Recommendations on incentives to promote the voluntary adoption of medical home principles by HFS’ providers of primary care services to children

Position Paper

Recommendations from the Incentives Workgroup of the CHIPRA Quality Demonstration Grant
Bureau of Quality Management, Division of Medical Programs
Illinois Department of Healthcare and Family Services

March 2014
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EXECUTIVE SUMMARY

The Patient-Centered Medical Home (PCMH, or medical home) is a model for delivering primary health care services that are accessible, patient-centered, coordinated, comprehensive, continuous, compassionate and culturally effective. Medical homes have proliferated since their introduction in the late 1960s to become a cornerstone of national health reform, state-level initiatives and small, local pilot programs alike.

With the growing emphasis on medical homes as a means to improve quality and lower costs, the CHIPRA Medical Home Incentives Workgroup makes six recommendations for the Illinois Department of Healthcare and Family Services (HFS) to adopt in order to expand the availability of medical homes for children.

1. Define and Use the Term PCMH Consistently
The CHIPRA Incentives Workgroup recommends adopting the medical home definition developed by the Patient Centered Primary Care Collaborative (PCPCC), adding a focus on the family in the context of a medical home for children. They agreed that a medical home should be patient and family-centered, comprehensive, coordinated, accessible and committed to quality and safety. For purposes of this report, when the word “patient” is assumed to include both the child and the family.

2. Use a Nationally Recognized Medical Home Recognition Program for Classifying Medical Homes
The CHIPRA Incentives Workgroup recommends that HFS adopt an existing PCMH recognition process rather than developing its own. NCQA’s PCMH is the most widely-used recognition standard and is well-suited for adoption by outpatient primary care practices as well as federally qualified health centers (FQHC). Other nationally-recognized programs could be acceptable for use in Illinois in the future if proponents demonstrate they are comparable to or exceed the NCQA standards.

3. Provide Financial and Non-Financial Support for Practice Transformation to Achieve PCMH Standards
The CHIPRA Incentives Workgroup recommends that HFS provide financial and non-financial incentives to promote achievement of PCMH recognition, including supporting transformation and rewarding practices that serve as medical homes.

4. Develop the Processes, Policies and Oversight Needed to Promote and Sustain PCMH, including Aligning Medical Home Incentives across HFS Programs and Involving Private Payers in Spreading and Sustaining Medical Homes
The CHIPRA Incentives Workgroup recommends that HFS provide ongoing oversight and support for PCMHs and adopt policies to promote expansion and sustainability for the populations HFS serves.

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1 This work is funded through the Children’s Health Insurance Program Reauthorization Act. Illinois, in conjunction with Florida, applied for and received $11.3 million over five years to improve the quality of care for children enrolled in Medicaid and CHIP. The funding supports several initiatives being led by HFS, including a workgroup to support the expansion of medical homes for children.
Promoting the alignment of public and private sector initiatives will further focus attention and resources on priority health improvements.

5. **Evaluate and Report on the Impact of PCMH Recognition**

Illinois should assess the contribution of PCMH to achieving Illinois’ health system goals including access and quality of care. The Workgroup recommends HFS track the number of practices who achieve recognition, the cost of financial and non-financial incentives, any subsequent improvement in quality and/or reduction in emergency room or hospital-based care, and patient and provider satisfaction in order to understand how best to spread and sustain improvements.
PURPOSE OF THIS REPORT

In February 2010, the Centers for Medicare and Medicaid Services (CMS) awarded grants to 18 states to improve health care quality for children enrolled in Medicaid and the Children’s Health Insurance Program (CHIP). Funded by the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA), the Quality Demonstration Grant Program aims to identify effective, replicable strategies to enhance the quality of care for children through the collection and reporting of data, health system infrastructure improvement and enhancements to the delivery of health care services. HFS and the Florida Agency for Health Care Administration are joint recipients of a five-year, $11.3 million grant.

In an effort to help ensure high performing pediatric primary care, the Illinois HFS, along with advisors from the Illinois Chapter of the American Academy of Pediatrics and the Illinois Academy of Family Physicians, identified the Patient-Centered Medical Home (PCMH) as a model of care to be promoted in the State. The PCMH creates a standard for primary care organization and delivery. It is a philosophy of health care delivery that ensures providers and care teams have a continuous and trusting relationship with patients, and that care is coordinated and received in the right place, at the right time, and in the manner that meets patients’ needs.

