IN THIS BRIEF: PATIENT CENTERED MEDICAL HOME, MEDICAID, SCHIP, REIMBURSEMENT METHODS

STATE HEALTH POLICY BRIEFING

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Supporting the Patient Centered Medical Home in Medicaid and SCHIP: Savings and Reimbursement

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A significant number of people in the United States do not have access to high quality, point-of-entry primary care.[1] For those with access to primary care, the health care system does not encourage primary care providers to develop relationships with them, and, when appropriate, their families, to better address the complete array of their health issues.

Availability of primary care is particularly limited for low-income individuals and members of racial and ethnic minorities – people who are disproportionately likely to be in poor health and least likely to have a dependable source of health care.[2] Substantial evidence indicates that access to a medical home – defined as timely, well-organized care with enhanced access to providers – can reduce or eliminate racial and ethnic disparities in health outcomes.[3]

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State Health Policy Briefing provides an overview and analysis of emerging issues and developments in state health policy.

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At the same time, there is a growing reluctance on the part of medical school graduates and interns to enter the field of primary care. In fact, from 1997 to 2005, the number of medical school graduates who chose to become primary care physicians decreased by 50 percent.[4]

Increasingly, private and public payers are interested in developing models that better support the provision of effective, patient-centered primary care, including the Patient Centered Medical Home (PCMH) model. In the PCMH model, care teams attend to the multi-faceted needs of patients, and provide whole person, patient centered care. The four major primary care physician groups – American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians, American Osteopathic Association – as well as national employers, health plans, and others agree that the PCMH model is a way to address the diminishing role primary care plays in our health system.

This *State Health Policy Briefing* explains the PCMH model and explores reimbursement strategies states are using to help medical practices become medical homes. It is the first in a series of four briefs that will explore different categories of policies that states can use to support improved delivery of primary care.

Defining the Patient Centered Medical Home

First advanced by the American Academy of Pediatrics (AAP) in the 1960s, the concept of the medical home is one that evolved as a site where children with special health care needs (CSHCN) could receive a unique brand of continuous and comprehensive care. The idea was conceived in response to the notion that "care for CSHCN is often provided

by many different practitioners who work in disparate locations independent of each other" and that "duplication and gaps in services... occur as a result of this lack of communication and coordination."[5] It is clear that this challenge is now not confined to the CSHCN population, but applies to a much broader swath of patients, particularly the people who have limited resources and the greatest health care needs.

The "Joint Principles" which define the PCMH model are as follows:

- **Personal physician** – Each patient has an ongoing relationship with a personal physician who provides first contact, and continuous and comprehensive care
- **Physician directed medical practice** – At the practice level, the personal physician leads a team of individuals who take responsibility collectively for the ongoing care of patients.
- **Whole person orientation** – The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for arranging appropriate care with other qualified professionals. This includes care for all stages of life, including acute care, chronic care, preventive services, and end of life care.
- **Care is coordinated and/or integrated** across all elements of the complex health care system (for example, subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (family, public, and private community-based services). Care is facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
- **Quality and safety** are hallmarks of the medical home:
  1. Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
  2. Patients and families participate in quality improvement activities at the practice level.
- **Enhanced access** to care is available through systems such as open scheduling, expanded hours, and new options for communication between patients, their personal physician, and practice staff.

The Patient Centered Primary Care Collaborative

Supporters of the PCMH model have formed the Patient Centered Primary Care Collaborative, (PCPCC) which is led by IBM and staffed by The ERISA Industry Committee (ERIC). ERIC is a trade association representing Fortune 200 employers in the area of health benefits provision. The PCPCC serves as the national convening entity for employers, medical specialty societies, health plans, and other organizations to discuss, strategize, and share information that will help transform practices, reform reimbursement, evaluate demonstrations, and broadly implement the PCMH.

According to the PCPCC, the key to implementing the PCMH model is aligning incentives through an enhanced reimbursement system that is structured to allow primary care providers to offer these services. Ideally, compensation to the practice takes the shape of a hybrid payment model, integrating a case management fee, or performance-based fee, with traditional per-visit fees. Within the enhanced reimbursement framework there is room for creativity and innovation, but it must dispose primary care providers to spend more time managing patients' health.

Implementing Patient Centered Medical Homes in Medicaid and SCHIP

The Commonwealth Fund is supporting a partnership between the National Academy for State Health Policy (NASHP) and the PCPCC to identify and develop strategies and policy options for implementing the PCMH model in Medicaid and the State Children's Health Insurance Program (SCHIP). We are seeking to identify strategies that can be used both by states that reimburse for primary care

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through fee-for-service and those that reimburse for primary care through capitation. To date, we have identified promising reimbursement structures in ten states.

