIII. Lessons from the International Experience Support Use of PCMH Instead of CM

Widespread adoption of the PCMH instead of CM reflects better health policy from a quality, cost, and access perspective based on the WHO's Health for All policy and trends in three countries.

A. Quality of Care

The Institute of Medicine ("IOM") defines quality of care as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." According to the IOM, quality health care has six attributes; it is safe, effective, patient-centered, timely, efficient, and equitable. Moreover, quality health care "is based on scientific and medical evidence." CM does not have a system to ensure clinical accountability, nor does it have a quality evaluative or performance reporting system. In contrast, the PCMH model as reflected in the TRHCA and the MHA have explicit criteria designed to ensure the provision of quality care.
Policies in the UK, the Netherlands, Belgium, and those established by domestic quality organizations like the National Committee for Quality Assurance demonstrate that there are at least three primary ways to ensure the delivery of quality care. They include: (a) mandating the use of evidence-based guidelines; (b) requiring practices to become accredited or undergo external and internal assessment of the quality of care provided; and (c) using technology to communicate with patients and providing access or care to patients.

Similarly to primary care provided in the Netherlands and the UK, care provided using the PCMH model under the MHA and TRHCA requires the provision of care based on evidence-based guidelines. In the Netherlands, there is high compliance by family physicians with the clinical guidelines. Additionally, in the UK, as a result of the clinical performance incentives in the 2004 GMS contract, there is significant GP compliance with chronic care guidelines.

Another tool used to ensure the provision of quality care is accreditation of practices or a requirement that a practice participate in independent or self assessment. Both Belgium and the Netherlands have programs for medical practices to become accredited. In the Netherlands, accreditation of primary care practices is voluntary and is run by the Dutch College of Family Physicians. The practices are evaluated on their "clinical performance, prevention, management of services, and patient experiences." The practices are expected to conduct an internal assessment of their performance and set improvement goals. The practices also are audited to ensure compliance with the standards. In Belgium, physicians receive financial incentives if they choose to become quality accredited. To become quality accredited, a GP must join a local medical evaluation group for GPs, participate in ongoing training, participate in quality initiatives, and not receive repeated negative feedback about his/her diagnostic and therapeutic practices.

With respect to the PCMH, only the MHA addresses methods to evaluate the performance of medical homes while TRHCA is silent on this issue. The MHA requires practices to undergo internal and external assessment of their performance. Practices must monitor their clinical process and performance,
and provide information to two other entities created by the bill that set standards and monitor the performances of the practices. A critical aspect of the external assessment that is missing from the MHA is a mandate that practices conduct patient surveys to assess the patient's experience. In contrast, both the Netherlands and an independent accreditation system in the United States include a patient evaluation component.

The final lesson from the international experience that impacts quality is the role of technology. Health information technology improves quality by facilitating the delivery of safe, effective, and efficient care. Technology is widely used in the delivery of primary care in the UK and the Netherlands. This use is the result of national policies in both countries that focus on supporting technology. As previously noted, in the UK and the Netherlands, GPs commonly use EMR and technology to order tests, prescribe medications, send patients notices about needed care, and generate lists of patients with a disease or at risk of developing a disease.

Use of health information technology is not as developed in the United States as it is in the UK and the Netherlands. However, the PCMHs under

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222 S. 2367, 110th Cong. § 3 (a)(5)(B)(vi). As noted previously, practices must adhere to evidence based guidelines selected by the Management Committee and comply with state and local initiatives developed by the Steering Committee to improve the quality of care. Id. at § 3(a)(4), (a)(11).


225 PCP Office Systems, supra note 51, at w557 - 558.

226 Id. at w558-559. The 2008 World Health Report also notes that HIT can improve the provision of primary care. In particular, use of "electronic health records, computerized prescribing systems, and clinical decision aids" enables health care practitioners to "provide safer care." WORLD HEALTH REPORT 2008: PHC - Now More Than Ever, supra note 125, at 51.

