

Health Affairs

At the Intersection of Health, Health Care and Policy

Cite this article as:

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Their Medicaid Populations

Health Affairs, 31, no.11 (2012):2432-2440

doi: 10.1377/hlthaff.2012.0447

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DOI: 10.1377/hlthaff.2012.0447
 HEALTH AFFAIRS 31,
 NO. 11 (2012): 2432–2440
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About Half Of The States Are Implementing Patient-Centered Medical Homes For Their Medicaid Populations

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ABSTRACT Public and private payers are testing the patient-centered medical home model by shifting resources to enhance primary care as an important component of improving the quality and cost-effectiveness of the US health care delivery system. Medicaid has been at the forefront of this movement. Since 2006 twenty-five states have implemented new payment systems or revised existing ones so that primary care providers can function as patient-centered medical homes. State Medicaid programs are taking a variety of approaches. For example, Minnesota's reforms focus on chronically ill populations, while in Missouri a 90 percent federal match under the Affordable Care Act is helping integrate primary and behavioral health care and address issues of long-term services and supports. These reforms have led to better alignment of payments with performance metrics that emphasize health outcomes, patient satisfaction, and cost containment. This article focuses on trends in Medicaid patient-centered medical home payment that can inform public and private payment strategies more broadly.

Payment reform is at the heart of efforts to improve the US health care delivery system, which has been described as wasteful and inefficient¹ because it rewards quantity over quality, sick care over preventive care, and specialty care over primary care.² Over the past six years, twenty-five states have enacted payment changes that seek to expand access to patient-centered medical homes in Medicaid or the Children's Health Insurance Program.³ A patient-centered medical home is a model of primary care in which care teams—led by a primary care provider—provide accessible, comprehensive, coordinated, and continuous patient-centered care. Increasing access to this kind of care is considered to be an important strategy designed to focus more resources on primary care.

This article reports on some of the most recent trends in state Medicaid patient-centered medi-

cal home reforms. These reforms have resulted in payment models that better emphasize the "Triple Aim" goals of lower costs, improved population health, and improved care and patient experience. The simultaneous pursuit of these three goals, according to the Institute for Healthcare Improvement, is essential to optimal health system performance.⁴

Study Data And Methods

This article reviews new trends in Medicaid patient-centered medical home payment that can inform other efforts to better support primary care. Information for this article was collected from a project funded by the Commonwealth Fund that assisted fourteen states from March 2011 to May 2012 with efforts to sustain, improve, and expand existing patient-centered medical home initiatives.⁵ States participating in this project received expert advice on their ini-

tatives through in-person meetings, webcasts, and ongoing consultations with project staff.

An advisory group of state, national, and federal experts identified and selected a total of fourteen states to participate in the project based on the size and scope of their patient-centered medical home initiatives; participation in Medicaid, Children's Health Insurance Program, or both; and plans to participate in federal health reform initiatives. Included in these fourteen states were four that had developed, but not fully implemented, patient-centered medical home initiatives.

Thirteen of the fourteen states completed a survey in February 2011 that provided data on provider, patient, and payer participation in each state's patient-centered medical home initiative; payment model and qualification criteria for the initiative; support for training medical practices to become patient-centered medical homes; and plans to expand the initiatives using resources made available by provisions of the Affordable Care Act.⁶ For the fourteenth state, we gathered information through other means, such as web-based sources.

In addition, ongoing monitoring of state Medicaid patient-centered medical home activity by the National Academy for State Health Policy contributed to this article. Information was also gathered from state and federal websites and from applications to federal demonstration projects, and it was verified through e-mail with key state policy makers.

Patient-Centered Medical Home Payments

Although the concept of what is now commonly known as a patient-centered medical home was first advanced by the American Academy of Pediatrics in the 1960s,⁷ states' interest in paying for this model of care is much more recent. Since 2006 twenty-five states have implemented new payments—or revised existing ones—to primary care providers so that they may function as patient-centered medical homes. Twelve of these states are participating in demonstration projects in which multiple payers in both the public and private sectors participate, including the Multi-payer Advanced Primary Care Practice demonstration described below.

Nineteen of the twenty-five states pay providers to perform the functions of a patient-centered medical home using a per member per month care management fee (Exhibit 1). Typically, care management fees are added to standard fee-for-service payments to providers for office visits, tests, or procedures. Commercial payers and Medicaid plans that participate in

state initiatives also use this payment method.

