In recent years there has been a growing movement to transform primary care by improving patient access to medical homes and health homes. A medical home is an enhanced model of primary care that offers comprehensive, coordinated, and ongoing person- and family-centered care.

Decision makers in both public and private sectors, as well as patients, purchasers, and primary care providers have all embraced the concept. Twenty-nine states are now making enhanced payments to primary care practices that demonstrate they are a medical home (National Academy for State Health Policy, 2013a). The Affordable Care Act (ACA) built on the medical home concept to create “health homes,” which are designed to better coordinate the primary care, behavioral health, and long-term services and supports (LTSS) provided to Medicaid beneficiaries with select chronic health conditions or a serious and persistent mental illness. As of July 2013, twelve states had implemented health homes.

**The Need for Primary Care Transformation**

The momentum to transform primary care has grown out of the recognition that although it is crucial to health, the way it is practiced needs improvement. The benefits for those who have ready access to primary care are clear: lower costs to the system, improved quality of care, and less frequent acute care utilization (Friedberg, Hussey, and Schneider, 2010; Sepulveda, Bodenheimer, and Grundy, 2008). Access to primary care has also been shown to reduce or eliminate racial and ethnic health disparities (Starfield, Shi, and Macinko, 2005; Beal et al., 2007). But primary care providers are in short supply, and data trends indicate that a growing proportion of medical students are choosing to specialize (Sepulveda, Bodenheimer, and Grundy, 2008).

While all patients benefit from improved primary care, individuals with complex needs may have the most to gain—particularly those...
who receive care from multiple medical providers and other systems, such as the LTSS system. The current American healthcare system is fragmented, and individuals with multiple co-morbidities see multiple specialists—each with their own care plan. Often, a primary care provider may not know that his or her patient was hospitalized unless informed by the patient.

**Medical homes transform the way primary care is delivered to all patients, while health homes focus on a subset of high-need patients.**

Efforts to improve care have not always adequately addressed the needs of people with complex health conditions. Clinical practice guidelines, for example, are typically focused on a single disease and may be insufficient to care for individuals with more than one condition (Bayliss et al., 2008; Vogeli et al., 2007). Disease-centered guidelines, as opposed to patient-centered guidelines incorporating all care needs of a patient, frustrate both physicians (Fried, Tinetti, and Iannone, 2011) and patients (Bayliss et al., 2008). Medical homes and health homes, whose goal is to provide comprehensive, coordinated, whole-person care, have the potential to better serve people with complex needs. Physicians have limited time to spend with each patient, and team-based care—especially when mid-level providers and social workers coordinate care across providers and connect patients with community-based resources—can help physicians better serve their patients.

Both purchasers and payers support medical and health homes because they are aware that chronic disease already has a tremendous impact on healthcare costs—and the number of people with chronic conditions will only increase as the American population continues to age. On average, individuals with one chronic condition incur healthcare costs double of those without a chronic condition, and individuals with multiple chronic illnesses can cost seven times that of a person with just one chronic condition (Stanton, 2006). In Medicare, individuals with multiple chronic conditions are estimated to account for 95 percent of programmatic spending (Vogeli et al., 2007).

But primary care investments are expected to help control these costs. Researchers estimate that permanently extending the ACA’s 10 percent Medicare payment increase for primary care services would increase preventive care utilization and decrease hospital and post-acute costs, returning $6 for every $1 spent and lowering Medicare costs by nearly 2 percent (Reschovsky et al., 2012).

**Advanced Primary Care Models**

Both medical and health homes are advanced models of primary care. The American Academy of Pediatrics introduced the term “medical home” in the 1960s, referring to centralized medical records. Over time, the concept has evolved to describe an approach for delivering primary care, and we now know that all patients would benefit from advanced primary care, yet not all primary care practices deliver it. In 2007, four major associations representing primary care physicians issued the Joint Principles of the Patient-Centered Medical Home, which define a medical home as a model of primary care that is “patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety” (American Academy of Family Physicians et al., 2007).