227 Passage of the American Reinvestment and Recovery Act (ARRA) will dramatically increase the numbers of health care providers that use health information technology in the United States by providing $19 billion in incentives for providers through the Medicare and Medicaid reimbursement system. Under the Medicare program, beginning in 2011, three groups of providers - physicians, hospitals, and critical access hospitals - will be eligible for temporary bonus payments if they demonstrate that they are meaningfully using a certified health information technology system. Also in 2011, physicians that see a high volume of Medicaid patients will be eligible to receive temporary subsidies to help adopt a certified health information technology system. American Reinvestment and Recovery Act, Pub. L. No. 111-5, §§ 4101, 4201, 123 Stat. 467 (2009). Physicians in the Medicare program who do not adopt health information technology by 2014 will incur a penalty. Id. The Congressional Budget Office estimates that the ARRA incentive mechanisms coupled with the existing mechanisms will increase adoption rates among physicians to 90% by 2019. Letter from Robert A. Sunshine, Acting Dir. Congressional Budget Office to the Honorable Charles B. Rangel, Chairman, Comm. on Ways and Means at 3 (January 21, 2009).
the MHA and the TRHCA both encourage use of health information technology. 228 Under the Medicare demonstration project, physicians are required to use health information technology "to monitor and track the health status of patients and to provide patients with enhanced and convenient access to health services." 229 Such technology could include "remote monitoring and patient registries." 230 Physicians also are required to provide "safe and secure technology to promote patient access to personal health information." 231 The MHA applies to Medicaid and SCHIP and also encourages the use of health information technology to improve the management and coordination of care. 232 Health information technology is viewed as a "crucial foundation for medical homes." 233 The value of health information technology is expressly recognized by highlighting the importance of EMR and the use of ITT to monitor the care provided to patients with chronic diseases, to prevent medical errors, to "facilitate communication between patients and providers," and to provide patient education. 234 MHA requires the use of health information technology, but does not mandate the form. 235

B. COST OF CARE

The WHO Declaration of Alma-Ata provides an important principle to keep in mind when thinking about costs. The Declaration of Alma-Ata provides that essential health services should be made universally accessible to individuals at a "cost that the community and country can afford to maintain." 236

There are several issues to be considered here. Cost must be assessed from an individual patient perspective and from a societal perspective. From the patient perspective, one must consider which model, PCMH or CM, makes primary care services more affordable for the patient. The other cost that needs to be considered is the cost to the health care system as a whole. Which model, PCMH or CM, provides primary care services in a cost-effective manner?

1. Individual Costs

The international experience reveals that patients in the UK and Netherlands have more affordable primary health care because there are

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228 Standard 9 of the PPC-PCMH governs advanced electronic communications. This standard includes use of a website, electronic patient identification, or electronic care management support. This is not a mandatory requirement. PPC-PCMH, supra note 223, at 1.


230 Id.

231 Id. § 204 (d)(2)(A).


233 Id. § 2(5).

234 Id.

235 Id.

236 S. 2376, 110th Cong. § 3(d)(2)(A)(VI)

237 Alma-Ata Declaration, supra note 108, at ¶ VI.
mechanisms in place to reduce the financial burden on individuals. Some of the mechanisms include universal coverage and minimal cost-sharing.

In the UK, the cost of primary care services to an individual patient is low. In the UK, there is universal health coverage for the delivery of primary care services and minimal cost sharing. Similarly, in the Netherlands, the cost of primary care services is covered through universal health insurance. Due to the comprehensive coverage in the UK and the Netherlands, a recent survey found that "Dutch and British adults reported the lowest out-of-pocket costs and access concerns related to cost[s]."

The PCMH model is more attractive than CM because the concierge fee, which averages $1,500 and is charged to patients, makes primary care under the CM model less affordable. In contrast, patients using the PCMH model do not incur an additional fee, as the government pays physicians for the additional time and effort required to provide the personalized, integrated, and coordinated care. Thus, provision of care under the PCMH model is like the experiences of patients in the UK and the Netherlands where there is universal coverage and minimal cost sharing with respect to the delivery of primary care services. Moreover, the PCMH model as implemented under the MHA and TRHCA is better than CM because MHA and TRHCA target provision of healthcare to financially vulnerable groups as recommended by the WHO Health for All policy and the 11th General Program of Work. By conducting demonstrations in the Medicaid, Medicare, and SCHIP programs, the poor, disabled, young, and elderly with multiple chronic illnesses have access to personalized, integrated, and coordinated health care.

