

By Mary Takach

Reinventing Medicaid: State Innovations To Qualify And Pay For Patient-Centered Medical Homes Show Promising Results

DOI: 10.1377/hlthaff.2011.0170
HEALTH AFFAIRS 30,
NO. 7 (2011): 1325-1334
©2011 Project HOPE—
The People-to-People Health
Foundation, Inc.

ABSTRACT This article describes patient-centered medical home initiatives that seventeen states have launched. These initiatives use national recognition or state-based qualification standards along with incentive payments to address soaring costs and lagging health outcomes in state Medicaid programs. Even though these initiatives are in their infancy, early results are encouraging. Modest increases in payment to physicians, aligned with quality improvement standards, have not only resulted in promising trends for costs and quality, but have also greatly improved access to care. Several state programs have already demonstrated declines in per capita costs for patients enrolled in Medicaid; increased participation of physicians in caring for Medicaid patients; and high patient and provider satisfaction. These early results give states good reason to continue developing patient-centered medical homes as part of their Medicaid programs. This article provides a closer look at these innovative models, to inform public and private reform efforts.

Mary Takach (mtakach@nahsp.org) is program director for the National Academy for State Health Policy, in Portland, Maine.

The US primary care delivery system—described in the May 2010 issue of *Health Affairs* as “horribly broken—the victim of underinvestment, misaligned incentives, and malign neglect”¹—is under repair in many state Medicaid and Children’s Health Insurance Programs (CHIP). Dissatisfied with outcomes of inadequate quality and plagued by uncontrolled cost growth, more than thirty-eight states are using the patient-centered medical home model to change the way in which primary care is delivered.² A patient-centered medical home is an enhanced model of primary care in which care teams, led by a primary care provider, attend to the multifaceted needs of patients and provide whole-person, comprehensive, coordinated, and patient-centered care.

States are laboratories of innovation for testing this model. Their experiences to date should be informative to policy makers and researchers looking for the right balance of incentives to

make primary care practices provide more-efficient and higher-quality care.

This article focuses on seventeen states that are aligning patient-centered medical home standards with incentive payments to support reform in the delivery of primary care. Most of these states’ initiatives are less than two years old, and their findings have not been published. This article provides early data from a few states’ annual Medicaid reports. Although limited, the data nevertheless demonstrate positive trends and have encouraged state policy makers to expand or continue their efforts.

Research for this article was conducted over four years. The author had direct working relationships with states as they embarked on patient-centered medical home initiatives. Data about each initiative were collected using standardized surveys and web-based research and were verified through correspondence with key state policy makers.

Health Affairs

At the Intersection of Health, Health Care and Policy

Cite this article as:

Mary Takach

Reinventing Medicaid: State Innovations To Qualify And Pay For Patient-Centered
Medical Homes Show Promising Results
Health Affairs, 30, no.7 (2011):1325-1334

doi: 10.1377/hlthaff.2011.0170

The online version of this article, along with updated information and services, is
available at:

<http://content.healthaffairs.org/content/30/7/1325.full.html>

For Reprints, Links & Permissions:

http://healthaffairs.org/1340_reprints.php

E-mail Alerts : <http://content.healthaffairs.org/subscriptions/etoc.dtl>

To Subscribe: <http://content.healthaffairs.org/subscriptions/online.shtml>

Health Affairs is published monthly by Project HOPE at 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133. Copyright © 2011 by Project HOPE - The People-to-People Health Foundation. As provided by United States copyright law (Title 17, U.S. Code), no part of *Health Affairs* may be reproduced, displayed, or transmitted in any form or by any means, electronic or mechanical, including photocopying or by information storage or retrieval systems, without prior written permission from the Publisher. All rights reserved.

Not for commercial use or unauthorized distribution

Local Input Leads To Variation

There is a great deal of variation in patient-centered medical home standards and payment approaches across the states. The differences are explained by the fact that reform of the primary care delivery system often begins at the local level.

In most of the states in this study, officials—from the state Medicaid agency, public health department, governor's office, insurance commissioner's office, or another executive branch office—participate in planning groups to develop medical home initiatives. In fourteen states, officials lead such groups, which comprise local leaders from the private sector who represent physicians, providers of mental health services, commercial insurers, state employees, and other stakeholders. In other states, similar groups have been formed at the request of the legislature or governor and are led by private citizens. For instance, in Nebraska the governor appointed a Medical Home Advisory Council that includes six primary care physicians and one hospital administrator.³

States often reach beyond their planning groups to elicit feedback, particularly from providers, on qualification standards and payment approaches for patient-centered medical homes. For instance, Oklahoma has held town-hall meetings to receive input from physicians.⁴

Recognition And Qualification Standards For Providers

There is a broad consensus among payers that new methods of payment for primary care providers should be aligned with new expectations for quality and efficiency. Seventeen states have achieved this alignment through the adoption of standards that either “recognize” the achievement of a practice in attaining certain standards or “qualify” practices as medical homes.

