

CAPITOL RESEARCH

HEALTH

State Initiatives in Patient-Centered Medical Homes

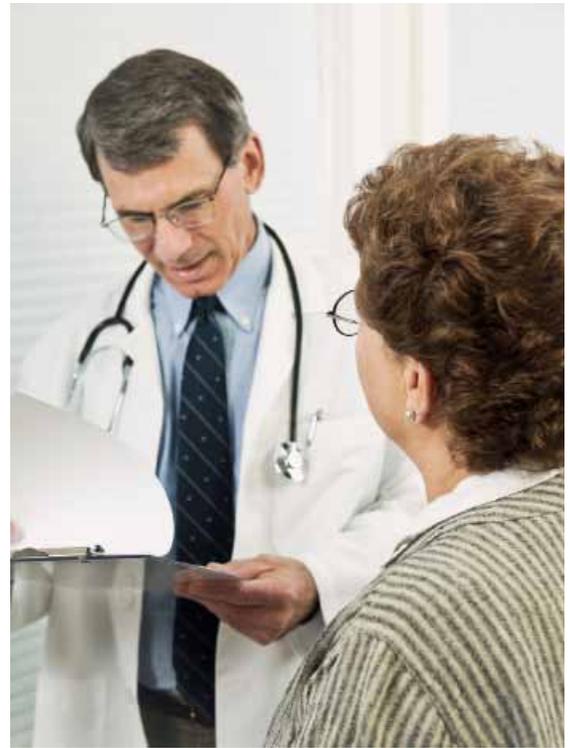
State Medicaid programs, which provide health insurance for the poor using state and federal funds, constantly strive to cut costs and achieve savings. That's because Medicaid's share of total state spending has more than doubled in the past 20 years, reaching nearly 22 percent of all state budget funds.¹ States are pursuing patient-centered medical home initiatives as one approach to improving the way health care is delivered while controlling rising health care costs. Based on the premise of rewarding doctors to keep their patients healthy—rather than paying exclusively for treating them when they're sick, this approach has many supporters, including policymakers, employers, physicians, patients and insurers.²

What is a patient-centered medical home?

At the core of the medical home is the patient's personal, comprehensive, long-term relationship with a primary care physician and a philosophy of care focused on preventing illness and helping patients take an active role in promoting their own good health. The primary care physician and staff act as a home base—or the patient's medical “home”—where the patient can access care during extended hours, patients actively participate in their care, and the medical home coordinates medical care across all health care settings such as hospitals, outpatient facilities and nursing homes.

Four major primary care physician groups—the American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians and American Osteopathic Association—define a patient-centered medical home as an approach that provides comprehensive primary care to children, youth and adults in “a setting that facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family.” Core features include a physician-directed medical practice with a personal doctor for every patient, the capacity to coordinate high-quality accessible care, and payments that recognize a medical home's added value for patients.

The patient-centered medical home is similar to



managed care approaches and health maintenance organizations, but asks providers to focus on improving care rather than managing costs. The patient-centered medical home focuses on improving the relationship between doctors and patients. It aims to put the patient at the center of the care system, and provides coordinated and integrated care over time and across care settings. Cost savings are expected as a result of providing better care for patients, not from withholding needed care. The primary care physician leads a team that serves as a patient advocate and guide through the health care system rather than a gatekeeper.

Patients who have a primary care provider incur about a third less in health care expenditures,⁴ and they are 7 percent more likely to stop smoking and 12 percent less likely to be obese.⁵ A June 2007 report

Principles of Patient-Centered Medical Home:³

- Each patient has an ongoing relationship with a personal physician who directs all care.
- Physician is responsible for all the patient's health care needs, provided by all health care professionals in all stages of the patient's life.
- Care is coordinated and integrated across all parts of the health care system.
- Quality of care and patient safety are monitored for all patients.
- Patients have enhanced access to care through expanded hours and new ways to communicate with physicians and other staff.
- Payment to physicians and staff recognizes the added value provided to patients.

released by the Commonwealth Fund, a private foundation that supports independent research on health care issues, concluded that health care settings with features of a medical home can potentially eliminate disparities in access to care among racial and ethnic minorities, suggesting that expanding access to medical homes could improve quality and improve equity in the health care system.⁶ Medical homes improve the percent of patients that received optimal care for chronic illnesses such as diabetes, with the potential to reduce unnecessary or avoidable medical care.⁷