2. Societal Costs

The cost to the health care system as a whole requires consideration. Which model, PCMH or CM, provides primary care services in a cost-effective manner? This inquiry includes an assessment of which model will likely improve population health outcomes in a cost-effective manner.

As discussed in section VII.A.1, governments in the UK, Netherlands, and Belgium recognize that an effective payment methodology should achieve two goals: adequately compensate the health care provider for the provision of health services and incentivize the physician to achieve the societal goal of providing quality health care. The UK decision to increase GP salaries by 25% and allocate $3.2 billion-dollars for a 3-year period to achieve this goal provides an example of the substantial financial commitments that governments may make to appropriately compensate GPs for providing primary care services.

Like the new reimbursement methodologies implemented in the UK, the Netherlands, and Belgium, MHA and TRHCA compensate physicians for

\[^{237}\text{PCP Office Systems, supra note 51, at w556.}\]
\[^{238}\text{Goenewegen, supra note 130, at 205.}\]
\[^{239}\text{Adults' HC Experiences, supra note 159, at 722. This survey assessed the experiences of adults in seven countries, the Netherlands, the UK, the United States, Australia, Canada, Germany, and New Zealand. Id.}\]
\[^{240}\text{GAO CONCIERGE REPORT, supra note 3, at 12.}\]
\[^{241}\text{See supra Part VII.A.1.}\]
\[^{242}\text{Doran, supra note 135, at 376-379.}\]
providing care valued by the federal government: personalized, coordinated, and integrated care. Both MHA and TRHCA pay physicians a care management fee. Additionally, under TRHCA, the medical home is compensated based on the cost savings it provides to the Medicare program.

PCMH is a better model to deliver health care from a societal cost perspective than CM. This is because an express component of the PCMH model is the recognition that health care should be integrated and coordinated to produce a positive health outcome and that a new reimbursement methodology is needed to achieve that result. While the CM model also recognizes that patients benefit from personalized, integrated and coordinated care, placing the burden for payment of these services on the individual limits the usefulness of the model to persons with the ability to pay. As a result, the positive health results are limited to individual health and do not accrue to the entire population. Governments have a duty to protect and promote population health in addition to individual health. Moreover, the policies in the UK, Netherlands, and Belgium require governments to shoulder the bulk of the cost incurred by paying health care providers to provide services valued by the governments as beneficial to population health.

Implementing the PCMH demonstration projects in Medicaid, SCHIP, and Medicare under MHA and TRHCA requires a substantial financial investment to reimburse health care providers for providing personal, integrated, and coordinated care; but such investment is expected to result in better health outcomes for the population. Providing sufficient compensation to physicians should result in the provision of more preventive services generally. Also, better management of patients with chronic diseases and efforts to teach patients to better manage their care should result in improved health. Implementation of the medical home model in the SCHIP and Medicaid populations might also be an effective tool to fight the rising incidence of childhood obesity. Additionally, cost savings are likely to result from preventing delayed treatment of care that results in avoidable and costly emergency room care and hospitalizations. However, it should be recognized that expanding primary care through the PCMH model might also increase health care expenditures to the extent that unmet health care needs are met, access to care improves, and utilization increases because of expanded services.

