UNIVERSITY OF WISCONSIN
POPULATION HEALTH INSTITUTE
*Translating Research into Policy and Practice*

Issue Brief

# Medical Homes and Retail Clinics: Policy Considerations for Accountable Health Care

Donna Friedsam and Branden Pfefferkorn

March 2009
Vol 9 No 1

"Medical homes" have recently attracted great expectations in the dialogue about health system and payment reform, promising to improve quality and reduce costs through comprehensive, patient-centered primary care. At the same time, walk-in "retail clinics," offering limited, episodic clinical services, have proliferated in pharmacy and retail store settings. To what degree do these parallel developments in health care contribute to improved quality and access? Do these models conflict with or complement one another? And what policy and financing considerations might assure accountability for improved health outcomes and overall cost-containment?

**The Medical Home Model**

Several of the major primary care specialty organizations — the American Academy of Family Physicians, the American Academy of Pediatrics, the American Osteopathic Association, and the American College of Physicians — have developed and endorsed[1] the "patient-centered medical home," a practice model that includes a personal primary care physician for each patient, multi-disciplinary team care, care coordination, and access to round-the-clock services.[2,3] A 2008 Wisconsin Legislative Council Study Committee reviewed the health and cost benefits of care coordination and disease management,[4] and has drafted legislation to advance medical home pilot programs.[5]

Growing evidence indicates how high quality primary care can improve health outcomes and lower costs, particularly for chronic disease care, reducing avoidable emergency room visits and hospitalizations.[6,7,8,9] Community Care of North Carolina, in a large pilot of 819,056 Medicaid patients, projected savings of $124 million over the fee-for-service model, improvements in adherence to preventive medicine guidelines and a 13% lower rate of emergency department use.[10] The Wisconsin Academy of Family Physicians projects an annual net savings from a fee-for-service baseline of $205 per participant,[11] while major national employers expect to save up to $300 per patient in the first year of medical home pilots.[12] If equally available to insured and uninsured populations, medical homes show potential for reducing health disparities and promoting health equity.[13]

The medical-home model also offers a method to bolster the financial stability of primary care clinics, reverse the trend toward subspecialty care and, some believe, make primary care a more attractive career choice for physicians-in-training.[14] Early pilots show promising results for physician satisfaction, clinical process and outcomes measures, practice revenue, and physician income.[15,16,17]

The medical home model relies on payment reforms to support care beyond what is typically billable under fee-for-service, such as care coordination, patient education, adoption of health information technology, and interaction with patients by telephone or e-mail. The non-profit National Committee on Quality Assurance (NCQA) has implemented voluntary standards for recognition of medical homes.[18] Each element is assigned points based on the degree of implementation, with three levels of recognition. Associated payment reforms generally involve a per-patient-per-month care management fee paid by health plans to NCQA-certified practices, with extra payments available to practices that receive higher scores.

Some large medical groups already have medical home components[19] but adoption of the medical home model is not yet widespread. No Wisconsin practices are currently NCQA certified, although several Wisconsin-based systems are conducting pilot projects. Safety net providers, including federally-qualified health centers that serve many uninsured and underserved communities, are currently less ready to meet standards as a medical home.[13]

Medicare is beginning to support demonstration projects[20] in which practices will be eligible for care management fees, increased payments for more complicated patients, and a portion of any savings in health care costs. States and private health plans are also investing in the implementation of the medical home.[21] These investments, however, come with expectations of budget neutrality -- that cost savings offset any increased expenditures.[22]

**Aligning Incentives**

Some argue that the medical home cannot constrain overall cost growth unless placed within a framework that also manages care and costs outside of primary care, through an integrated delivery system. Fisher and colleagues[23] instead propose a global shared savings approach through an "Accountable Care Organization" model, asserting "the medical home needs a hospitable and high-performing medical neighborhood."[24]

**NCQA Medical Home Recognition Standards**

- Patient access and communication (9 points)
- Patient tracking and registry function (21 points)
- Electronic prescribing (8 points)
- Test tracking (13 points)
- Referral tracking (4 points)
- Advanced electronic communications (4 points)
- Care management and coordination (20 points)
- Patient self-management support (6 points)
- Performance reporting and improvement (15 points)

University of Wisconsin
SCHOOL OF MEDICINE AND PUBLIC HEALTH

Department of Population Health Sciences • Suite 760, 610 Walnut Street, Madison, WI 53726-2397
Phone: (608) 263-6294 • Fax: (608) 262-6404 • http://www.pophealth.wisc.edu/uwphi

Indeed, the existing medical home model has weaknesses. This model depends on assignment of patients to a primary care provider, which consumers may resist as perceived gatekeeping. Physician practices serving as medical homes also have limited leverage to coordinate care with specialists who are not immediate colleagues. Since additional payments are typically targeted to primary care physicians, specialists outside the medical home have few incentives to collaborate and share decision-making for patients.