HFS convened a workgroup of stakeholders and advisors to develop recommendations for the State of Illinois to promote the transformation of traditional child-serving primary care practices to a PCMH model of care. This paper presents key issues related to promoting this transformation and relevant recommendations. (Refer to Appendix 1 for a list of workgroup participants.)
The Patient-Centered Medical Home (PCMH) originated with the American Academy of Pediatrics which, in 1967, described the medical home as primary care that is accessible, family-centered, coordinated, comprehensive, continuous, compassionate and culturally effective. A 1996 Institute of Medicine report, *Primary Care: America’s Health in a New Era*, defines primary care as “the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health needs, developing a sustained partnership with patients, and practicing in the context of family and community” and references the medical home concept as a means for re-envisioning primary care. In 2006, the American College of Physicians developed *The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care*, which proposed fundamental changes in the delivery of and payment for primary care. In the same year, the four major primary care medical associations in the United States – the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP) and the American Osteopathic Association (AOA) – published their “Joint Principles for the Patient-Centered Medical Home,” and the Patient-Centered Primary Care Collaborative was established with the intention of promoting and studying the widespread transformation of primary care to a PCMH model of care. Payers began identifying the PCMH as one strategy for improving outcomes and controlling costs. The federal government also identified the PCMH as an important element in meeting the Triple Aim – better health and better care at lower cost.

Though not every medical home initiative follows exactly this model, Figure 1 depicts the relationship between promoting medical homes and improving outcomes. The PCMH model seeks to strengthen the delivery system and improve appropriate utilization and patient engagement in care. Most medical home programs provide training, technical assistance, stakeholder engagement, administrative supports and incentive payments to facilitate change. Numerous short-, mid-, and long-term outcomes anticipated to stem from medical homes are shown in the right-hand portion of the figure.
Figure 1: Medical Home Program Model

Health care costs are high and rising, while quality is inadequate and uneven.
- Care is sought in high-cost settings
- Lack of care coordination
- Lack of access
- Racial and ethnic disparities
- Inefficient deployment of medical expertise
- Misaligned incentives
- Lack of patient engagement and satisfaction
- Provider dissatisfaction

Activities
- Practice application and enrollment
- Learning collaboratives
- Training
- Technical assistance
- Preparation of NCQA recognition
- NCQA assessment
- Practice coaching
- Use of registries
- Development of relationships with specialists/hospitals

Participants
- Plans
- Practices (lead and staff)
- Technical assistance providers
- Legislature
- Patients

Short-Term
- Improved care coordination
- Improved access
- Improved quality
- Appropriate utilization
- Shifting costs
- Medical home recognition
- Improved medical home level
- Program continued
- Adoption/acceptance/use of PCMH components
- Leaders/model practices

Mid-Term
- More practices engaged
- More patients engaged
- Fewer disparities
- Lessons for spread and sustainability
- Return on investment

Long-Term
- Improved population health
- Rational delivery system
- Lower costs
- Improved patient and provider experience
Nationally, the Patient Protection and Affordable Care Act (ACA) promotes the expansion of the PCMH model and highlights it as a cornerstone of Accountable Care Organizations (ACOs) – a key to health system reform. On a state level, most Medicaid programs are using the PCMH model to ensure access to primary care and coordination of health care services for Medicaid beneficiaries. Twenty-five state Medicaid programs adopted the PCMH model between 2006 and 2012. Subsequently, 12 states adopted or enhanced their PCMH in FY 2013 and an additional nine states plan to implement or expand their use of PCMH in 2014. In these states, PCMHs function as stand-alone initiatives or components of other initiatives such as ACOs, health homes or managed care plans.

The proliferation of medical homes nationally is likely to continue through increased Medicare payments now being considered by Congress. A Medicare physician payment reform bill that would make new payments available to PCMHs is under consideration in early 2014. Key House and Senate Committees have already approved versions of the bill, which would include enhanced payments for chronic care management services, including billing for non-face-to-face services to patients with two or more chronic conditions, and automatic achievement of the “clinical practice improvement activities” that are part of a new value-based purchasing program.