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244 Tax Relief and Health Care Act § 204 (e)(1)-(2).
245 Yarnall, supra note 21.
247 Starfield, supra note 10, at 459-484. MHA requires medical homes to be designed to reduce inappropriate emergency room care. S. 2367, 110th Cong. § 2.
248 Atun, supra note 13, at 4; Crossing the Quality Chasm, supra note 15, at 52, 202; MedPac, REPORT TO CONGRESS: INCREASING THE VALUE OF MEDICARE 41 (2006); Medicare Physician Hearing, supra note 43 (testimony of Glenn M. Hackbarth, Chairman, Medicare Payment Advisory Commission).
C. Access to Care

Access to care reflects "the degree to which individuals and groups are able to obtain needed services from the medical care system." More specifically, access to health care is "the timely use of personal health services to achieve the best possible health outcomes." A key dimension of access to health care is organizational; that is, the arrangement of health care resources to facilitate encounters between patients and physicians. Some specific categories of organizational access can include office hours, availability of after-hours care (home, evening, weekend, or emergency hours), and waiting time to make an appointment.

Patients in Belgium have high access to care. As noted previously, it has the highest rate of home visits in the world. Belgium is also increasing the availability of GP care by creating pilot projects of primary care outposts. These organizations facilitate patients' access to on-call services for GPs.

In the Netherlands, patients have enhanced access to care with respect to after-hours care and emergency care. Patients are assigned to primary care cooperatives where they can receive after-hours care. Additionally, from an appointment scheduling perspective, surveys of physicians in the Netherlands reveal that 85% offer patients early morning hour appointments (before 8:30 a.m.) and 95% of practices have an "arrangement where patients can be seen by a doctor or nurse if needed when the practice is closed, not including the emergency room."

Patients in the UK have access to after-hours care through Primary Care Organizations. However, patients have more limited access to their physicians in scheduling appointments during office hours. Forty percent of UK primary care physicians reported that they did not have early morning, evening, or weekend hours for patient appointments.

Another way to expand organizational access to health care services is for practices to use teams in the delivery of care. Over half of the primary care physicians surveyed in both the UK and the Netherlands use nonphysician clinicians to manage patients with multiple chronic conditions, use multidisciplinary teams routinely in their practices, and would support...
expanding the roles of nonphysicians in the delivery of health care to their patients. Like primary care practices in the UK and the Netherlands, both CM and PCMH provide enhanced patient access to care with respect to office hours. CM patients can get same day or next day appointments for non-urgent matters, can receive home visits, and have enhanced access to their physicians via cell phone, email, or pager access. Under the MHA, the PCMH must ensure that patients have “increase[d] access to appropriate health care services . . . at times convenient for patients.” (emphasis added). Similarly, TRHCA provides that the medical home should provide patients with accessible care. The statute further provides that health information technology should be used “to provide patients with enhanced and convenient access to health care services.” While the MHA and TRHCA require medical homes to structure themselves to increase organizational access, the statutes are appropriately silent on the details of how to achieve those goals. Leading articles describing the PCMH provide some guidance on tools that can be used to increase patient access to convenient services. Patients will have access via open scheduling that will allow same day appointments regardless of the reason, and the use of email and voicemail for non-urgent matters. TRHCA implicitly addresses the use of teams to deliver care under PCMH. TRHCA requires the personal physician to have a “staff . . . to manage” the provision of “comprehensive and coordinated care.”

Despite the fact that there are key similarities to enhance patient organizational access to care under CM and PCMH, there is one core reason that use of PCMH constitutes better health policy than CM. CM enhances individual patient access at the expense of systematic patient access. CM physicians have significantly smaller patient panels with an average of 191 patients. The primary reason that CM physicians can provide personalized services is by having a small number of patients in their practice. The small size is achieved by reducing the physician’s existing panel or limiting the size of the physician’s patient panel. Either way, there are fewer physicians available to provide patient care. In contrast to the CM model, PCMH achieves enhanced access via the use of teams, infrastructure changes, and scheduling methods.