In recent years, commercial and public payers have implemented programs that make enhanced payments to a subset of primary care providers who have demonstrated that they function as medical homes. Payers establish the requirements providers must meet in order to receive payments. Many payers base requirements using recognition programs administered by national accrediting organizations, such as
the National Committee for Quality Assurance. Others have developed and administer their own recognition programs. Both nationally and locally administered programs assess a primary care provider’s ability to coordinate care—often not just within the medical system but also across systems of care.

Section 2703 of the ACA created a new state Medicaid option to implement health homes, which provide enhanced primary care to Medicaid beneficiaries with select chronic conditions or severe mental illness. This provision enables Medicaid agencies to set standards for increased coordination of primary care, acute care, behavioral health, and LTSS, and pay practices to provide it.

The ACA defines six services health homes are expected to provide—four relate to coordinating care: comprehensive care management; care coordination; comprehensive transitional care; and referral to community and social support services. The other two health home services are health promotion and support for patients and families. Medicaid agencies must amend their state plan to implement a health home program. In the amendment, states define which beneficiaries qualify for the services, which types of providers can serve as health homes, qualifications for these providers, and payment policies.

Although both medical homes and health homes are advanced models of primary care and emphasize whole-person, coordinated care, there are clear differences between them. Medical homes are intended to transform the way primary care is delivered to all patients, while health homes are focused on the care delivered to a subset of high-need patients. Also, because of the focus on primary care, only primary care providers are considered medical homes; other types of providers (such as mental health providers) can serve as health homes because of an emphasis on behavioral health and LTSS. Finally, while most medical home programs exclude those who qualify for both Medicare and Medicaid (dual eligibles), health home programs must include dual eligibles.

State Approaches to Promoting Advanced Primary Care
As of July 2013, twenty-nine states are making payments to medical homes for Medicaid enrollees; eighteen of these states have partnered with the private sector to form multi-payer initiatives. Medicare is participating in fourteen of the multi-payer initiatives through two programs led by the Centers for Medicare & Medicaid Services (CMS): the Multi-Payer Advanced Primary Care Demonstration and the Comprehensive Primary Care Initiative. Advanced primary care models are also a major element of the statewide delivery system reforms six states will test under the Center for Medicare & Medicaid Innovation’s State Innovations Models Initiative (National Academy for State Health Policy, 2013a).

Also as of July 2013, twelve states have received CMS approval to implement a health home program (National Academy for State Health Policy, 2013a). Many of these states were already making enhanced payments to primary care providers in an existing medical home program. However, because health homes serve only the chronically ill (a subset of those served by medical homes), states have successfully leveraged their medical home infrastructure to implement health homes, while still maintaining existing medical home programs for the broader population.

Oklahoma: a Medicaid approach
In 2009, the Oklahoma Health Care Authority began expanding SoonerCare Choice—a primary care case management program offered to most Medicaid fee-for-service enrollees—into a medical home program. The Health Care Authority developed three tiers of medical home standards reflecting the range of medical home services a practice was able to provide. Providers able to deliver comprehensive and coordinated
care for patients with complex health needs are placed in the highest tier, a designation that rewards the practice with larger medical home payments. Providers also have an opportunity to receive performance-based payments through the SoonerExcel program, which rewards medical homes that meet or exceed specific quality and efficiency benchmarks, including breast and cervical cancer screenings and emergency department use. SoonerCare Choice medical homes are supported by regional Health Access Networks, which provide clinical and wraparound support services for providers and enrollees, including case management, behavioral health, and pharmacy services (National Governors Association, n.d.).

Oregon: a managed care approach
Oregon had early experience in supporting primary care transformation through its Medicaid managed care plans. In 2007, CareOregon began its Primary Care Renewal program, a safety-net medical home program that served all patients, including dual eligibles. As a health plan serving this vulnerable population through its dual eligible Special Needs Plan, CareOregon had a direct financial incentive to reduce Medicare costs. The Primary Care Renewal program fostered practice-level improvements to benefit all patients, building upon the plan’s 2004 centralized case management program, CareSupport, which focused primarily on providing case management by phone, and care coordination services for approximately 5 percent of CareOregon’s highest-risk and highest-need enrollees. Specifically, clinics participating in the Primary Care Renewal program formed new multidisciplinary care teams generally with a primary care provider, medical assistant, care manager, and a behavioral health practitioner. The care teams met daily to discuss the needs of assigned patients being seen that day (Klein and McCarthy, 2010).