Despite these benefits, only 27 percent of adults—an estimated 47 million people—have a medical home—defined as a regular doctor or source of care that is organized and well run, with access to care on nights, weekends and by telephone. Another 54 percent of adults have a regular doctor or source of health care, but it does not meet all defined conditions to be a medical home, and the remaining adults do not have a regular source of care or use emergency rooms.⁸ Only half of young children have a specific clinician to provide continuous well-child care.⁹

States Lead the Way in Promoting Medical Homes

The National Academy for State Health Policy identified 39 states that have incorporated medical homes into their Medicaid and CHIP—state Children's Health Insurance—programs. Because Medicaid covers 60 million people and is growing, it could drive adoption of medical homes nationally. Some state examples include:

The **Colorado** Department of Health Care Policy and Financing implemented a patient-centered medical home program for low-income children enrolled in the state's Medicaid and CHIP programs. As of March 2009, 150,000 children were enrolled and 97 different community-based practices and 310 physicians participated in the program. The median annual cost for children enrolled in the program was \$785 compared to \$1,000 for a comparison group, due to reductions in emergency room visits and hospitalizations.

North Carolina's medical home program, Community Care of North Carolina, is the oldest and probably the most successful medical home initiative in the country. It started in 1998 as a small pilot program aimed at lowering emergency room use for patients with asthma. The program includes 14 community

networks and more than 3,500 physicians, and serves more than 950,000 enrollees (more than two-thirds of the state's Medicaid recipients). Community Care of North Carolina pays each network \$3 per Medicaid patient per month, and each physician receives an additional \$2.50 per month for each Medicaid patient. Studies indicate that the program saved the state \$60 million in Medicaid costs in 2003¹¹ which increased to \$154 million in 2007.¹²

The Rhode Island Chronic Care Sustainability Initiative is a statewide pilot program that began in October 2008 at five medical practices, involving 26 doctors and 26,000 patients. The initiative is different in that it involves the state's Medicaid program as well as the major health care payers in the state, except Medicare. Each medical practice receives \$3 per month for each patient covered by the participating payers. The pilot sites' contracts ended in September 2010 and the state is considering continuing the project.

The **Washington** legislature mandated a disease management program for Medicaid in 2001. After focusing on disease management for several years, Washington Medicaid transitioned to a chronic care management/medical home model approach. Washington's Medicaid medical home program is in partnership with King County Care Partners, and approximately 8,000 Medicaid recipients are eligible for the program each month. King County Care Partners receives a per-member monthly fee of \$8.70, \$2.50 of which goes directly to provider clinics and practices. The program connects recipients with clinics that assess and provide health care to the recipients. It also coordinates clinical and other services for recipients, including mental health and chemical dependency treatment, housing, transportation and other social services.

Legislative Actions

The patient-centered medical home approach attracts support from patients, payers and physicians, but also has inspired both federal and state legislation. The federal Patient Protection and Affordable Care Act of 2010 includes a provision to establish medical home demonstration projects. The Multi-Payer Advanced Primary Care Practice Demonstration is the first federal demonstration project to bring together Medicare, Medicaid and private health insurers; as many as six states are expected to participate in the project.

Many states considered medical homes during the 2009 and 2010 legislative sessions. Examples of the bills enacted that authorize demonstration projects for implementing or expanding medical homes include:

- **Florida Senate Bill 1986** (2009) directs the Agency for Health Care Administration to develop a plan to implement a medical home pilot project. The project uses primary care case management enhanced by medical home networks to provide coordinated care and cost estimates.
- **Nebraska Legislative Bill 396** (2009) creates a Medicaid medical home pilot project and establishes reimbursement policies and incentives to encourage both physicians and patients to participate in the program.
- **New Mexico House Bill 710** (2009) requires the Department of Human Services to obtain any necessary waivers or state plan amendments from the federal government and establish a “medical home program” for the state Medicaid, state children’s health insurance and state coverage initiative programs.
- **New York’s Chapter 58 of Assembly Bill 158B**, the 2009 budget bill, authorized the state Department of Health to implement an initiative to incentivize the development of patient-centered medical homes for Medicaid.
- **Maryland House Bill 929/Senate Bill 855** (2010) directs the Maryland Health Care Commission to establish by January 2011 a program consisting of all-payer and single-payer patient-centered medical home pilot projects. The legislation allows participating insurance carriers to pay bonuses and incentives to medical practices for improved patient outcomes. The legislation also explicitly permits the exchange of medical records and information among health care providers involved in the pilot projects.