IX. RECOMMENDATIONS

There are several recommendations that should be incorporated into future legislation governing the use of PCMH in the Medicaid, SCHIP, and Medicare programs to improve the benefits that flow from widespread promotion of the model. First, the scope of patients that have access to the PCMH model should be expanded. The MHA provides care to the Medicaid

258 Id. at 2363.
261 Id. § 204(c)(3)(C).
262 Kahn, supra note 16, at 815.
263 Kahn, supra note 16, at 815.
264 Tax Relief and Health Care Act § 204 (c)(2)(b) (emphasis added).
265 GAO CONCIERGE REPORT, supra note 3, at 13.
and SCHIP populations, the poor, disabled, and children. Under TRHCA some elderly patients in the Medicare program have access to the PCMH. While implementation of the PCMH under MHA and TRHCA focuses on patient populations that are consistent with the WHO Health for All agenda (i.e. vulnerable, marginal, and the sickest patients), all patients can benefit from a health care delivery model that emphasizes coordination of care and prevention. Thus TRHCA should not only cover high cost beneficiaries (beneficiaries with more than one chronic condition), it should cover all Medicare beneficiaries. Providing universal access to the medical home will likely result in long term improved population health and lower health care costs.

Second, both MHA and TRHCA should be designed to satisfy all nine of the standards established by the National Committee for Quality Assurance Physician Practice Connections-Patient Centered Medical Home (PPC-PCMH) accreditation program. The National Committee for Quality Assurance ("NCQA") is world renowned for developing high quality accreditation standards. NCQA created the PPC-PCMH standards in consultation with the four primary care organizations that have the most experience using the medical home model: (1) the American Academy of Family Physicians, (2) the American Academy of Pediatrics, (3) the American College of Physicians, and (4) the American Osteopathic Association. As currently drafted, neither the MHA nor the TRHCA comply with PPC-PCMH standard 8. Standard 8 requires performance reporting and improvement which includes assessment of the patient experience. It is ironic that a model entitled “patient-centered” with a focus to satisfy the patients' needs, values, and preferences, fails to monitor whether the patient believes that these goals are being achieved.

Third, the reimbursement methodology used to compensate physicians and medical homes needs to be carefully designed to incentivize health care providers to provide care that is consistent with the quality, access, and cost-effectiveness goals of society. A possible concern with the MHA model might be that reimbursement under-compensates physicians, consistent with the Medicaid reimbursement history of significantly under-reimbursing physicians for the services that they provide. In trying to right-size the incentive structure, the Medical Homes Act could be amended to share a percentage of the savings generated by the medical home with the medical home itself. TRHCA might pose the other problem, where the medical home is overcompensated by receiving 80% of the Medicare savings attributable to

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265 While I recommend expansion of the benefits of the PCMH to all beneficiaries, I also recognize the cost-effectiveness of beginning the provision of such a benefit with the beneficiaries that cost the Medicare program the most.

266 Standard 8 is entitled Performance Reporting and Improvement. PPC-PCMH, supra note 223, at 60. The other eight standards listed include (1) Access and Communication, (2) Patient Tracking and Registry Functions, (3) Care Management, (4) Patient Self-Management Support, (5) Electronic prescribing, (6) Test Tracking; (7) Referral Tracking; (8) and Advanced Electronic Communications. Id.

267 Id. Some of the other listed factors by which medical homes are evaluated with respect to performance and improvement include: (a) whether the home measures clinical and/or service performance by physician or across the practice, (b) whether the medical home reports performance across the practice or by physician, and (c) whether the medical home sets goals and takes actions to improve performance. Id.
the medical home instead of reinvesting a larger percentage of the savings into Medicare. Use of the PCMH model is designed to ensure the provision of care that is patient-centered, but also cost-effective. The government objective of using the PCMH as a method to control the increase in health care costs is undermined by overpaying the medical home for the services provided.

Fourth, both TRHCA and the Medical Homes Act could be amended to provide incentives\(^ {266} \) to Medicare, Medicaid, and SCHIP beneficiaries to change behavior toward or continue healthy lifestyle choices and to encourage compliance with treatment regimens. The nature and extent of the incentive depends on national health policy goals, including financial goals, and the type of patient behavior changes that are targeted. Following countries like Belgium,\(^ {269} \) patient-beneficiaries of Medicare and SCHIP could be rewarded with lower cost sharing obligations for their behavior changes that result in improved health. The incentive could be to lower premiums for Part B of Medicare or lower co-payments. For Medicaid and SCHIP beneficiaries, competitive programs could be created where beneficiaries compete for prizes for the most significant health behavior changes. The prizes could include exercise equipment, bicycles, membership to gyms, transportation vouchers to health related places, grocery store or restaurant vouchers for healthy food options, etc. The incentives can be determined at the Federal or State\(^ {270} \) level to be consistent with national or state health policy goals or at the medical home level to more tailor the reward to address the unique characteristics of individual beneficiaries.