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4 NCQA Recognition Notes, December 2013. See http://www.ncqa.org/Programs/Recognition/RelevanttoAllRecognition/RecognitionNewsletter.aspx
Putting the Medical Home Definition Into Practice

Implementing the elements that are included in the medical home definition require significant effort from primary care practices. Figure 2 identifies numerous activities that a medical home performs. The list of activities is extensive, though not exhaustive, and requires commitment to careful planning over time to achieve workflow changes. The breadth and complexity of these activities, and the focus needed to implement them, may be daunting to practices for which these are new concepts.

**Figure 2: Medical Home Capabilities Aligning with PCMH Elements**

<table>
<thead>
<tr>
<th>PCMH Elements</th>
<th>Capabilities related to this PCMH Element</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accessibility of the practice</strong></td>
<td></td>
</tr>
<tr>
<td>PCMH is an accessible point of entry into the health care system each time new care is needed (i.e., first contact care)</td>
<td>• Open scheduling</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Continuity of care</strong></td>
<td></td>
</tr>
<tr>
<td>“Each patient has an ongoing relationship with a personal physician in the PCMH” Person-focused (not just disease-specific) care over time</td>
<td>• Each patient has an identifiable primary care clinician for ongoing care</td>
</tr>
<tr>
<td></td>
<td>• Patient is able to make appointments with that particular clinician</td>
</tr>
<tr>
<td></td>
<td>• Discussion between personal physician and patient on the roles and expectations for the medical home, including making visible to the patient who the team members are</td>
</tr>
<tr>
<td></td>
<td>• PCMH has a registry of patients for which it is responsible</td>
</tr>
<tr>
<td></td>
<td>• Complete medical records are retrievable and accessible</td>
</tr>
<tr>
<td><strong>Coordination of care</strong></td>
<td></td>
</tr>
<tr>
<td>“across all domains of the health care system”</td>
<td>• PCMH coordinates care that patients receive from other providers (e.g. specialists, behaviorists, pharmacists, hospitals and home health agencies to ensure patients get the indicated care when and where they need and want it, including medication review and management)</td>
</tr>
<tr>
<td></td>
<td>• Referral tracking and follow-up to ensure that the visit occurred and results are known</td>
</tr>
<tr>
<td><strong>Comprehensiveness</strong></td>
<td></td>
</tr>
<tr>
<td>PCMH recognizes and provides, or arranges for “care for all stages of life, including: acute care, chronic care, preventive services and end-of-life care”</td>
<td>• Planned visits</td>
</tr>
<tr>
<td></td>
<td>• Registry of patients’ facilitates comprehensive care and population health management by enabling searches of patients with particular conditions and characteristics.</td>
</tr>
<tr>
<td>PCMH Elements</td>
<td>Capabilities related to this PCMH Element</td>
</tr>
<tr>
<td>---------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td><strong>Physician directed medical practice</strong> with a team that “takes collective responsibility for ongoing care of patients”</td>
<td>• A team approach can, in theory, leverage the relative clinical and organizational training skills of each member (e.g. physician, nurse, medical assistant, care coordinator, social worker) to ensure that the increasingly complex and inter-related needs of patients with multiple chronic conditions are met. Teamwork can facilitate comprehensiveness and coordination of care.</td>
</tr>
</tbody>
</table>
| **Quality and safety** | • Decision making guided by evidence-based medicine and decision support tools  
• Measurement and quality improvement efforts  
• Patients participate in decision making  
• Patient feedback is sought to ensure expectations are met |
| **Information technology**  
“Uses HIT appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication” | • Use of a registry to identify PCMH’s patients, facilitate disease management, population health and evidence-based care (consensus that this is the most relevant IT improvement to the immediate progress of the PCMH)  
• Electronic communication for referrals for medical care and community resources, as well as patient-provider communication |

Source: Based on Ann S. O’Malley, Deborah Peikes and Paul B. Ginsburg, “Qualifying a Physician Practice as a Medical Home.” Center for Studying Health System Change, December 2008, with additional characteristics provided by the Incentives Workgroup.
THE COSTS OF BECOMING A MEDICAL HOME

Practices making the transition to a medical home usually incur new costs that are not accounted for in fee-for-service payments. The practice transformation process is complex and often requires expert assistance from trained facilitators to help with workflow redesign, the design and use of registries, staff training, new care management processes and improved patient engagement techniques. Some practices may spend money to acquire an electronic medical record, add a care coordinator, or extend evening or weekend hours. While the workgroup recognizes that the initial start-up and recurrent costs may be significant, few studies have addressed the financial impact on a practice becoming a PCMH, and the research that does exist has shown widely inconsistent results.\(^5\) Two examples follow.