The standards vary considerably across the states. Most states—especially those whose initiatives involve more than one payer—either use or modify the standards of the National Committee for Quality Assurance (NCQA).⁵ However, some states create their own standards (Exhibit 1).

NCQA STANDARDS States choose the NCQA standards for many reasons. For example, both public and private payers find the organization's “national brand” appealing. In addition, the standards can easily be aligned with different payment models, and payers do not need to be involved in the recognition process.

The NCQA's 2008 and 2011 standards both use a point-based system to assess provider performance on a number of different standards.

Within each standard, there are several elements—all with point values—that indicate the kinds of documentation required to pass or achieve points. For instance, both the 2008 and 2011 sets of standards include one on performance reporting. An element in this standard requires providers to share their reports with commercial insurers, the public, or other external entities. There are a number of elements that practices “must pass” at a 50 percent performance level; practices can also earn points on optional elements at a 25 percent performance level.

Providers assess their own performance and submit the necessary documentation directly to the NCQA. The organization reviews the documentation; scores the provider; and assigns it to level 1, 2, or 3, with level 3 being the most advanced. The NCQA notifies the provider and its payers of the results.

The NCQA's 2008 standards posed challenges for states, particularly those launching initiatives in which the patient-centered medical homes were paid by Medicaid only. The challenges included too little emphasis on patient-centeredness and too much emphasis on physician-led practices. These and other problems have been addressed in the updated 2011 standards, but both versions place a heavy emphasis on the use of health information technology. The costs of meeting all of the standards—especially if expensive technology must be purchased—may still pose barriers for some Medicaid providers, particularly those in small practices and those located in rural and remote areas without access to information technology infrastructure.

It should be noted that new federal efforts are addressing some of these challenges. The Health Resources and Services Administration is offering support to 500 community health centers to help them qualify as patient-centered medical homes according to the NCQA standards.⁶

In addition, there are new federal incentives for Medicaid providers to adopt electronic health record systems, as well as technical assistance in how to achieve the new standards for “meaningful use” of such technology.⁷ The NCQA 2011 standards have also been aligned with the meaningful-use requirements, offering Medicaid providers an opportunity not only to be recognized as a patient-centered medical home but also to qualify for federal incentive payments.⁸

However, states have alternative sets of standards to consider. The accreditation organization URAC, formerly known as the Utilization Review Accreditation Commission, introduced new patient-centered medical home standards in 2010,⁹ and the Joint Commission plans to release its own standards later this year.¹⁰

EXHIBIT 1

State Patient-Centered Medical Home Initiatives

Initiative	Multipayer	Medical home standards	Technical assistance for practices
Colorado: Medical Home Initiative	No	State-developed	Coaching for providers, on-site assistance with qualification scoring
Iowa: IowaCare Medical Home Model	No	NCQA or equivalent	Learning collaborative
Maine: Patient-Centered Medical Home Pilot ^a	Yes	NCQA, with modifications	Coaching for providers, learning collaborative, data feedback
Maryland: Patient Centered Medical Home Pilot	Yes	NCQA, with modifications	Coaching for providers, learning collaborative
Massachusetts: Patient-Centered Medical Home Initiative	Yes	NCQA, with modifications	Coaching for providers, learning collaborative
Michigan: Primary Care Transformation Demonstration Project ^a	Yes	NCQA or BCBSM	Coaching for providers, learning collaborative, online training for practice staff, data feedback
Minnesota: Health Care Homes Program ^a	Yes	State-developed	Learning collaborative, registry support, online and in-person training for practice staff
Nebraska: Medicaid Medical Home Pilot Program	No	State-developed	Coaching for providers, learning collaborative
New York: Adirondack Medical Home Demonstration Project ^a	Yes	NCQA, with modifications	Coaching for providers, health information technology support
New York: Medicaid Statewide Patient-Centered Medical Home Incentive Program	No	NCQA	Limited practice support from a quality organization contracted by the state
North Carolina: Community Care of North Carolina ^{ab}	Yes	NCQA	Coaching for providers, health information technology support, data feedback, practice support networks
Oklahoma: SoonerCare Choice	No	State-developed	Coaching for providers, practice support networks
Oregon: Patient Centered Primary Care Home Program	Yes	State-developed	Coaching for providers, learning collaborative; data feedback
Pennsylvania: Chronic Care Initiative ^a	Yes	NCQA, with modifications	Coaching for providers, learning collaborative, phone-based training sessions, data feedback
Rhode Island: Chronic Care Sustainability Initiative ^a	Yes	NCQA	Coaching for practices, learning collaborative, registry support, data feedback
Vermont: Blueprint for Health ^a	Yes	NCQA	Coaching for providers, learning collaborative, registry support, data feedback, assistance with NCQA scoring, community health teams
Washington: Multi-Payer Medical Home Reimbursement Pilot	Yes	State-developed	None identified
West Virginia: Medical Home Performance Incentive Pilot	Yes	NCQA	Coaching for providers, online information sharing system; phone-based training sessions; data feedback