Care management fees vary considerably across states and sometimes within a state. Fees are often adjusted to reflect the acuity of a patient's condition, the age of the patient, or the level of the patient-centered medical home—that is, how well a particular medical home practice scores according to the patient-centered medical home qualification standards created by the National Committee for Quality Assurance. For initiatives that serve predominantly mothers and children on Medicaid and the Children's Health Insurance Program, the range of care management fees begins at the low end at \$1.20 per patient per month in Vermont and \$4.68 per patient per month in Maryland, and tops out at \$2.39 and \$8.66 per patient per month, respectively.⁸

Of the twenty-five states that are making patient-centered medical home payments, twenty-one also support practice training through individual practice coaching, group practice education through learning collaboratives, or both. Fourteen of the states provide performance-based payments, and five provide payments to support up-front costs (Exhibits 1 and 2).

Care Management Fees Target Complex Populations

Early Medicaid patient-centered medical home initiatives primarily served mothers and children. Because of budget pressures, compelling evidence about the ability to improve the quality of care and lower costs with a focus on high-risk patients,^{9,10} and new opportunities through the Affordable Care Act, states are now adapting early initiatives or developing new ones to serve their most costly populations—patients with chronic conditions.

Minnesota was an early innovator in efforts to focus on chronically ill populations. The state designed a care management fee that was adjusted according to the number of a patient's chronic conditions and that was added to a practice's fee-for-service payments. The adjustment was designed to take into account the time and resources—including staff and information technology—that a primary care practice required to manage the care of patients with complex conditions.

The care management fee started at \$10 per patient per month for patients with one to three major chronic conditions and increased to \$60 for patients with ten or more conditions.¹¹ Practices received an additional 15 percent if either the patient or caregiver had a serious and persistent mental illness or used a primary language

nity mental health centers must meet the patient-centered medical home standards of a national accrediting body such as the National Committee for Quality Assurance.¹⁵ Because the committee will review only applications from primary care practices, the Missouri Department of Mental Health will review applications from community mental health centers in the state to make sure they meet qualification standards. If they do not meet standards, the centers risk losing health home payments.

Missouri's health home state plan amendment builds on successful demonstration projects with community mental health centers, including one project that enrolled Medicaid patients with severe mental illnesses into an intensive case management program. Over the twenty-four-month demonstration period after the enrollment month, the average per person per month cost decreased by about \$300, even with the additional costs of the new services.¹⁶

Monthly Payments To Support Shared Teams Or Networks

A core principle of a patient-centered medical home is team-based care. In 2012 Alabama, Maine, Michigan, and Minnesota added shared, locally based teams or networks to help practices—particularly small ones—become medical homes and provide resources to better address the needs of Medicaid patients with complex conditions. The shared teams may include registered nurses, behavioral health specialists, pharmacists, nutritionists, and community health workers; teams are often based at a hospital or a community health center. New York, North Carolina, Oklahoma, and Vermont had team or network care models under way before 2012.

Per member per month payments generally flow directly from payers to the teams or networks. The payments range from \$0.30 for privately insured patients in Maine to \$13.72 for aged, blind, or disabled Medicaid patients in North Carolina.¹⁷ These teams or networks can serve one large practice or many small to medium-size practices.

For example, the Alabama Medicaid Agency launched a pilot project in 2011¹⁸ to develop three community care team networks to support primary care providers as patient-centered medical homes—a project modeled after the Community Care of North Carolina program. Alabama Medicaid pays providers a per patient per month care management fee of \$2.60–\$3.10, and the networks receive a per patient per month fee of \$5 for each elderly, blind, and disabled enrollee and \$3 apiece for other patients.¹⁹

Payments That Spur Continuous Quality Improvement

Targeted payments can serve as a strong incentive to encourage practices to become qualified patient-centered medical homes by meeting existing national or state-specific standards. These standards often include criteria such as referral tracking and follow up, and providing after-hours care.