- **New Jersey Senate Bill 665/Assembly Bill 226** (2010) requires its Medicaid program to establish a three-year medical home demonstration project to expand the options for Medicaid recipients to receive patient-centered and coordinated primary care.
- **Ohio House Bill 198** (2010) authorizes a pilot project to change how primary care is delivered in Ohio. The project focuses on converting 44 medical practices in Ohio to the patient-centered medical home model of care. It also overhauls payment methods so doctors and other caregivers are paid not only a fee-for-service, but for how well they manage chronic disease. The bill does not set aside any state funds for the project.

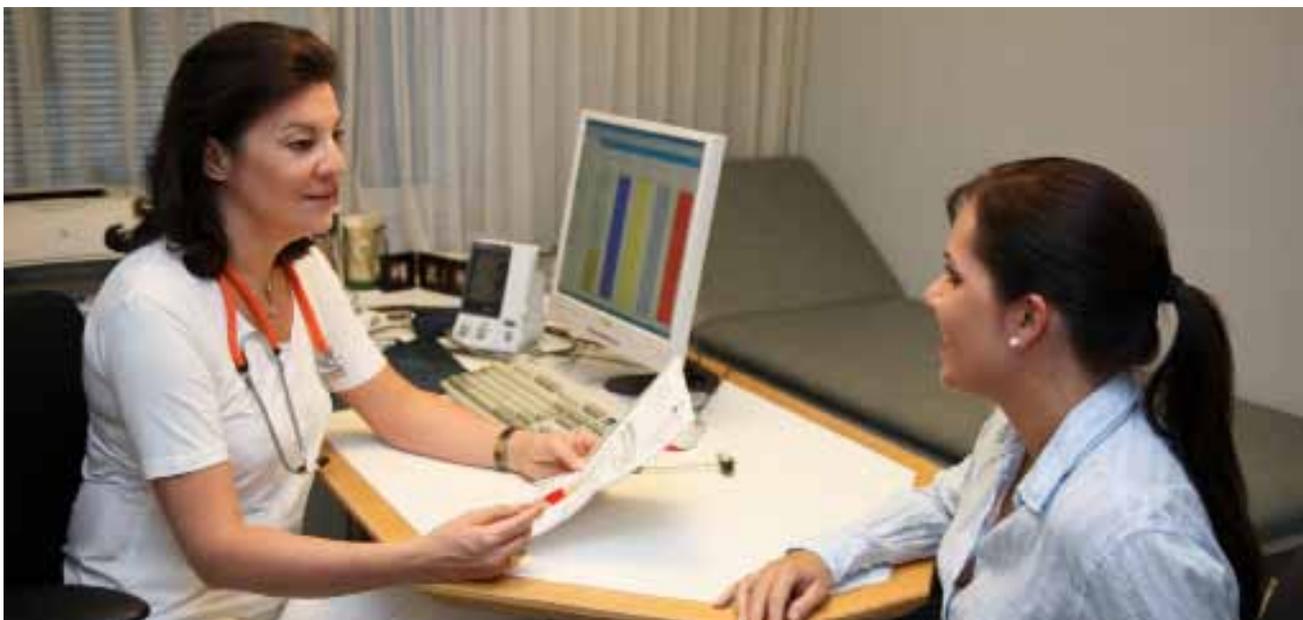
The Council of State Governments has adopted a resolution urging its members to implement and fund patient-centered medical home pilot projects. The resolution, adopted at CSG’s 2008 annual meeting in Oklahoma City, encourages CSG members to support the Joint Principles of the Patient-Centered Medical Home developed by four primary care physician organizations to improve health care quality and reduce costs. In addition, the resolution encourages states to “implement and fund pilot programs to demonstrate the quality, safety, value and effectiveness of the patient-centered medical home.”