SOURCE Author's analysis of state government information. **NOTES** The initiatives presented are those in which a state participates as payer or leader, or both, and that have established standards for recognizing or qualifying providers as a patient-centered medical home. Not all payers have begun making payments to providers. "Coaching for providers" means helping providers meet medical home standards. "Data feedback" is giving information to providers regarding their patient panel and provider performance. "Registry support" is helping practices understand how to use registries—databases of confidential patient information—to compare outcomes and safety of patient care. NCQA is National Committee for Quality Assurance. BCBSM is Blue Cross Blue Shield of Michigan. ^aParticipating in the Multi-Payer Advanced Primary Care Initiative (see Note 25 in text). ^bCommunity Care of North Carolina is a statewide program. This description applies only to the seven-county region included in the Multi-Payer Advanced Primary Care Initiative (see Note 25 in text).

MODIFIED NCQA STANDARDS Several states have indicated a growing interest in building on the strengths of the NCQA standards by modifying them to fill perceived gaps. Maryland's Pa-

tient Centered Medical Home Pilot added more weight to certain elements that appeared in both the 2008 and 2011 NCQA standards. For instance, in both versions the use of electronic

prescribing is an optional element. However, Maryland deemed electronic prescribing a required or “must pass” element for practices to reach the NCQA’s levels 2 and 3.¹¹

STATE-SPECIFIC STANDARDS Six states have chosen to develop their own qualification standards (Exhibit 1). All of the accompanying qualification processes are free to practices. In addition, all six states give (or plan to give) practices direct technical assistance to help them make needed changes. Most of the six states audit the practices to make sure that they have met the qualification criteria.

State-specific qualification standards can pose challenges for some Medicaid providers that may be required by other payers to meet national standards. Although state and national standards may have a considerable amount of overlap, the six states have found their ability to audit practices valuable. Consequently, they have chosen to keep their own standards.

State-specific standards have either one or multiple tiers of qualification. The single-tier standards have one core set of standards that all practices must meet to qualify as a patient-centered medical home. Multiple-tier standards have a basic level of qualification to include a broad swath of providers, with higher levels designed as incentives for practices to improve their performance further.

► **SINGLE-TIER STANDARDS:** Colorado, Minnesota, and Washington developed their own single-tier qualification processes. In Colorado, the legislature required such standards and gave the state’s Public Health Department and Medicaid program responsibility for developing a medical home system and standards.¹² With thousands of Colorado families unable to find primary care providers who accepted Medicaid and CHIP, state officials worried that if those programs required enrolled providers to meet NCQA standards, the already serious access issues would be exacerbated. Local providers felt that NCQA recognition would have excluded many small practices lacking such resources as health information technology.

Colorado used many elements of the 2008 NCQA standards and other standards, and it incorporated feedback from providers, parents, and consumer advocates who responded to a survey. The Colorado standards do not require practices to have electronic health records or report data electronically.

Practices receive on-site technical assistance to help them with the qualification process. A core feature of the annual recertification process is the requirement that practices undertake a quality improvement project of their choice each year. Practices may use a quality improvement

There is a great deal of variation in patient-centered medical home standards and payment approaches across the states.

“coach” provided by the state to help with this project.

► **MULTIPLE-TIER STANDARDS:** In Nebraska, Oklahoma, and Oregon, state officials developed multiple-tier qualification systems. For instance, the Oklahoma Health Care Authority created a three-level system that applies to all of a provider’s SoonerCare (Oklahoma Medicaid) patients.¹³ Providers audit their own practices and place them in one of three tiers. Using an on-site or telephone audit, Medicaid later verifies the providers’ assessments.

Tier 1, for the “entry level medical home,” has eight requirements in addition to the usual contract requirements for Medicaid providers. The eight range from providing or coordinating all medically necessary primary and preventive services to maintaining a “tickler” system to track tests and referrals, including follow-up care. Tier 2, for the “advanced medical home,” adds nine more requirements, including offering after-hours care and open scheduling—that is, same-day appointments. Tier 3, for the “optimal medical home,” adds other criteria, including the use of a practice team and of evidence-based guidelines for screening, brief interventions, referrals, and treatment.¹⁴

New Payment Incentives

States have aligned their qualification processes with new incentive payments to support providers who establish patient-centered medical homes. Many states also offer additional support to providers in the medical homes, including access to learning collaboratives, disease registries, electronic health record systems, care coordinators, practice coaches, and data feedback (Exhibit 1).