X. CONCLUSION

Primary care is an important component of a country’s health care system. Primary care improves the performance of a health care system in several ways: by increasing access to needed services, especially among the disadvantaged; by providing better quality of care; by emphasizing prevention; by managing health problems early; and by reducing unnecessary and potentially harmful care.\(^ {271} \) The WHO views the provision of primary care as a critical component of its Health for All agenda, which seeks to ensure that every citizen has a basic level of health.\(^ {272} \) The importance of primary care to the Health for All agenda is reinforced through publication of the 2008 World Health Report, Primary Care Now More Than Ever.\(^ {273} \)

In the United States, both physicians and patients are dissatisfied with the delivery of primary care. Primary care physicians proposed CM and the PCMH as solutions to improve primary care services. CM provides

\(^ {266} \) A possible source of funding can be a percentage of any savings generated from use of the PCMH model.

\(^ {267} \) See supra note 171, and accompanying text.

\(^ {268} \) See supra notes 98-100, and accompanying text. The expanded duties would include the creation and administration of incentives directed toward Medicaid and SCHIP beneficiaries to engage in behavior that improves their health outcomes.

\(^ {270} \) State level initiatives could be implemented by expanding the scope of duties given to the steering committee created in the Medical Homes Act. See supra notes 98-100, and accompanying text. The expanded duties would include the creation and administration of incentives directed toward Medicaid and SCHIP beneficiaries to engage in behavior that improves their health outcomes.

\(^ {271} \) Starfield, supra note 10, at 459-84.

\(^ {272} \) See supra Part VI.A.

customized, comprehensive medical care in exchange for payment of a fee to be a part of the concierge practice, while the PCMH provides accessible, continuous, integrated, evidenced-based care for all of a patient's health care needs.

Congress chose PCMH over CM as the method to deliver primary care. MHA and TRHCA authorize demonstration projects using the PCMH in Medicare, Medicaid, and SCHIP. Consistent with WHO's *Health for All* policy, MHA and TRHCA provide care to vulnerable and marginalized groups: the poor, children, the disabled, and the elderly. Moreover, lessons from the international context reveal that the PCMH model is the better model from a quality, access, and cost perspective.

Unlike CM, the PCMH has explicit criteria designed to ensure the provision of quality care. Those criteria are consistent with the quality policies in the UK, Netherlands, and Belgium which require an external assessment of the performance of the medical home; the use of evidenced-based guidelines in the provision of care; and the use of technology to communicate with patients and provide enhanced access to care. Unlike the CM model, PCMH makes access to primary care services for individuals more affordable because the government compensates the physician for providing personalized, coordinated, comprehensive care instead of requiring a patient to pay the physician a concierge fee. This result is consistent with the policies of the UK, Netherlands, and Belgium which seek to minimize the financial burden placed on patients to secure primary care services. Indeed, several governments redesigned their reimbursement policies to allow performance based reimbursement. The PCMH is better than CM from an access perspective because PCMH improves patients' access to appropriate health care services at times convenient to the patient through health information technology, scheduling, and the use of teams to deliver care. These same means are used in the UK, Netherlands, and Belgium.

In light of the benefits that arise from providing primary care through the PCMH, future legislation governing the use of the PCMH model should provide access for all Medicare, Medicaid, and SCHIP beneficiaries. Second, the PCMH should be required to comply with the NCQA PPC-PCMH accreditation guidelines. Third, the reimbursement methodology should be carefully tailored to incentivize physicians to provide care that improves beneficiary health outcomes and is cost-effective. Fourth, since improved patient health outcomes is also dependent on patient behavior, TRHCA and the Medical Homes Act should be amended to provide incentives to encourage beneficiaries to engage in healthy lifestyle choices and comply with treatment regimens.