Conclusion

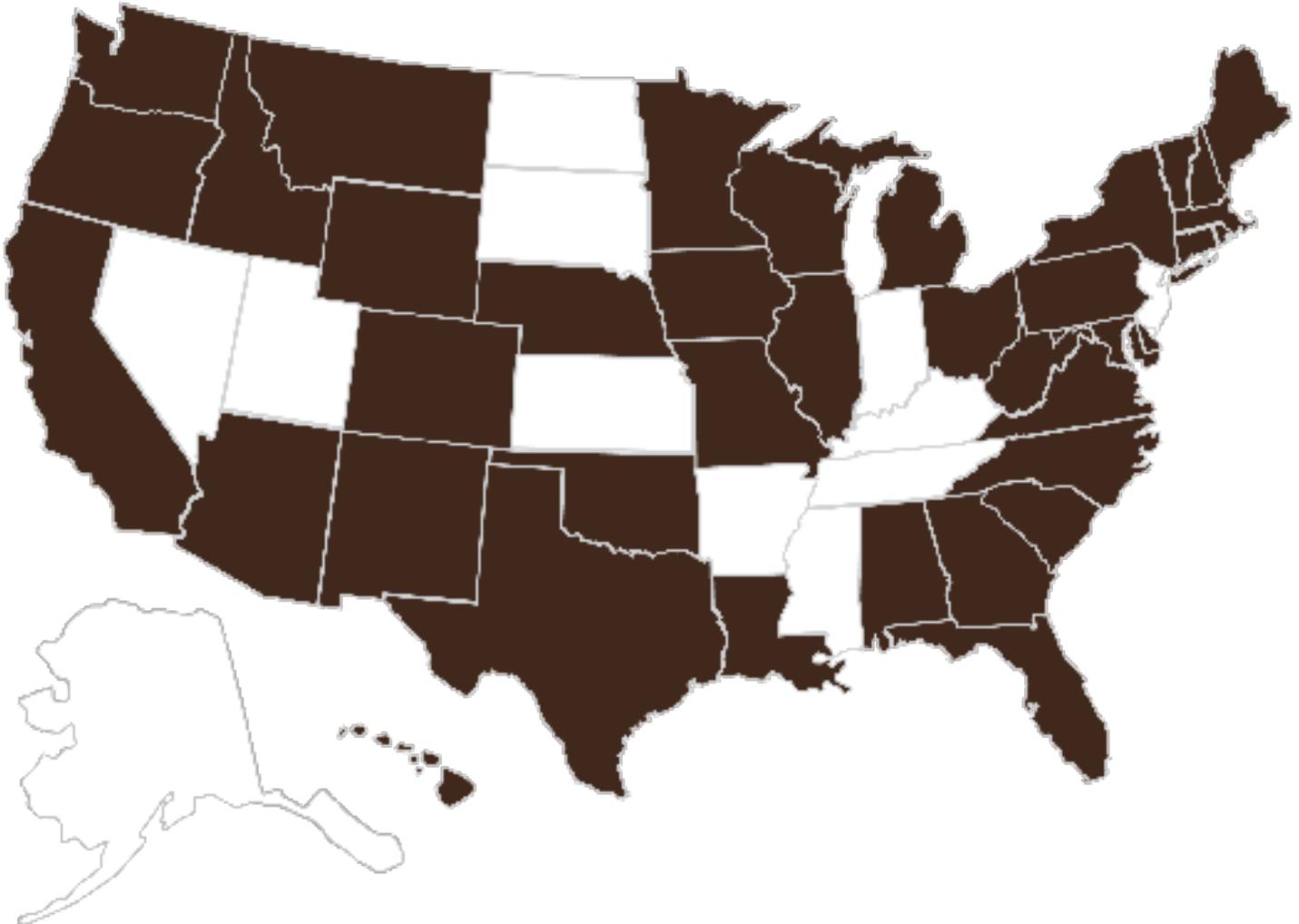
As states grapple with the unsustainable growth in Medicaid health costs, innovative solutions to transform the health care delivery system through medical homes are being tested in several states. Early results from a few programs show promise in controlling health care costs and improving care, but further validation of these findings is needed in other states and programs. Ultimately, states will have to demonstrate results in each of their own Medicaid programs.



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Medical Home Initiatives in State Medicaid and SCHIP Programs¹⁰



Source: National Academy of State Health Policy. See <http://nashp.org/med-home-map> for description of Patient-Centered Medical Home program in every state.

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