In 2008, the Deloitte Center for Health Solutions developed a medical home model to assess the return on investment.\(^6\) Due to the lack of cost studies in the medical literature from which to build a model, the potential medical home care coordination impact was modeled on known disease management assumptions. The results of the assessment showed that, for an individual primary care physician, developing a medical home program would require an initial investment of $100,000 and recurrent costs of $150,000 or more. The assessment suggests that offsetting this financial investment would likely require a long-term bonus structure, upfront capital from a strategic partner and a collaboration of local payers and community-based health information exchange to support a community-based care management model.

Taking a very different approach, another study of 35 NCQA-recognized practices examined the cost of incremental improvements towards becoming a medical home and found no significant increases in costs as “medical homeness” increased.\(^7\) This study analyzed the practices’ costs compared to the degree to which the practices function as medical homes using data from NCQA’s online PCMH self-assessment tool. The results showed a less than $1-per-month difference in patient costs between the third of practices with the highest PCMH intensity compared to practices in the lower two-thirds. Health information technology (HIT) costs did differ modestly but significantly, however, with the third of practices with the highest PCMH intensity spending $11,000 per FTE physician, while those in the lowest third only spent $5,000 per FTE physician. This study concludes that “becoming a PCMH may only require adjustments to how practice inputs are used, as opposed to incurring significant additional expenditures.”

Regardless of future research findings, it always may be hard to generalize from such studies because of the diversity of starting points among those practices making the transformation. Those that are farther

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\(^5\) Berenson, R., Devers, K., Burton, R. Will the Patient-Centered Medical Home Transform the Delivery of Health Care? The Urban Institute, Health Policy Center, August 2011.

\(^6\) The Medical Home: Disruptive Innovation for a New Primary Care Model. Deloitte Center for Health Solutions, 2008.

along the medical home spectrum to begin with will not have as many changes to implement and will thus experience fewer costs compared to practices with lower levels of medical homeness at the outset. Practice and patient population size impact costs, as well. Medical home models also differ in their requirements, and depending on which model a practice chooses to adopt, the staff, tools and processes needed, and their associated costs, will likewise vary. Finally, a relationship between a medical home and a hospital or health system can skew the costs. As the next section will further describe, achieving recognition or accreditation as a medical home also has associated costs, in terms of application fees and staff time; and these costs vary depending on the model.

It is important to note that the actual cost burden to a practice also depends on more than just the dollar figure alone. Large primary care practices may be better able to provide the capital needed to implement and sustain a medical home – particularly a large practice under the umbrella of a hospital or health system with infrastructure supports that could be extended to the PCMH such as health information technology, performance improvement, social services support and health education.

A PCMH initiative for a group of privately insured families in Fresno, California, is illustrative of the type of expense some programs have incurred to make a transition to medical homes. In that city, a pilot program for 2,500 school district employees and families required consulting ($450,000 for 18-months of consulting time); $135,000 and hundreds of hours of staff time contributed by the professional association (California AAFP); hundreds of hours of physician and staff time to install patient registries; and hiring and sending a practice coach and complex care manager to training. Project leaders have been pleased with the results. The net savings in the first 18 months was $1 million and quality metrics showed improvement, though they were not statistically significantly in the first year. Most savings were achieved through lower hospital utilization.\(^8\)

The cost burden of becoming a medical home can be reduced if net savings are shared with the practice to cover its costs. To the extent that the medical home can reduce spending on hospital stays, emergency room visits, specialty care and other services or capitation costs, payers who realize these gains and are willing to finance the PCMH among its primary care practices are able to minimize the risk to primary care practices in assuming potential costs and encourage its adoption.

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\(^8\) Personal communication, Susan Hoagland and Leah Newkirk, California Academy of Family Physicians, January 20, 2014.
ACCREDITATION

Many payers have developed, or are looking toward developing, incentives to offset the cost burden and to encourage practices taking on the medical home responsibilities. Accreditation, recognition, or certification programs have become the tools used to set a standard for medical homes and also identify and distinguish practices that achieve them. Payers utilizing these programs provide a financial incentive for practices that have achieved an established recognition, as detailed in the following section.