A few states, such as Maine¹⁵ and Vermont,¹⁶ appropriated new funding for medical home initiatives to increase payments to providers and pay for practice support. But most states have

Getting commercial insurers and Medicaid plans to voluntarily participate in a pilot program has been difficult for many states.

not, usually because they must operate any new Medicaid initiatives on a budget-neutral basis. In New York, legislation enabled the state Medicaid program to make several investments in primary care—including the New York Medicaid State-wide Patient-Centered Medical Home Program—from reductions in inpatient payments.¹⁷

States have been adopting one or more of five basic payment strategies to support medical homes. These strategies are monthly care management fees plus fee-for-service payments; enhanced fee-for-service payments for certain office or outpatient visits known as “evaluation and management” visits; lump-sum payments for up-front costs; network payments; and pay-for-performance (Exhibit 2).

CARE MANAGEMENT FEES Most state patient-centered medical home initiatives have aligned qualification standards to a monthly care management fee, in addition to fee-for-service payments that average around \$3–\$4 per member per month for eligible populations (Exhibit 2). Minnesota’s higher payments are an exception.

A majority of the states pay qualified practices the care management fee without dictating how the practices should spend that money. However, some states do provide explicit guidance. For example, in the Chronic Care Initiative in northeast Pennsylvania, monthly payments to practices do not begin until after the provider shows proof that a qualified on-site care manager has been hired.¹⁸

Rhode Island and the initiative in northeast Pennsylvania pay a fixed, single-tier, monthly care management fee to practices. However, most other states stratify or adjust the fee based on one or more factors: the nature of the population served, such as adults, children, or both groups; level attained in medical home rankings (that is, NCQA level); or the presence of certain chronic conditions.

For instance, patient-centered medical homes in Minnesota that care for chronically ill Medicaid patients can receive a monthly complexity-adjusted care management payment. Providers assess their patients and place them in one of four “complexity tiers” using an assessment tool provided by the state. The care management payment is based on the number of chronic conditions the patient has, with the first tier being one to three major chronic conditions and the fourth tier being ten or more conditions. Providers also can receive supplemental care management payments of an additional 15 percent if patients (or their caregivers) have a primary language other than English or have a serious and persistent mental illness.¹⁹

ENHANCED FEE-FOR-SERVICE PAYMENTS The Medicaid programs in Colorado¹² and New York²⁰ are giving qualified providers enhanced fee-for-service payments for certain primary care or “evaluation and management” visits. For instance, New York’s program provides three levels of incentive payments for fee-for-service providers that are aligned with the providers’ achievement of the NCQA recognition levels.²⁰

This strategy rewards “well care” more highly than “sick care”—that is, it favors proactive over reactive treatment, thus reducing overall costs. Another reason for using it is that it works well in older claims systems lacking the technical capacity to process a monthly care management payment that was not generated by a bill from a provider. Colorado and New York have increased payments for certain evaluation and management codes in a way that resembles what a monthly care management payment would be.

LUMP-SUM PAYMENTS Another strategy to help practices qualify as patient-centered medical homes is to provide up-front funding to help them hire needed staff or invest in needed infrastructure.²¹ For instance, in southeast Pennsylvania, practices receive a lump-sum payment to assist with patient registry software fees, the NCQA survey and application fees, and the loss of revenue caused by taking time to participate in learning collaboratives.

NETWORK PAYMENTS In addition to monthly care management and fee-for-service payments to qualified providers, North Carolina²² and Vermont²³ pay networks or teams to support patient-centered medical homes. These community-based networks or teams help connect patients to services such as public health programs, behavioral health counseling, and social services. They also connect primary care providers to specialists, pharmacists, care coordinators, and so forth. Participating in a network or team helps small and medium-size practices that could not afford to hire additional staff.

EXHIBIT 2

Care Coordination Payments To Practices In State Patient-Centered Medical Home Initiatives

Initiative	Payment	Adjusted for patient	Adjusted for medical home level	Enhanced payment to practice	Medicaid managed care organizations
Iowa: IowaCare Medical Home Model	\$1.50–\$3.00	No	Yes	Yes, based on performance	No
Maine: Patient-Centered Medical Home Pilot ^a	\$3.00–\$7.00 ^b	No	No	No	No
Maryland: Patient Centered Medical Home Pilot	\$4.68–\$8.66 ^c	Yes	Yes	Yes, based on performance	Yes
Massachusetts: Patient-Centered Medical Home Initiative	\$2.10–\$7.50	Yes	No	Yes, lump sum based on performance	Yes
Michigan: Primary Care Transformation Demonstration Project ^a	\$3.00–\$4.50	Yes	No	Yes, based on performance	Yes
Minnesota: Health Care Homes Program ^a	\$10.14–\$79.05 ^d	Yes	No	No	Yes
Nebraska: Medicaid Medical Home Pilot Program	\$2.00–\$4.00	No	Yes	Yes, based on performance	No
New York: Adirondack Medical Home Demonstration Project ^a	\$3.50	No	No	No	Yes
North Carolina: Community Care of North Carolina ^{a,e}	\$2.50–\$5.00	Yes	To be determined	No	No
Oklahoma: SoonerCare Choice	\$2.93–\$8.41	Yes	Yes	Yes, lump sum based on performance	No
Pennsylvania: Chronic Care Initiative ^a	\$3.00–\$8.50 ^f	Yes	Yes	Yes, lump sum based on performance	Yes
Rhode Island: Chronic Care Sustainability Initiative ^a	\$3.00	No	No	Yes, lump sum based on hiring a nurse care manager	Yes
Vermont: Blueprint for Health ^a	\$1.20–\$2.39	No	Yes	Varies ^g	Yes
Washington: Multi-Payer Medical Home Reimbursement Pilot	\$2.00–\$2.50	No	No	Yes, based on performance	Yes

