

# STATE HEALTH POLICY

STATE HEALTH POLICY BRIEFING PROVIDES AN OVERVIEW AND ANALYSIS OF EMERGING ISSUES AND DEVELOPMENTS IN STATE HEALTH POLICY.

Since 2006 more than 30 states have developed policies to improve Medicaid and Children's Health Insurance Programs (CHIP) to advance medical homes. With support from The Commonwealth Fund, *Building Medical Homes in State Medicaid and CHIP Programs* summarizes the work in the states and provides state policy makers with examples of promising practices, lessons learned and ideas they can adapt to work in their state. Eight state Medical Home Summit teams from Colorado, Idaho, Louisiana, Minnesota, New Hampshire, Oklahoma, Oregon, and Washington informed a significant aspect of this paper.

The State Health Policy Briefing contains the executive summary of the paper. The entire report is available at [www.nashp.org](http://www.nashp.org).



NATIONAL ACADEMY  
for STATE HEALTH POLICY

# Briefing

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## BUILDING MEDICAL HOMES IN STATE MEDICAID AND CHIP PROGRAMS

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Supported by The Commonwealth Fund

With 47 million uninsured Americans, double digit inflation in medical spending and health outcomes that lag far behind other nations, comprehensive health care reform that addresses access, cost and quality issues is a national priority. A primary care oriented system may have benefits for population health, equity in health and cost containment and has been shown to reduce racial and ethnic disparities,<sup>1</sup> and result in significantly lower health care costs and improved life expectancy diseases for those with chronic diseases.<sup>2</sup>

A medical home is an enhanced model of primary care in which care teams attend to the multi-faceted needs of patients and provide whole person comprehensive and coordinated patient-centered care. First advanced by the American Academy of Pediatrics in the 1960's for certain pediatric populations, the medical home concept has evolved to embrace all populations. In 2007, four major physician groups agreed to a common concept of the patient centered medical home (PCMH) defined by seven "Joint Principles." Supporters of the PCMH model have joined together to form the Patient Centered Primary Care Collaborative (PCPCC) that represents employers, medical specialty societies, health plans and other organizations.

Since 2006 more than 30 states have initiated projects to improve Medicaid and Children's Health Insurance Pro-

grams (CHIP) to advance medical homes. Several states also are driving state-wide transformation by using their purchasing leverage to make changes in state health benefits plans and in the private sector. This paper summarizes these activities and provides state policy makers with examples of promising practices, lessons learned and ideas they can adapt to work in their state.

This paper was informed by research that started with a brief survey of Medicaid and CHIP directors and targeted Internet research. A working meeting of eight leading states (Colorado, Idaho, Louisiana, Minnesota, New Hampshire, Oklahoma, Oregon and Washington) convened in July 2008 provided for a significant amount of NASHP's research. These eight states - in addition to North Carolina and Rhode Island which have well-developed medical home initiatives - helped us identify five major strategies for other states to consider in developing their own plans:

1. Forming partnerships with key players (including patients, providers and private sector payers) whose practices the state seeks to change,
2. Defining medical homes to help establish provider expectations and implementing processes to recognize primary care practices that meet those expectations,
3. Aligning reimbursement and purchasing to support and reward practices that meet performance expectations,
4. Supporting practices to help advance patient-centered care, and
5. Measuring results to assess whether their efforts are succeeding in containing costs, improving quality and patient experience.

### **FORMING KEY PARTNERSHIPS**

State Medicaid agencies play a key role in advancing medical homes but they are not doing this alone. All 10 study states are partnering with other stakeholders such as other payers, primary care providers and the organizations that represent them, patients and advocacy groups to affect broad system change. These partnerships take many different forms including multi-payer stakeholder collaboratives —bringing commercial

insurers and other purchasers such as state employees' health benefit groups to the table to further spread transformation. Other states have formed formal stakeholder groups that participate in planning the state initiative. Finally, all study states are using means such as surveys and public meetings to get feedback on their plans from a broad range of stakeholders.

### **DEFINING AND RECOGNIZING A MEDICAL HOME**

The foundation for building a medical home begins with a definition that describes valued principles or characteristics. The 10 study states are divided on how to define medical homes. Four have adopted the Joint Principles, others developed their own definition. Although states do not agree on a single definition, most definitions used reflect core primary care values.

States that reimburse practices that function as medical homes are putting in place measurable standards and developing a process for recognizing which practices meet those standards. Many of the states that have adopted the Joint Principles as their definition also plan to use the National Committee for Quality Assurance Physician Practice Connections - Patient Centered Medical Home (NCQA PPC-PCMH) tool—either alone or in conjunction with other state requirements. Some states, providers and other experts have raised concerns that this tool places too much weight on technology, is too costly and limits recognition to physician practices only. These states are using other tools and processes to recognize medical homes.