In 2012, Oregon redesigned its Medicaid program, replacing traditional managed care plans with Coordinated Care Organizations. In an effort to reduce care fragmentation and control costs, locally governed entities receive a fixed rate to manage mental, physical, and (ultimately) dental care for their Medicaid enrollees, including Medicare-Medicaid beneficiaries (Oregon Health Authority, n.d.). The Coordinated Care Organizations are expected to emphasize preventive care and make patient-centered and team-based care available for their members. As such, the Coordinated Care Organizations are required, to the extent possible, to contract with providers recognized under the state’s medical home program, the Patient-Centered Primary Care Home Program (Oregon Health Authority, 2013). Oregon received a $45 million grant from the Center for Medicare & Medicaid Innovation to further test the model.

Vermont: a multi-payer approach
Vermont, a state participating in the Medicare Advanced Primary Care Practice Demonstration, is implementing a statewide, public-private multi-payer medical home initiative through the state’s Blueprint for Health. The state started with three pilot sites launching between June 2008 and January 2010, and is expanding the program. It will include all willing providers by October 2013. Nurse-led multidisciplinary community health teams support Vermont’s medical home providers. In addition to providing care coordination and patient education and self-management services, community health teams connect providers and patients to community-based service organizations that can meet a patient’s health or psychosocial needs (Bielaszka-DuVernay, 2011).

One unique feature of the Vermont Blueprint is the role of the Support and Services at Home (SASH) teams, which help individuals with LTSS needs continue living at home. SASH teams, composed of a SASH Coordinator and a Wellness Nurse, bridge the physical health, mental health, and long-term-care systems for Medicare beneficiaries. SASH teams work with
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home health agencies, area agencies on aging, and other providers to develop Individual Healthy Aging Plans for each participant, as well as a Community Healthy Aging Plan reflecting the common needs of individuals in the community. Since 2009, the number of SASH teams across the state has grown from one to twenty-six, and the number of participants has risen twenty-fold (Department of Vermont Health Access, 2013).

Missouri: a health home approach
On October 20, 2011, Missouri became the first state to receive approval of a Medicaid health home state plan amendment. Missouri’s first health home program targets individuals with severe and persistent mental illness or other behavioral health conditions served by the state’s community mental health centers (Missouri Department of Social Services, 2011a). Two months after the first approval, CMS approved a second amendment for a program targeting individuals with physical chronic conditions (asthma, diabetes, heart disease, or a body mass index greater than twenty-five) served by federally qualified health centers, rural health clinics, and hospital-operated primary care clinics (Missouri Department of Social Services, 2011b). Missouri requires community mental health centers to meet criteria developed by the Council on Accreditation of Rehabilitation Facilities and primary care health homes are required to achieve National Committee for Quality Assurance Patient-Centered Medical Home recognition or meet equivalent recognition standards developed by the state.

Each physician-led health home is supported by a team that includes nurse care managers and care coordinators. Also, Missouri integrated the physical and behavioral health systems in both health home programs; primary care physician consultants work in community mental health centers and behavioral health consultants work in primary care clinics. The health home teams coordinate care for eligible Medicaid enrollees, including transitional and follow-up care after hospital admissions and discharges. Health home enrollees work with their care team to develop an individualized care plan addressing physical, psychosocial, and long-term-care needs. Health homes create links to community-based organizations, including organizations providing LTSS. Health home enrollees also benefit from self-management and education activities, including health education groups facilitated by nurse care managers and wellness and prevention initiatives.

Medical Homes Lower Costs, Improve Care
Early results of medical home programs are promising (please note that the first health home state plan amendment was approved in late 2011; as such, it is premature to provide any results for that model). Recent reviews of medical home initiatives across the country have found that the model successfully advances the Institute for Healthcare Improvement’s Triple Aim (improved experience, improved health, and reduced cost), creating short- and long-term cost-savings (Nielsen et al., 2012; Takach, 2011). Still, more quantitative evaluations are needed; a rigorous review of medical home evaluations published or disseminated between January 2000 and September 2010 found that the impact of medical home interventions was mixed, but evidence showed promising results (Peikes et al., 2012).