National Committee for Quality Assurance PCMH Recognition

The National Committee for Quality Assurance’s (NCQA) PCMH Recognition program is the most commonly used recognition program among freestanding medical practices.⁹ The program, which was developed in 2008 and updated in 2011 and 2014, is based on the Joint Principles but requires practices to meet certain standards in order to achieve one of three recognition levels as an NCQA-certified medical home. NCQA’s PCMH 2011 includes 6 standards, comprising 27 total elements. Six elements are “must pass” items and require a passing score for the practice to receive any level of recognition, while any combination of the remaining 21 elements can be used by the practice to achieve recognition. The 2011 standards were updated to align closely with specific elements of CMS’ Electronic Health Record (EHR) Incentive Program Meaningful Use Requirements, have a stronger focus on integrating behavioral health and care management, have enhanced applicability to pediatric practices and include an optional patient experience survey and standardized methodology. The 2014 standards are being presented in March of this year.

The Joint Commission PCMH Certification

In 2010, The Joint Commission (TJC), a leading healthcare accreditation body, added an optional medical home module to their accreditation process. The TJC medical home module has 177 elements, of which 123 were already embedded in their ambulatory care standards. Staff of TJC noted significant overlap with NCQA¹⁰ standards. Unlike NCQA, which is self-reported with random audit, TJC accreditation involves an onsite review process.

The Accreditation Association for Ambulatory Health Care Medical Home Accreditation and Certification

The Accreditation Association for Ambulatory Health Care (AAAHC) accredits a wide range of health care providers and delivery systems, the most relevant for this topic is federally qualified health centers. Providers who already use the AAAHC for accreditation are able to additionally receive accreditation for being a medical home if they meet an additional set of standards and pass an onsite review.

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⁹ [www.ncqa.org](http://www.ncqa.org)
¹⁰ Lon Berkely, Joint Commission, presentation at the Medical Home Summit, 2011.
**URAC Patient Centered Health Care Home**

The accrediting organization URAC has created a checklist for medical homes that organizations customize to fit their organizational structure. As of 2010, URAC had accredited 500 total organizations of a wide variety. Some, such as Veterans Administration call centers, are not related to pediatric primary care. Although not relevant to Illinois’ agenda now, URAC may be making plans to enhance its role in accrediting patient-centered medical homes in the future.11

Figure 4 displays some of the important features of each of these nationally recognized medical home programs.

**Figure 3: Features of Nationally Recognized Medical Home Programs**

<table>
<thead>
<tr>
<th>Tool Name</th>
<th>NCQA PCMH</th>
<th>TJC PCMH</th>
<th>AAAHC Medical Home Accreditation/Certification</th>
<th>URAC Patient Centered Health Care Home (PCHCH)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type/duration of Medical Home Program</strong></td>
<td>Recognition (3 yrs)</td>
<td>Certification (3 yrs)</td>
<td>Accreditation (more comprehensive, up to 3 yrs) or certification (3 yrs)</td>
<td>Achievement (2 yrs)</td>
</tr>
<tr>
<td><strong>Intended User/Setting</strong></td>
<td>Outpatient primary care practices and similarly focused specialty practices</td>
<td>Health care systems seeking full Joint Commission Accreditation</td>
<td>Organizations providing health care services in the ambulatory care setting</td>
<td>Various settings; achievement is specific to the practice site</td>
</tr>
<tr>
<td><strong>Audit</strong></td>
<td>NCQA reviews practice-submitted documentation, and audits 5% of practices. May also conduct discretionary audits of recognized practices, including an off-site document review, onsite review, or a teleconference.</td>
<td>TJC conducts onsite evaluations for all applicants. TJC also conducts unannounced onsite surveys of 5% of these organizations previously certified to verify the accuracy of the evidence submitted.</td>
<td>AAAHC audits all applicants onsite and also conducts random, unannounced, onsite surveys of accredited organizations.</td>
<td>Auditors conduct onsite reviews. Mid-cycle, onsite reviews of randomly-selected practices are conducted with days’ notice.</td>
</tr>
<tr>
<td><strong>Cost</strong></td>
<td>The cost is scaled to practice size, ranging from $520 for a one-provider practice, to over</td>
<td>No cost for first time PCMH or full TJC accreditation resurveys. PCMH extension surveys</td>
<td>The cost is scaled depending on the size, type and range of services provided by the organization.</td>
<td>Cost is scaled based on practice size. The Patient Centered Health Care Home</td>
</tr>
</tbody>
</table>