In twenty-one state initiatives that seek to encourage practices to become patient-centered medical homes by aligning payments with a set of qualification standards, all but six require practices to achieve National Committee for Quality Assurance recognition.³ As an incentive for practices to continue to improve care processes, three states—Connecticut,²⁰ Maryland,²¹ and New York²²—have required practices to move up from being recognized as level 1 homes to being recognized as level 2 or level 3 homes as a condition of receiving patient-centered medical home payments. The National Committee for Quality Assurance uses a point-based system to assess practices on the processes they have in place to organize care around patients, work in teams, and coordinate and track care over time. Practices must score a minimum of 35 points to achieve level 1 recognition and can advance up to level 3 by scoring 85–100 points.

Payers can also promote continuous quality improvement by aligning the patient-centered medical home payment with performance outcomes. In 2008 three commercial insurers and two Medicaid plans participating in the Rhode Island Chronic Care Sustainability Initiative paid practices that had qualified as patient-centered medical homes a fixed \$3 per patient per month care management fee in addition to sharing support for an on-site nurse care manager.

In 2010 Rhode Island was selected as one of eight states to participate in the Multi-payer Advanced Primary Care Practice demonstration.²³ This federal demonstration project added Medicare as a payer to eight existing state multipayer patient-centered medical home initiatives. Because Rhode Island providers participating in the project had already received practice training, data support, and care managers and were already recognized as patient-centered medical homes, the expansion of the initiative provided an opportunity for the participating practices and the state's commercial insurers to develop a new contract, with the support of the Office of the Health Insurance Commissioner. The new contract raised expectations, and payments, by requiring participating providers to do more than simply maintain National Committee for Quality Assurance recognition. Providers are required to meet a number of targets for utiliza-

tion, quality, and patient satisfaction measures, rather than simply producing clinical reports with no expectations of accountability.

As of April 1, 2012, the original Rhode Island pilot practices, as part of their renewal contract, receive the following per patient per month care management fees: \$5.00, if the practice reaches only one of the three specified performance targets, which are hospital utilization, clinical quality or patient experience, and National Committee for Quality Assurance recognition; \$5.50, if the practice reaches the utilization performance target and one other target; and \$6.00, if the practice reaches all three targets.²⁴

The Rhode Island renewal contract also requires that practices expand patients' access to care outside of normal business hours. Although access around the clock, seven days a week, is expected of patient-centered medical homes, typically this requirement can be met by practices' expanding remote access options such as e-mail or telephone consultations.

In addition, practices are required to establish agreements with local specialists and hospitalists to share information and coordinate care. New practices joining the project initially received payments similar to the original pilot program payments—that is, fixed monthly care management fees and support for a nurse care manager—and are making the transition to the new payment structure.

Providers participating in the Rhode Island pilot program already have the electronic health records required by this new payment method. In addition, Rhode Island is establishing a system that will enable the electronic exchange of health information. A notification system has begun to link enrolled hospitals and providers electronically so that when a patient is admitted or discharged from a hospital or its emergency department, the primary care provider receives notification and a summary of the care the patient received.²⁵

Adding Payments To Support Up-Front Costs

Recent studies showed that most primary care practices fall far short of functioning as patient-centered medical homes and will need to dedicate time and resources to redesigning themselves.^{26,27} For time-limited demonstrations and for states that need to show a budget impact in a short period of time, providing practices with up-front payments to jump-start their transformation to patient-centered medical homes may make sense, but this type of payment strategy has not been widely adopted (Exhibits 1 and 2).

One example of a state that has embraced such

payments is Massachusetts, with its Patient-Centered Medical Home Initiative. The pilot program paid practices their first up-front payments several months in advance of their first monthly care management fees in 2011. Payments were as high as \$15,000 in the first year of the program and \$3,500 in the second year. They were intended to support activities such as populating patient registries with patient data and supporting practice team training.²⁸

Evolving Performance Payments

As mentioned above, fourteen state patient-centered medical home initiatives give providers performance-based payments.³ So far, these payments have been mostly based on process and structural measures, as well as a few outcome measures.

With the advent of provider registries, electronic health records, all-payer claims databases, and risk-adjustment processes, payers have better tools to align payments based on outcome measures. The availability of such tools, combined with the budget pressures that payers are facing, have increased payer interest in using shared savings payment models. Under shared savings, if a practice spends less than its projected costs for a particular panel of patients, the practice gets to keep some portion of the savings.²⁹

The use of shared savings is most often seen in states with multipayer initiatives, such as Maryland, Massachusetts, Pennsylvania, and Washington. Using shared savings may result in more buy-in on the part of payers because it allows them to avoid some of the financial risks of participating in a patient-centered medical home pilot program: Payments are made only if practices produce savings by meeting certain agreed-on targets. Sharing savings is often a harder sell among primary care providers because provider performance, typically measured as reductions in emergency department visits or thirty-day readmission rates, is based on many factors that primary care providers cannot control.