Improved health outcomes and lower costs are linked. Medical homes and health homes are expected to produce short-term cost-savings based on an assumption that improved care management and care coordination will result in lower healthcare use—particularly expensive hospital visits.

Vermont Medicaid decreased hospital inpatient use by 21 percent, reducing inpatient costs by 22 percent.

index greater than twenty-five) served by federally qualified health centers, rural health clinics, and hospital-operated primary care clinics (Missouri Department of Social Services, 2011b). Missouri requires community mental health center health homes to meet criteria developed by the Council on Accreditation of Rehabilitation Facilities and primary care health homes are required to achieve National Committee for Quality Assurance Patient-Centered Medical Home recognition or meet equivalent recognition standards developed by the state.
The Economics of Medical and Health Homes

Early data from state programs validate the assumption that medical homes and health homes produce short-term savings through improved care management and coordination, which results in lower healthcare use.

- **Oklahoma.** Oklahoma Medicaid improved access to primary care services while reducing per capita costs for participating enrollees by $29 per year (Takach, 2011; National Governors Association, n.d.).

- **Oregon.** CareOregon increased preventive screenings and improved chronic disease care management, which reduced median costs for dual eligibles by $89 per member, per month (9 percent). Approximately two-thirds of the cost-savings were attributed to reduced hospital inpatient use (Klein and McCarthy, 2010; Nielsen et al., 2012).

- **Vermont.** In the first year of one regional pilot, Vermont Medicaid decreased hospital inpatient use by 21 percent, reducing inpatient costs by 22 percent. Emergency department use fell by 31 percent, reducing emergency costs by 36 percent. Overall, total healthcare use fell 8.9 percent, reducing overall per person, per month costs by 11.6 percent. (Bielaszka-DuVernay, 2011; Takach, 2011).

Private payers are seeing similar results. Group Health (a Seattle-based integrated delivery system) reduced emergency department use by 29 percent and reduced hospitalizations by 6 percent, saving an estimated $10.30 per member, per month, after twenty-one months—a 1.5:1 return on investment. Patient satisfaction surveys also found that medical home patients had improved doctor-patient interactions, enhanced access to care, and increased shared decision making (Nielsen et al., 2012). Similarly, WellPoint (a commercial health insurer that covers nearly one of every nine Americans and has participated in ten medical home programs across the country) realized a return on investment ranging from $2.50 to $4.00 for every $1.00 spent in the Colorado program (Raskas et al., 2012).

Beyond short-term savings, advanced primary care models are expected to create long-term savings by increasing preventive service and primary care use, which would improve population health and reduce rates of chronic diseases. Geisinger, a Pennsylvania-based integrated delivery system with a long-standing medical home program, found that longer exposure to their ProvenHealth Navigator Program was associated with significantly lower costs (Maeng et al., 2012).

**Why Not Expand the Model If It Improves Care and Lowers Cost?**

Seeing a clear need to transform primary care, many payers and purchasers have already implemented medical home programs. These programs are showing early indications of success in improving quality, improving patient experience, and containing cost. States also continue to strengthen their Medicaid programs by partnering with private sector payers, drawing Medicare into their initiatives, or implementing health homes to better coordinate care across the medical, behavioral health, and LTSS systems. A few states have also begun to implement accountable care models explicitly grounded on advanced primary care that include the full care continuum, including transitions across different settings (National Academy for State Health Policy, 2013b).

Many states participating in the demonstrations to integrate care for dual eligibles plan to require managed care organizations to rely on
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medical homes to provide primary care. Furthermore, several states that are implementing managed fee-for-service models are using health homes as their platform for coordinating all primary care, acute care, behavioral health, and long-term services and supports on behalf of dual eligibles. Provided that the evidence base showing improved care at a lower cost continues to grow, payers and purchasers will continue to invest in primary care transforma-
tion to provide comprehensive, whole-person care to all of their members.

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