SOURCE Author’s analysis of state government information. **NOTES** The initiatives presented are those that align payment with patient-centered medical home standards. Not all payers have begun making payments to providers. “Payment” is a fixed per member per month amount or the range of such amounts that a provider is eligible to receive. “Adjusted for patient” means adjusted to reflect the complexity of a patient’s health status or demographic characteristics. ^aParticipating in the Multi-Payer Advanced Primary Care Initiative (see Note 25 in text). The payment ranges do not include the monthly care management fees paid by Medicare. ^bPayments vary by payer and by practice. Amounts paid by commercial payers are considered proprietary information. ^cPayments vary by payer and by practice. Smaller practices receive higher per member per month payments. ^dReflects Medicaid fee-for-service rates; other state-regulated payers are required to adopt “consistent” methodologies. Payments are made for beneficiaries with one or more chronic conditions. Rates reflect the 15 percent supplemental payment for patients who have a severe and persistent mental illness or whose primary language is not English. ^eCommunity Care of North Carolina is a statewide program. This description applies only to the seven-county region included in the Multi-Payer Advanced Primary Care Initiative (see Note 25 in text). ^fThe Pennsylvania Chronic Care Initiative rollouts in the northeast, south central, and southwest regions of the state vary in their per member per month payments to providers. In the southeast region, practices receive startup payments and then annual payments based on their NCQA certification level. ^gSome practices receive funding to hire support staff. Other practices share staff with community health teams. In both cases, expenses are shared by the payers.

PAYMENT FOR PERFORMANCE Three states (Nebraska,³ Oklahoma,²⁴ and Pennsylvania¹⁸) are using performance-based payments to complement other payments to patient-centered medical homes. For instance, in northeastern Pennsylvania, providers in the Chronic Care Initiative receive “value reimbursement payments.” For the first three years of the initiative, practices that have met a certain number of performance criteria will qualify to share in any savings that they generate. The value reimbursement payments are made only if the savings exceed the

annual value of the other ongoing medical home payments.¹⁸

MEDICAID PLANS AND COMMERCIAL INSURERS Medicaid fee-for-service is a central payer in most state-based patient-centered medical home initiatives. Many of these initiatives either encourage or require Medicaid plans or commercial health insurance carriers to participate.

Seventeen states are participating or plan to participate in multipayer patient-centered medical home initiatives. Eight states—Maine, Michigan, Minnesota, New York, North Caro-

The patient-centered medical home model is very young, but the evidence so far is encouraging.

lina, Pennsylvania, Rhode Island, and Vermont—will add Medicare as a payer later this year as part of the Multi-Payer Advanced Primary Care Initiative being conducted by the Centers for Medicare and Medicaid Services.²⁵ Bringing Medicare as a payer into the states' patient-centered medical home initiatives will create powerful momentum to increase the scope of providers and patients involved in the initiatives. For instance, the medical home multipayer pilot program in Rhode Island currently covers 76 percent of the states' residents who have health insurance. Once Medicare has joined the Rhode Island program, it will cover 98 percent (personal communication from Deidre Gifford, clinical assistant professor of community health, Brown University, April 19, 2011).

Getting commercial insurers and Medicaid plans to voluntarily participate in a pilot program has been difficult for many states. States can require Medicaid plan participation through contracting language. For instance, Pennsylvania Medicaid requires its plans to pass to providers \$1 per member per month of their performance-based payments received from the state for Medicaid patient-centered medical home incentives.²⁶ But many states have faced challenges in engaging Medicaid plans and commercial insurers in pilot programs and required strong authority to secure their participation. Pennsylvania²⁷ needed an executive order; Maryland²⁸ and Vermont²⁹ relied on legislation; and Rhode Island³⁰ used existing statutory authority through the health insurance commissioner to bring both Medicaid plans and commercial insurers to the table.

Does The Medical Home Model Work?