Pennsylvania, like Rhode Island, revised its patient-centered medical home payment model when Medicare joined as a payer in a federal demonstration in 2010.²³ Participating payers and practices in Pennsylvania had the benefit of three years of experience with the state's multipayer Chronic Care Initiative, a payment model that varied by region. In the second phase of the initiative, Medicare, commercial insurers, and Medicaid plans have adopted a single payment model across two regions that varies by initiative year and patient age. Practices receive

EXHIBIT 2

Characteristics Of State Patient-Centered Medical Home Payment Initiatives, June 2012

State	Multipayer	Payment aligned with qualification standards ^a	CM fee and fee-for-service payments ^b	Performance payments	Transformation support ^c	Payments to support up-front costs	Shared teams or networks
AL			•	•	•		•
CO ^d		S		•	•		
CT		N		•	•	•	
IL			•	•	•		
IA		N	•	•	•		
LA ^e							
ME	•	N	•		•		•
MD	•	N	•	•	•	•	
MA	•	N	•	•	•	•	
MI	•	N	•	•	•		•
MN	•	N, S	•		•		•
MO		N	•		•		
NE		S	•		•		
NJ ^e		N					
NM ^e		N					
NY ^f	•	N	•		•		•
NC ^g	•	N	•		•		•
OK		S	•	•	•	•	•
OR		N, S	•		•		
PA	•	N	•	•	•	•	
RI	•	N	•	•	•		
SC			•	•			
VT	•	N	•		•		•
WA	•	S	•	•	•		
WV	•	N		•	•		
Total	12	21	19	14	21	5	8

SOURCE Author's analysis of data from National Academy for State Health Policy. Medical home and patient-centered care (Note 3 in text). **NOTES** N = 25. Shared teams and networks are explained in the text. Colorado, Connecticut, and New York (in the New York Statewide Patient-Centered Medical Home Program) offer enhanced fee-for-service payments for certain office or outpatient visits known as "evaluation and management" visits in lieu of monthly care management payments for practices that qualify as medical homes. ^aStandards are qualification standards for patient-centered medical homes. Some states allow providers to choose between state standards (S) and national standards (N). ^bCare management (CM) fee is per member per month. ^cTransformation support is providing training, coaching, or learning communities to help practices transform themselves into patient-centered medical homes. ^dThe Colorado Medical Home Initiative, one of several Medicaid patient-centered medical home initiatives in the state. ^eIn Louisiana, New Jersey, and New Mexico, Medicaid's contracts with managed care plans require medical home initiatives but offer flexibility on how to structure payments to practices. Because of variation among the contracted plans, we were not able to determine how the payments were being implemented. ^fThe Multi-Payer Advanced Primary Care Practice Demonstration in the Adirondack region of New York, one of several medical home initiatives in the state. ^gThe Multi-Payer Advanced Primary Care Practice Demonstration in seven counties of North Carolina, one of several medical home initiatives in the state.

a fee consisting of two payment streams, both of which decrease by 15 percent in the second and third years of the initiative. The first stream is a fixed medical home payment of \$1.50 per patient per month. The second is a per patient per month care management fee adjusted for age, which ranges from \$0.60 for the pediatric population to \$7.00 for patients age seventy-five or older.³⁰

In the Pennsylvania initiative, shared savings are calculated using a number of key measures that include outcome measures, such as diabetes and hypertension management, and utilization measures, such as thirty-day readmission rates and emergency department visits. Practices are eligible to share up to 40 percent of net savings in the first year, 45 percent in the second, and 50 percent in the third. Each payer looks at the practices' actual versus expected cost trends

to calculate savings. To address the problem of small numbers of patients, the payers plan to group practices together to improve the stability of the estimates.

A Bridge To Accountable Care Models

The patient-centered medical home infrastructure—which includes data support, training, practice teams, and health information technology—is an essential foundation for preparing payers and providers for accountable care payment models. These models may use global payments that hold a group of providers—including primary care and specialty care providers and hospitals—at financial risk for the care that patients receive in a given time period. In addition

to the infrastructure, patient-centered medical home payment models that use shared savings can serve as a bridge, preparing providers for risk-based payment models.