11 Alan Speilman, URAC, presentation to the Medical Home Summit, 2011.
<table>
<thead>
<tr>
<th>Tool Name</th>
<th>NCQA PCMH</th>
<th>TJC PCMH</th>
<th>AAAHC Medical Home Accreditation/Certification</th>
<th>URAC Patient Centered Health Care Home (PCHCH)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$6,680 for a non-sponsored practice with 50+ providers.</td>
<td>are $4,130 for the 1\textsuperscript{st} day and $1,965 for any additional days, if needed.</td>
<td></td>
<td>Program Toolkit is $59.</td>
</tr>
<tr>
<td>Participating Practices (national &amp; IL)</td>
<td>National: ~6,000 practices (9/2013)\textsuperscript{12} IL: 569 clinicians and 141 sites (12/2012)\textsuperscript{13}</td>
<td>National: 106 IL: 7 (as of October 30, 2013)\textsuperscript{14}</td>
<td>National: 242 organizations IL: 13 organizations\textsuperscript{15}</td>
<td>National: unknown IL: unknown</td>
</tr>
</tbody>
</table>

“Homegrown” Medical Home Approaches

Other payers have developed their own medical home standards rather than relying on a nationally recognized program. For example, the Minnesota Department of Health developed its own medical home approach with an onsite audit by health department staff as part of their 2008 health reform legislation.\textsuperscript{16} Primary care providers that become certified as a “health care home” in Minnesota are eligible for increased payment for partnering with patients and families to provide coordination of care. Minnesota’s program works because the standards are endorsed across a range of programs and by both public and private entities. Some medical home programs opt for a “homegrown” approach because it offers flexibility and control in developing their own standards and audit requirements. A risk associated with homegrown approaches, however, is that they can lead to confusion in the provider marketplace as some public programs use the state PCMH standard, while some privately funded health plans use other, nationally recognized standards. Practices becoming medical homes incorporate the associated activities into their workflows and processes for all patients; being subject to disparate standards by different payers may be burdensome and difficult to implement. Further, a homegrown approach requires a greater staff role at the state level to define and monitor standards and implement audits and oversight, as well as to periodically update standards.

\textsuperscript{13} CHIPRA Medical Home Incentives Subgroup, January 3, 2013.
\textsuperscript{16} See Minnesota Department of Health website, http://www.health.state.mn.us/healthreform/homes/certification/index.html
INCENTIVES

While the demand for medical homes has increased tremendously, relatively few practices have gone through a recognition program except in those cases where payers have created financial incentives to do so. The incentives offered by payers are varied. Some incentives have been structured to support practices’ initial implementation costs. They may underwrite the time and expense of participating in the recognition program, provide technical support to achieve each facet of the medical home model, fund the hardware or software needed to achieve some aspects of medical homes (e.g., registries), or augment staff, such as by providing care coordination, case management and others services to promote patient engagement. Without augmented payment to offset these start-up costs, many practices, particularly smaller practices, find the burden of practice transformation to be too much to bear. In addition, many practices find that community health workers, care coordinators, case managers or other similarly trained individuals are better suited to such patient supports than are the physicians. The cost of employing these workers directly can be a high proportion of the cost of a small practice.

Incentivizing medical home transformation is similar to the approach used by the federal and state governments to encourage adoption and meaningful use of electronic health records (EHRs). Incentives available through Illinois’ EHR Medicaid Incentive Payment Program (eMIPP) have resulted in more than 4,000 providers and more than 160 hospitals involved in adapting, adopting, or using EHRs in a meaningful way. In many instances, EHR adoption and meaningful use would not have occurred without financial incentives. Similar to EHR adoption and meaningful use, medical home transformation requires extensive resources and staff time to effect change and is not likely to occur without financial incentives to support transformation.

Once medical home recognition is achieved, it is common for providers to earn some form of ongoing payment. The form an incentive payment takes depends on the payer’s needs and preferences. A 2009 National Academy for State Health Policy (NASHP) report on ten states’ early work in recognizing medical homes in their Medicaid programs found that all states were planning on adding payments for medical home practices, and strategies being considered included:

- Per member per month and/or lump sum payments for care coordination, over and above standard payments for medical services;

- Enhancing rates for certain services (e.g., well child visits) to encourage outreach to patients, and which would minimize the changes that the practices and payers have to make to their existing payment and billing systems;

• Leveraging the managed care procurement process to favor medical homes by modifying selection criteria or contractual requirements;

• Shared savings; and

• Pay-for-performance, based on achieving set benchmarks on measures of quality.

