



In the Literature

Highlights from Commonwealth Fund-Supported Studies in Professional Journals

About Half of the States Are Implementing Patient-Centered Medical Homes for Their Medicaid Populations

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Synopsis

To help primary care providers function as patient-centered medical homes, 25 states have implemented a variety of payment policy changes and other reforms in Medicaid and the Children’s Health Insurance Program since 2006. These have included: paying providers per-member per-month fees for care management services; focusing initiatives on high-cost patients, including people with chronic illnesses; enabling smaller practices to share the services of registered nurses, behavioral health specialists, and other health professionals; and aligning payment with quality-of-care standards.

“The desire to achieve . . . lower costs, improved population health, and improved patient experience is driving the evolution of state patient-centered medical home initiatives.”

The Issue

Efforts to improve U.S. health care must include payment reforms that encourage greater efficiency and reduce waste. Over the past six years, 25 states have pursued changes in how their two major public insurance programs for low-income families—Medicaid and the Children’s Health Insurance Program—pay primary care practices. The goal of these states is to incentivize and support physician practices to become patient-centered medical homes (PCMHs), where clinicians and other health professionals team up to provide comprehensive, coordinated, accessible services that meet the specialized needs of their patient populations. With Commonwealth Fund support, Mary Takach of the National Academy for State Health Policy researched recent developments in state Medicaid payment policy that might inform payment strategies more broadly.

Trends in State Medicaid Patient-Centered Medical Home Reforms

- Nineteen of the 25 states that have implemented payment changes are paying providers a per-member per-month care management fee to perform the functions of a PCMH.

- Some states are adapting initiatives to serve their most costly populations—patients with chronic conditions. Minnesota, for instance, designed a care management fee that was adjusted according to the number of a patient’s chronic conditions. And, under a provision of the Affordable Care Act, Missouri was able to include community mental health centers in its medical home demonstration. In return for a \$78.74 per-member per-month care management fee, mental health centers coordinate with their patients’ primary care physicians to ensure adherence to behavioral and general medical care and proper follow-up after hospital discharges.
- In 2012, Medicaid agencies in Alabama, Maine, Michigan, and Minnesota began deploying “shared teams” to help practices—particularly small ones—provide a range of services to patients with complex conditions. Shared-team members may include registered nurses, behavioral health specialists, pharmacists, and nutritionists, among others.
- Many states are asking practices to link payments with meeting standards of care, like those set by the National Committee for Quality Assurance (NCQA). An initiative in Rhode Island goes beyond the NCQA standards, requiring providers to meet targets for utilization, quality, and patient satisfaction measures. The Rhode Island initiative also requires practices to expand patients’ access outside of normal business hours through use of e-mail and telephone consultations.
- In Massachusetts, a pilot program made up-front payments to practices of as much as \$15,000 in the first year and \$3,500 in the second year to support PCMH transformation activities, like populating patient registries with data and training for practice teams. However, this type of payment strategy has not been widely adopted.
- Some states that have launched multipayer initiatives—like Maryland, Massachusetts, Pennsylvania, and Washington—are using a shared-savings approach, under which a practice that spends less than its projected costs keeps a portion of the savings. Pennsylvania Medicaid officials calculate shared savings based on key outcomes measures, like those for diabetes or hypertension control, as well as 30-day readmission rates and emergency department visits. Practices are eligible for shares of net savings that rise from 40 percent to 50 percent over three years.

The Bottom Line

Half of state Medicaid programs are taking new approaches to provider payment—focusing on chronically ill populations, using shared teams, aligning payments with national quality standards, and implementing shared-savings programs—to help primary care practices become patient-centered medical homes for their low-income patients.

Citation

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