



In the Literature

Highlights from Commonwealth Fund-Supported Studies in Professional Journals

Reinventing Medicaid: State Innovations to Qualify and Pay for Patient-Centered Medical Homes Show Promising Results

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Synopsis

Seeking to address soaring costs and lagging health outcomes in their Medicaid programs, a number of states are promoting the spread of patient-centered medical homes through a combination of incentive payments and qualification standards for physician practices. Early results show promising trends in costs, quality, and access to care.

Background

Looking to improve care and halt cost growth in their Medicaid programs, many states are turning to the patient-centered care medical home model for delivering primary care. This Commonwealth Fund–supported article in *Health Affairs* focuses on 17 states that are aligning medical home standards with incentive payments to support primary care reform.

“Modest increases in payments coupled with other kinds of assistance have been enough to motivate providers to meet medical home quality standards.”

Standards for Patient-Centered Medical Homes

Most states designate medical practices as patient-centered medical homes using standards set by the National Committee for Quality Assurance (NCQA). Six of the states in this study, however, opted to develop their own qualification standards. Three developed a “single-tier” qualification process—meaning all practices must meet a single set of standards to qualify as a patient-centered medical home—while another three have multiple-tier qualification systems that provide incentives for practices to attain higher levels of medical home recognition.

New Payment Incentives

Monthly care management fees. Most of the states studied pay patient-centered medical homes a per-member per-month fee averaging about \$3 to \$4, in addition to fee-for-service payments. Most states

adjust the fee based on certain factors, such as whether a patient has a chronic condition or has a primary language other than English.

Enhanced fee-for-service payments. Medicaid programs in Colorado and New York are giving qualified providers enhanced fee-for-service payments for certain primary care visits, such as new patient visits. This strategy rewards “well care” more highly than “sick care.”

Lump-sum payments. In southeastern Pennsylvania, practices receive a lump-sum payment to defray patient registry software fees, NCQA survey and application fees, and revenue lost from taking time to participate in learning collaboratives.

Network payments. North Carolina and Vermont pay networks or teams to support patient-centered medical homes. These teams help connect patients to public health programs and social services and connect primary care providers to specialists, pharmacists, and care coordinators.

Pay-for-performance. Nebraska, Oklahoma, and Pennsylvania are using performance-based payments to complement other payments to patient-centered medical homes. Pennsylvania practices that have met certain performance criteria can share in any savings they generate.

Medicaid plans and commercial insurers. Seventeen states are participating or plan to participate in multipayer patient-centered medical home initiatives. Eight will add Medicare as a payer later in 2011 as part of a federal pilot program, a step that will create powerful momentum to increase the scope of providers and patients involved in the initiatives, the authors say.

Early Results

Although the initiatives described in the study are very young—the oldest began in 2008—early findings are promising. For example:

- Oklahoma’s patient-centered medical home initiative has reduced Medicaid costs \$29 per patient per year from 2008 to 2010. Moreover, use of evidence-based primary care, including screening for breast and cervical cancer, increased.
- The Colorado initiative expanded access to care. Before the initiative, only 20 percent of pediatricians in the state accepted Medicaid; as of 2010, 96 percent did.
- In the first pilot community in Vermont, inpatient care use and related per-person per-month costs decreased 21 percent and 22 percent, respectively, from July 2008 to October 2010. Emergency department use and related per-person per-month costs decreased 31 percent and 36 percent, respectively.

The Bottom Line

Some state patient-centered medical home initiatives that use qualification standards and financial incentives are starting to show an impact in access to care, quality, and cost control.

Citation

M. Takach, “Reinventing Medicaid: State Innovations to Qualify and Pay for Patient-Centered Medical Homes Show Promising Results,” *Health Affairs*, July 2011 30(7):1325–34.