- Seven states operate Primary Care Case Management (PCCM) programs in which primary care providers (PCPs) receive fee-for-service payments for all services they provide to enrolled beneficiaries (members) and additional reimbursement to recognize the cost of performing the functions of a medical home (PCCM fee): Alabama, Illinois, Louisiana, Minnesota (planned), North Carolina, Rhode Island, and Pennsylvania.[6] Among these states:
  - Alabama, Illinois, Minnesota (planned), Rhode Island, and Pennsylvania pay a per member per month PCCM fee that varies based on the characteristics of the practice and/or the members.
  - Alabama, Louisiana, and North Carolina all offer reimbursement in addition to the per member per month PCCM fee paid to the PCP. Alabama shares savings, Louisiana pays an additional quarterly payment to PCPs who meet criteria related to provision of immunizations to children, and North Carolina pays an additional per member per month fee to the 'network' that must be used to provide care coordination or undertake quality improvement initiatives at the practice level.
- Four states pay for primary care through capitation: Connecticut, Rhode Island, and Washington pay capitation payments to Managed Care Organizations (MCOs) that deliver a comprehensive set of benefits, including primary care; Oklahoma pays capitation payments to practices for delivering primary care. (Oklahoma plans to transition to a fee for service PCCM program with a variable case management payment). Among these four states, Rhode Island pays financial incentives to MCOs that achieve specific performance benchmarks that indicate the presence of a functioning medical home, such as having PCP telephone access after business hours and the percent of children who receive well-child visits. The other three states are developing such programs.

The approaches used by two states (Alabama and Rhode Island) illustrate how Medicaid agencies can combine these reimbursement strategies to support and reward PCPs for functioning as effective medical homes for all beneficiaries.

ALABAMA

According to the Alabama Medicaid Agency, more than 420,000 patients participate in the state's PCCM program called "Patient 1st." The program requires Medicaid beneficiaries to designate a "personal medical provider" (PMP), whose role is to provide first contact and continuous, comprehensive care. The PMP's compensation has three components:

1. Fee-for-service payment for services provided by the PMP to members.
2. A per member per month PCCM fee that is calculated individually for each PMP based on nine characteristics of the practice: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) participation; Vaccines for Children (VFC) participation; Medical Home CME completion; provision of around-the-clock coverage seven days a week; hospital admitting privileges; in-home monitoring (disease management); InfoSolutions participation; electronic notices; and electronic educational materials.
3. A share of program savings. In 2007, Alabama Medicaid distributed 50 percent of documented savings ($5.7 million) to PMPs. Individual payments were calculated based on a combination of efficiency and performance outcomes produced by the PMP.[7]

RHODE ISLAND

Rhode Island Medicaid has a long-standing interest in providing access to medical homes for all beneficiaries.

Medicaid and SCHIP beneficiaries who qualify for the programs as members of poor or low-income families are required to enroll into MCOs that deliver a comprehensive set of services, including primary care. This program (RIte Care) has the second oldest Medicaid pay-for-performance (P4P) program in the United States. More than 45 percent of the overall points available to Health Plans in RIte Care's Performance Goal Program are within the Medical Home/Preventive Care category. Plans may receive an incentive for meeting or exceeding the 90th or 75th percentile for each of a series of HEDIS® measures that address: access to PCPs for children and adolescents; adults' access to preventive/ambulatory health services; well-child visits in the first 15 months of life; and well-child visits in the 3rd, 4th, 5th, & 6th years of life. In medical home categories, the statistics show MCOs performing at or above 90th percentile rankings.[8]

Rhode Island also has a PCCM program available to Medicaid beneficiaries who are not enrolled into an MCO (mostly those who qualify due to disability or age). This program, called "Connect Care Choice" (CCC) has a provider

network that includes Federally Qualified Health Centers (FQHCs) as well as group practices that meet "advanced medical home" standards. The payment to participating practices has three components:

1. Fee-for-service payment for services provided by the practice to members, with the agency paying participating providers more than other providers for some services.
2. A per member per month PCCM fee of either $5 or $10 based on the enhanced services a practice offers, such as electronic tracking of patient information or open scheduling.
3. An additional $30 per member per month to practices that have a nurse case manager to help manage the care of members who are at moderate to high risk.[9]

Currently, both the Rhode Island Medicaid agency and the MCOs that contract with the agency are participating in a multi-stakeholder collaborative that is developing an all-payer demonstration project. The purpose of the project is to manage chronic illness more effectively by aligning physician incentives to provide medical home services. The collaborative is working with the Medicaid agency's external quality review organization, Quality Partners of Rhode Island, on this "Chronic Care Sustainability Initiative." In this demonstration, qualified medical homes will receive a per member per month fee, in addition to the usual fee-for-service.[10]

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Notes

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2. N. Lurie and T. Dubowitz, "Health Disparities and Access to Health." *Journal of the American Medical Association.* 297(10):1118-21, March 14, 2007.

3. Beal, et. al., op. cit.

4. Martin Sepulveda, Thomas Bodenheimer, and Paul Grundy. "Primary Care: Can it Solve Employers Health Dilemma?" *Health Affairs*. 27.1 (2008): 151-158.

5. Calvin Sia, et al. *History of the Medical Home Concept*. www.pediatrics.org.

6. In most Primary Care Case Management (PCCM) programs the Medicaid and/or SCHIP agency contracts directly with primary care providers (PCPs) who agree to provide primary care services and coordinate other health care services enrolled beneficiaries (members) need. In return, PCPs receive fee-for-service payment for all services they provide directly to their members and an additional per member per month (PMPM) case management fee that usually ranges from $2-$3.

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