The patient-centered medical home model is very young and has only recently been implemented in mainstream practices. The evidence so far is encouraging. A literature review in 2010 found that investments in patient-centered medical

homes yielded a return on investment in terms of quality of care, patient experiences, care coordination, access, and ability to “bend the cost curve.”³¹

However, a 2010 analysis of patient-centered medical home evaluations conducted by Mathematica Policy Research and the Agency for Healthcare Research and Quality noted that only a few high-quality evaluations have been published, and almost all of these involved patient-centered medical homes within integrated health care delivery systems. These evaluations showed limited evidence of improvements in quality and cost outcomes.³²

The initiatives described in this article are also very young, and evaluations of them have not been published. The oldest initiatives began in Colorado and Rhode Island in 2008. Most states participating as payers in multipayer initiatives will have independent evaluations of their efforts—some funded by the state, others by private foundations. Many of these evaluations will compare control and study practices; use quality measures, including the Healthcare Effectiveness Data and Information Set;³³ and conduct surveys on provider and patient satisfaction.

Colorado, Oklahoma, and Vermont have reported limited data on their initiatives in their annual reports to Medicaid or the state legislature. There are considerable differences in the information that is reported and the sources of data. Nevertheless these early findings are worth noting and are briefly summarized below.

OKLAHOMA Oklahoma implemented its Medicaid-wide patient-centered medical home program in January 2009 under a budget-neutral imperative, which meant that the program could not result in any increase in the state's Medicaid outlays. In fact, the initiative has demonstrated a decline of \$29 per patient per year in per capita member costs under Medicaid from 2008 to 2010. It has also demonstrated increases in evidence-based primary care, including screening for breast and cervical cancer (personal communication from Rebecca Pasternik-Ikard, state Medicaid chief operating officer, Oklahoma Health Care Authority, January 5, 2011).

The program has received positive feedback from both providers and patients. More than 244 new physicians have enrolled in Medicaid since the implementation of Oklahoma's medical home initiative. Also since implementation, patient inquiries related to same-day/next-day appointment availability decreased from 1,670 inquiries to 13 in a one-year period.³⁴ A 2010 health survey of adult SoonerCare Choice enrollees showed an increase of 8 percent of patients “always getting treatment quickly” from 2008.³⁵



COLORADO The Colorado Medical Home Initiative—aimed at improving the quality of care for children in Medicaid and CHIP—has had similar success in expanding access to care. Before the initiative, 20 percent of pediatricians in Colorado accepted Medicaid. As of 2010, 96 percent did.

According to survey data, 90 percent of parents now have little or no trouble getting appointments for their children when needed. From fiscal year 2007 to fiscal year 2009, median costs in Colorado's Medicaid program declined from \$215 per patient per year for children in a patient-centered medical home relative to children enrolled in control group practices.³¹ During the same period of time, the portion of children with Medicaid coverage who had at least one well-care visit increased dramatically, from 54 percent to 73 percent (personal communication from Gina Robinson, program administrator, Colorado Department of Health Care Policy and Financing, June 14, 2011).

VERMONT Vermont recently published early results of its multipayer Blueprint for Health in the initiative's 2010 annual report. The pilot program was discussed in depth in the March 2011 issue of *Health Affairs*.²³ In summary, the first pilot community, launched in July 2008, found that inpatient use and per person per month costs had decreased 21 percent and 22 percent, respectively, by October 2010.³⁶ Emergency department use and per person per month costs decreased 31 percent and 36 percent, respectively. Vermont's second pilot community had mixed results.

PROMISING TRENDS Some of the early findings from Colorado and Oklahoma, which have statewide Medicaid initiatives, demonstrate that modest increases in payment aligned with quality improvement standards have not only resulted in promising trends for costs and quality, but have also greatly improved access to care. This is an important finding for other states as they consider how to meet the tremendous increase in demand for care that will result from the expansions to Medicaid in the Affordable Care Act of 2010.

States are laboratories for innovation with the patient-centered medical home model.

Conclusion

The patient-centered medical home model is a promising vehicle for achieving the goals of the primary care delivery system. The model is fueled by aligning payments with increasing expectations that primary care practices improve the way they deliver care. This is not a fuel-guzzling vehicle. States have found that modest increases in payments coupled with other kinds of assistance to practices have been enough to motivate providers to meet medical home quality standards.

The Affordable Care Act allows states to test new—or improve existing—patient-centered medical home models. The opportunities that the act provides include improving primary care for patients who are eligible for both Medicaid and Medicare; integrating behavioral health care and long-term care services into “health homes”; and improving the quality and efficiency of services by improving coordination among primary care providers, hospitals, and specialists through accountable care organizations. In addition, the chance for Medicaid and Medicare providers to receive federal “stimulus” funds through the meaningful use of electronic health records to support medical home efforts⁷ may further states' efforts to expand the number of patient-centered medical homes.

States are laboratories for innovation with the patient-centered medical home model. The strategies they try and the lessons they learn can inform new approaches to primary care in both the public and private sectors. ■

The author thanks Melinda Abrams and the Commonwealth Fund for their generous support of this research, and Jason Buxbaum, a policy analyst at the National Academy for State Health Policy, for preparing the exhibits and providing research support.