Any increase in total payments to primary care providers, under a policy of budget neutrality, would come at the expense of payments to other physicians or specialty services. Fewer visits and stays from medical-home patients could lead hospitals and specialists to increase the discretionary ordering of return visits (volume) or diagnostic tests (intensity) for other patients. A failure to align incentives outside of the medical home thereby undermines overall cost containment goals.

The Accountable Care Organization model responds to this challenge by proposing global shared savings to an integrated group of providers, including and extending beyond the primary care providers. Providers would not offset savings (revenue reductions) in one patient group by increasing service volume or intensity for another patient population. Instead, the full group of providers, with a global budget, could preserve their net incomes by improving efficiency to their entire patient population.

**Retail Clinics: Complement or Conflict?**

Parallel to the medical home trend, limited service retail-based clinics have proliferated nationally and in Wisconsin—operated here by Aurora Health Care, Bellin and Meriter Health Services, and by Walgreens. Retail clinics, located within chain pharmacies and high-volume retail stores, offer limited medical services on a walk-in basis with extended hours. They are generally staffed by advanced nurse practitioners and provide low-cost diagnosis and treatment of common ailments, physical exams, health screenings, vaccinations, and other episodic services. Consumers have responded very favorably, with satisfaction rates exceeding 90 percent on quality of care, convenience and cost.[25]

The national Convenient Care Association, the industry's trade group, promotes retail clinics as an extension of primary care and a solution to challenges of access and cost. Clinics offer the promise of increased primary care access and less pressure on hospital emergency departments. A 2006 survey conducted by Wisconsin's Aurora QuickCare reports high use and satisfaction, particularly by patients with no health insurance and those with high deductibles. A recent RAND study confirms the reliance on retail clinics by persons with otherwise limited access to care.[26]

The retail clinic industry has adopted its own standards for quality certification, addressing quality monitoring, quality of care, patient referrals to primary care providers and use of electronic medical records.[27,28] But some industry observers worry about how such clinics fit into the continuum of care, asserting that retail clinics offer fragmented, episodic treatment that cannot substitute for a medical home.

Physician groups have offered lukewarm responses that recognize some value in retail clinics. The American Academy of Pediatrics, however, has adopted a statement that opposes their use for infants, children, and adolescents. The AAP statement outlines a broad set of concerns: fragmentation and possible effects on quality of care, lack of access to a central health record or reporting back to primary physicians, use of tests for diagnosis without proper follow-up, and public health issues surrounding exposure to contagious diseases in a retail environment.[29] A number of states are now considering legislation to impose standards and oversight, and to ensure that retail clinics are integrated into the larger medical community.[30]

**Provider Integration and Accountability**

Regulatory and payment reforms can advance the quality of the medical home model alongside the convenience of retail clinics. But Wisconsin stands well-positioned to go beyond payment add-ons that support piecemeal additions to an already fragmented system. Wisconsin already boasts nationally-recognized integrated health systems[31] advances in electronic medical records,[32,33] and innovations in quality measurement and reporting.[34] Payers and purchasers can develop consistent and mutually reinforcing incentives that align the interests of providers across the spectrum of care. Providers, in turn, can integrate the convenience clinics and medical homes, and build accountable systems that improve quality and reduce costs.[35]

**REFERENCES**

Complete references available online at

**http://www.pophealth.wisc.edu/uwphi/Publications/IssueBriefs.htm**

**Comparison of current payment reforms**

| | Primary Care Medical Home | Episode Bundled Payments | Global Shared Savings | Full Capitation |
|---|---|---|---|---|
| Strengthens primary care | Yes | No | Yes | Yes |
| Fosters coordination among participating providers | No | Yes | Yes | Yes |
| Removes payment incentives to increase volume | No | No | Yes | Yes |
| Fosters accountability for total costs of care | No | No | Yes | Yes |
| Requires providers to bear risk for excess costs | No | Yes | No | Yes |
| Requires "lock-in" of patients to specific providers | Yes | No | No | Yes |

Source: Eliott Fisher, MD, MPH, The Dartmouth Institute for Health Policy and Clinical Practice