Although no state has implemented global payments to date, there is widespread discussion among policy makers and a good deal of state legislative interest in accountable care models. Massachusetts³¹ and Vermont³² have been developing global payment models in collaboration with commercial payers. These two states and the three others described below have made a major investment in primary care infrastructure for patient-centered medical homes to allow practices to advance toward accountable care models.

North Carolina's statewide primary care infrastructure consists of fourteen community-based networks staffed to support Medicaid providers in patient care and engage providers in using data to improve the management of their patient panels and meet community health goals.³³ The networks are supported by a central organization, known as Community Care of North Carolina, that hosts a robust informatics center. Other payers and purchasers are using this infrastructure to support the care of non-Medicaid populations.^{34,35}

North Carolina's predominant payment model is fee-for-service payments for providers plus monthly care management fees for both providers and networks. However, appropriations legislation passed in 2010 called for a comprehensive plan to move the state toward using this infrastructure to test new payment models that employ accountable budget and shared savings models.³⁶

In 2011 Colorado launched regionally based organizations supported by a central informatics center to work with Medicaid providers to address costs and quality goals,³⁷ producing a model similar to North Carolina's. Colorado's Accountable Care Collaborative uses a payment model like North Carolina's and plans to use shared savings as a way to prepare regional organizations and providers to share financial risk.

In 2012 Oregon began the process of certifying regionally based organizations—called Coordi-

nated Care Organizations—to support Medicaid providers. The regional organizations will replace the state's current delivery system, which consists of sixteen fully capitated health plans, ten mental health organizations, and eight dental care organizations.^{38,39} Oregon is required by law to pay the Coordinated Care Organizations using a global budget.

Discussion

This review of state Medicaid patient-centered medical home activity suggests that payment models are not static. Many are being redesigned for a variety of reasons, such as to take advantage of opportunities provided by the Affordable Care Act, respond to budget pressures, add new payers, and target specific populations. States' experimentation with earlier pilots has informed newer payment models that better align payment with performance metrics emphasizing health outcomes, patient satisfaction, and cost containment. Five states are using their experience with medical home initiatives to move toward accountable care payment models.

Notably absent from this review of state patient-centered medical home initiatives are rigorous evaluations of whether or not these initiatives and their payment models work. Independent, university-led evaluations are under way in some states, but their results have yet to be published. For instance, both Pennsylvania and Rhode Island have commissioned independent, privately funded evaluations of their initiatives.⁴⁰ Both states have also revised their payment models before receiving the results of the studies, based on experience with early pilot programs and to move forward with the expansion of their initiatives.

The desire to achieve the "Triple Aim" goals of lower costs, improved population health, and improved patient experience is driving the evolution of state patient-centered medical home initiatives. These initiatives will ultimately provide a deep well of experience and innovation that can inform and shape future public and private payment policies. ■

The author thanks Melinda Abrams of the Commonwealth Fund for her input on this article and her long-time support

of this research. The author also thanks Charles Townley, Sarah Kinsler, and Kimm Mooney of the National Academy

for State Health Policy for their research support, including development of the exhibits for this article.

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In this month's *Health Affairs*, Mary Takach describes Medicaid's role in advancing the patient-centered medical home model to improve the quality and cost-effectiveness of US health care. Since 2006 half of the fifty states have implemented variations on medical homes, paying primary care providers increased fees to manage chronically ill populations, integrate primary and behavioral

health care, and address long-term services and supports, among other goals. Takach observes that these reforms have led to the better alignment of payments with performance metrics that emphasize health outcomes, patient satisfaction, and cost containment.

Takach is a program director for the National Academy for State Health Policy (<http://www.nashp.org>). In this role, she leads organizational work focused on primary care delivery system reform, including a multiyear Commonwealth Fund grant that supports states' advancement of Medicaid medical home initiatives and a multiyear federal Health Resources Services Administration cooperative agreement that is

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Takach also leads work as a subcontractor on a federal contract with the Centers for Medicare and Medicaid Services to evaluate the state policy implementation of the Multi-payer Advanced Primary Care Practice Demonstration and is the principal investigator on a Commonwealth Fund grant to build a central resource map for researchers and policy makers on state accountable care activity. She earned a master's degree in public health from the Johns Hopkins University.