NOTES

- 1 Dentzer S. Reinventing primary care: a task that is far "too important to fail." *Health Aff (Millwood)*. 2010;29(5):757.
- 2 National Academy for State Health Policy. Medical home states [Internet]. Portland (ME): NASHP; [cited 2011 Jun 3]. Available from: <http://www.nashp.org/med-home-map>
- 3 Nebraska Department of Health and Human Services. Nebraska Medicaid program: Nebraska Medicaid medical home pilot program [Internet]. Lincoln (NE): The Department; [last updated 2011 May 19; cited 2011 Jun 3]. Available from: <http://www.hhs.state.ne.us/med/Pilot/>
- 4 Oklahoma Health Care Authority. SoonerCare program operations: March 2010 MAC meeting [Internet]. Oklahoma City (OK): The Authority; 2010 Mar [cited 2011 Jun 3]. Available from: <http://www.okhca.org/WorkArea/DownloadAsset.aspx?id=11565>
- 5 National Committee for Quality Assurance. Patient-centered medical home [Internet]. Washington (DC): NCQA; [cited 2011 Jun 14]. Available from: <http://www.ncqa.org/tabid/631/Default.aspx>
- 6 Health Resources and Services Administration. HRSA Patient-Centered Medical/Health Home Initiative [Internet]. Rockville (MD): HRSA; [cited 2011 Jun 3]. Available from: <http://bphc.hrsa.gov/policiesregulations/policies/pal201101.html>
- 7 Centers for Medicare and Medicaid Services. Medicare and Medicaid programs; electronic health record incentive program: final rules. *Fed Regist*. 2010;75(144):44314-588.
- 8 National Committee for Quality Assurance [Internet]. Washington (DC): NCQA; c2011. Press release, New NCQA standards take patient-centered medical homes to the next level; 2011 Jan 28 [cited 2011 Jun 3]. Available from: <http://www.ncqa.org/tabid/1300/Default.aspx>
- 9 URAC. URAC's patient centered health care home program [Internet]. Washington (DC): URAC; [cited 2011 Jun 3]. Available from: http://www.urac.org/healthcare/prog_accred_pchch_toolkit.aspx
- 10 Zahni EE. The Joint Commission developing primary care home option [Internet]. Oakbrook Terrace (IL); Joint Commission; 2010 Sep 7 [cited 2011 Jun 3]. Available from: http://www.jointcommission.org/the_joint_commission_developing_primary_care_home_option
- 11 Maryland Health Care Commission. Patient Centered Medical Home Program participation agreement [Internet]. Baltimore (MD): The Commission; 2011 [cited 2011 Jun 3]. Available from: <http://mhcc.maryland.gov/pcmh/documents/PCMH%20Prog%20Partic%20Agmt%20050411.pdf>
- 12 Concerning medical homes for children, and making an appropriation therefor. Session Laws of Colorado 2007, Chapter 346, First Regular Session of the 66th General Assembly.
- 13 Oklahoma Health Care Authority. Addendum 1—medical home to SoonerCare physician agreement for choice primary care providers [Internet]. Oklahoma City (OK): The Authority; 2008 Dec 16 [cited 2011 Jun 3]. Available from: http://www.okhca.org/pdf/Physician_Addendum.pdf
- 14 More information regarding this evidence-based practice can be found at White House Office of National Drug Control Policy. Screening, brief intervention, referral, and treatment [Internet]. Washington (DC): ONDCP; [cited 2011 Jun 24]. Available from: http://www.whitehouse.gov/treat/screen_brief_intv.html
- 15 An act making unified appropriations and allocations. Pub. L. No. 213; 124th Maine Legislature; 2009.
- 16 An act making appropriations for the support of government. Act 1 of the 2009 Special Session of the Vermont State Legislature.
- 17 An act to amend the public health law and the elder law. Chapter 58 of the Laws of 2009; New York State Legislature.
- 18 Pennsylvania Governor's Office of Health. Participation agreement for participation in the Northeast Pennsylvania Rollout of the Pennsylvania Chronic Care Initiative. Harrisburg (PA): The Office; 2009.
- 19 Centers for Medicare and Medicaid Services. Transmittal and notice of approval of state plan material [Internet]. Baltimore (MD): CMS; 2010 Jul 6 [cited 2011 Jun 3]. Available from: <https://www.cms.gov/MedicaidGenInfo/downloads/MN-10-006-179.pdf>
- 20 New York State Department of Health. Announcing New York Medicaid's statewide Patient-Centered Medical Home Incentive Program. New York State Medicaid Update [serial on the Internet]. 2009 Dec [cited 2011 Jun 3]. Available from: http://www.health.state.ny.us/health_care/medicaid/program/update/2009/2009-12spec.htm
- 21 Landon BE, Gill JM, Antonelli RC, Rich EC. Prospects for rebuilding primary care using the patient-centered medical home. *Health Aff (Millwood)*. 2010;29(5):827-34.
- 22 Steiner BD, Denham AC, Askin E, Newton NP, Wroth T, Dobson LA. Community Care of North Carolina: improving care through community health networks. *Ann Fam Med*. 2008;6(4):361-7.
- 23 Bielaszka-DuVernay C. Vermont's blueprint for medical homes, community health teams, and better health at lower cost. *Health Aff (Millwood)*. 2011;30(3):383-6.
- 24 Oklahoma Health Care Authority. SoonerExcel [Internet]. Oklahoma City (OK): The Authority; [cited 2011 Jun 3]. Available from: http://www.okhca.org/providers.aspx?id=9426&menu=74&parts=8482_10165
- 25 Department of Health and Human Services. Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration fact sheet [Internet]. Washington (DC): HHS; [last updated 2010 Nov 3; cited 2011 Jun 16]. Available from: http://www.cms.gov/DemoProjectsEvalRpts/downloads/mapcpdemo_Factsheet.pdf
- 26 Kelley D. Medical home payment models implemented in Pennsylvania Medicaid. Presentation at: National Academy for State Health Policy 2nd State Consortium to Advance Medical Homes Learning Session; 2009 Oct 20; Baltimore, MD.
- 27 Chronic Care Management, Reimbursement, and Cost Reduction Commission. Pennsylvania executive order 2007-05. Harrisburg (PA): The Commission; 2007 May 21.
- 28 An act concerning patient centered