### **ALIGNING REIMBURSEMENT AND PURCHASING**

Although three of the primary study states have not yet made a final decision on payment structure, all 10 are planning to add payments for high performing medical home practices. Strategies include:

1. Providing separate per member per month and/or lump sum payments (in addition to standard payments for medical services).
2. Enhancing some visit rates (e.g. well child visits) to minimize the changes providers and payers need to make to their existing billing and payment systems and to create an incentive for provider outreach to patients.

**TABLE 1: CHARACTERISTICS OF MEDICAL HOME PROGRAMS IN 10 LEADING STATES**

State	Targeted population	Focus of Care: Chronic Conditions/all conditions	Definition	Recognition
Colorado	Medicaid, CHIP Plans to extend to all children in state.	Children: all conditions Adult Pilot: Cardiovascular Disease, Diabetes, Low Back Pain, Prevention, Depression	Children’s definition found in 2007 legislation (SB 07-130) Joint Principles (adult pilot)	Developed own standards (pediatric practices) NCQA PPC-PCMH (adult pilot)
Idaho	All residents of Idaho	All conditions	Joint Principles	TBD
Louisiana	Medicaid/CHIP	All Conditions	Joint Principles (modified)	NCQA PPC PCMH plus additional criteria
Minnesota	Medicaid/CHIP Plan to extend to all insured Minnesotans by 2010	Complex conditions first	Defined in 2008 Minnesota statute	Developed own standards
New Hampshire	Medicaid adults	Chronic conditions	Joint Principles	NCQA PPC-PCMH
North Carolina	Medicaid/CHIP	All conditions	Defined in provider handbook	Developed own standards
Oklahoma	Medicaid/CHIP	Children, Pregnant women and women in breast and cervical cancer prevention and treatment programs	Joint Principles	Developed own standards
Oregon	All residents of Oregon	All conditions	Defined in 2007 legislation Healthy Oregon Act	Developed own standards
Rhode Island	Medicaid adults	Adults with disabilities Multi-payer pilot: adults with coronary artery disease, depression and diabetes	Joint Principles	NCQA PPC-PCMH
Washington	Medicaid/CHIP	Children and adults with disabilities	Defined in 2007 legislation. (Senate Bill 5930 Chapter 259)	Developed own standards

3. Leveraging the managed care purchasing process by modifying selection criteria or contracts.

**SUPPORTING PRACTICES**

There are a number of policies states are using to support the delivery of patient-centered care both within a medical practice and between a practice with other providers, settings, and patients, families and caregivers.

Within practices, these policies include designating medical home providers, establishing open schedul-

ing and expanded hours and securing provider/patient agreements to ensure a point of first contact care for beneficiaries. In addition, states are providing incentives for practices to form teams, attend learning collaboratives, use practice coaches and hire care coordinators. To help facilitate coordination outside practices between other providers, settings and patients, states are establishing health information exchange networks, referral tracking systems and patient engagement activities including self-management workshops, personal health records and decision making tools.

## MEASURING RESULTS

The increasing interest in improving access to high-performing medical homes is based on the evidence that doing so will improve care and contain costs. Ultimately, however, state Medicaid and CHIP officials will need to demonstrate these results in their own initiatives. By providing enhanced access to primary care, North Carolina Medicaid was able to reduce health spending by \$244 million over a two-year period while improving overall health outcomes.<sup>3</sup> States are examining rates of hospitalizations for ambulatory care sensitive conditions and emergency department utilization using claims data and measures drawn from nationally recognized measurement sets such as Healthcare Effectiveness Data and Information Set (HEDIS). In addition, states are developing surveys to measure patient and provider satisfaction.

## CONCLUSION

As many states grapple with the unsustainable growth in health costs, innovative solutions that seek to transform the health care delivery system through medical homes are being considered. State Medicaid and CHIP have strong foundational bases to develop policies that support medical homes. Expanding access to coverage cannot be sustained without attending to quality improvement and cost containment goals. The lessons learned by North Carolina Medicaid and a smaller number of other programs have shown that the provision of good, comprehensive primary care via medical homes has promise in achieving the goals of quality improvement and cost containment. Time will be required to validate these findings in other states and programs.

## ENDNOTES

- 1 A.C. Beal et al., *Closing the Divide: How Medical Homes Promote Equity in Health Care: Results from The Commonwealth Fund 2006 Health Care Quality Survey* (New York, NY: The Commonwealth Fund, June 2007). Retrieved May 6, 2009. <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2007/Jun/Closing-the-Divide--How-Medical-Homes-Promote-Equity-in-Health-Care--Results-From-The-Commonwealth-F.aspx>.
- 2 P. Franks and K. Fiscella, "Primary Care Physicians and Specialists as Personal Physicians: Health Care Expenditures and Mortality Experience," *Journal of Family Practice* 47, no. 2 (1998): 105–109.
- 3 Community Care of North Carolina. NC Foundation for Advanced Health Programs, Inc. Retrieved May 6, 2009. <http://www.communitycarenc.com>.

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