- medical home program. Chapters 5/6. Maryland General Assembly; 2010.
- 29** An act relating to managed care organizations, the Blueprint for Health, and immunizations of children prior to attending school and child care facilities, and the immunizations registry. Act 204; Vermont General Assembly; 2008.
- 30** Rhode Island General Law 42-14.5-2; 2004.
- 31** Grumbach K, Grundy P. Outcomes of implementing patient centered medical home interventions: a review of the evidence from prospective evaluation studies in the United States [Internet]. Washington (DC): Patient-Centered Primary Care Collaborative; 2010 Nov 16 [cited 2011 Jun 3]. Available from: http://www.pcpcc.net/files/evidence_outcomes_in_pcmh.pdf
- 32** Myers D. Preliminary evidence and what to do about it. Presentation at: National Academy for State Health Policy 3rd State Consortium to Advance Medical Homes Kick-off Meeting; 2011 Mar 31; Baltimore, MD.
- 33** National Committee for Quality Assurance. HEDIS and quality measurement [Internet]. Washington (DC): NCQA; [cited 2011 Jun 3]. Available from: <http://www.ncqa.org/tabid/59/default.aspx>
- 34** Johnson P, Botten K (Oklahoma Health Care Authority). Evaluating the patient-centered medical home: potential and limitations of claims-based data [Internet]. Portland (ME): National Academy for State Health Policy; 2010 May 5 [cited 2011 Jun 3]. Available from: <http://www.nashp.org/archives/1997>
- 35** APS Health Care. CAHPS adult health survey for SoonerCare Choice: executive summary and technical specifications [Internet]. Oklahoma City (OK): APS Health Care; 2010 May [cited 2011 Jun 3]. (Report for Fiscal Year 2010). Available from: http://www.okhca.org/pdf/Adult_CAHPS%20Member_Survey_SFY2010.pdf
- 36** Vermont Blueprint for Health. 2010 annual report. Williston (VT): Department of Vermont Health Access; 2011 Jan.

ABOUT THE AUTHOR: MARY TAKACH



Mary Takach is program director for the National Academy for State Health Policy.

In this issue of *Health Affairs*, Mary Takach writes about how seventeen states that were dissatisfied with primary care outcomes for Medicaid beneficiaries have become laboratories of innovation for testing medical home models. Despite budget deficits and strong pressure to cut Medicaid programs, she observes, many states are passing legislation to implement medical home programs and

increasing payments to primary care providers, while also raising quality standards.

One of her most interesting findings, Takach says, is that community health centers have been “pivotal in state medical home efforts,” not only as providers of care, but also in “their leadership in helping private practices adopt new models of care delivery.”

Takach is program director for the National Academy for State Health Policy, in Portland, Maine, where she directs policy research focused on primary care, patient-centered medical homes, and workforce and delivery system issues. As the lead researcher on a Commonwealth Fund project, she helps states advance medical homes

in their Medicaid and Children’s Health Insurance Programs.

Takach is also the lead researcher on a National Cooperative Agreement from the Health Resources and Services Administration of the Department of Health and Human Services. With a background in health policy and clinical care, she joined the National Academy for State Health Policy in 2007, after working as a legislative assistant to two members of Congress.

A registered nurse, Takach has lectured at the University of Maryland Graduate School of Nursing. Her master of public health degree is from the Johns Hopkins Bloomberg School of Public Health.