Non-monetary incentives are under consideration also, such as the provision of resources to help with medical home transformation or enhanced/improved care delivery, including:

• Continuing education credits;

• Linkages to care coordination networks;

• Learning collaboratives/information sharing/assistance incorporating best practices;

• Onsite practice coaches;

• Provision of data on patients and practice performance;

• Supporting/enhancing health information exchange; and

• Supporting patient engagement through patient education and measurement.

The authors also noted that the benefits of incentives were more apparent when multiple payers and other stakeholders’ incentives were aligned. Practices transforming to PCMH provided these enhanced services to all patients – payers who do not support the care model still accrue benefits to their members, but threaten the viability of the PCMH. The myriad of incentive options available have allowed each state to develop their own tailored program to meet their specific needs. As Figure 5 shows, each of the 10 states assessed by NASHP has adopted a unique set of incentives.

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**Figure 4: Examples of Other State’s PCMH Contractual Requirements**

<table>
<thead>
<tr>
<th>State</th>
<th>Recognition Requirements</th>
<th>Transformation Incentives</th>
<th>Ongoing/Care Coordination Incentives</th>
<th>Multi-Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arkansas</td>
<td>NCQA Level 3</td>
<td></td>
<td>PMPM incentive payment, in addition to its Medicaid prospective payment system (PPS) or APM (cost-based rate)</td>
<td>Yes</td>
</tr>
</tbody>
</table>
| Connecticut | NCQA Level 2 or Level 3 | PCMH Glide Path option provides financial and technical support. To qualify, practices must submit:  
• Complete PCMH application and Glide Path application, complete glide path gap analysis,  
• Complete Glide Path Work Plan documentation  
• Provide ongoing documentation for each Glide Path phase  
**Incentives:**  
• Up to 125% of the estimated annual incremental PCMH costs using a hybrid reimbursement approach  
• Start-up Supplemental Payment (small independent practices only) | • PCMH participation fee differential payment  
• PMPM performance payments  
• Incentive Payments  
• 25th-50th percentile – 25% of possible incentive payment  
• 51st – 75th percentile – 50% of possible incentive payment  
• 76th – 90th percentile – 75% of possible incentive  
• 91st – 100th – 100% of possible incentive  
• Improvement payments  
• 5% improvement over prior year results – 50% of the possible improvement payment  
• 10% improvement over prior year results – 75% of the possible Improvement payment  
• 90th – 100th percentile relative to all Qualified PCMH practices – 100% of the possible Improvement Payment | No          |
| Hawaii    | State defined, NCQA, AHRQ Minimum State defined requirements 1. One PCMH Training Program, Conference, or |                                                                                                           | Population Health Management (PHM) fee  
• PHM fees will be paid on a monthly basis in 2013 the PHM fees were as follows: Level 1 - $2.00 PMPM, Level 2 - $3.00 PMPM, Level 3 – $3.50 PMPM                                                                                                                                 | No          |
<table>
<thead>
<tr>
<th>State</th>
<th>Recognition Requirements</th>
<th>Transformation Incentives</th>
<th>Ongoing/Care Coordination Incentives</th>
<th>Multi-Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maryland</td>
<td>• NCQA&lt;br&gt;• Level 1 by June 2011&lt;br&gt;• Level 2 by June 2012</td>
<td>• Payment of NCQA application fees</td>
<td>• Quest members receive Level 1 - $1.00 PMPM, Level 2 - $1.50 PMPM, Level 3 - $2.00 PMPM</td>
<td>Yes</td>
</tr>
</tbody>
</table>

2. Collaborative PCMH Meetings (8 for level 1)
3. Access during office hours
4. Document and track transitions of care
5. Implement PCMH provider-patient agreement
6. Counsel to adopt healthy behaviors
7. Registry use
8. Track additional quality measures
9. Complete assessment and share findings with physician organization leadership
10. Provider quality metric or patient access improvement
11. Physician organization priority project
12. Action plan based on survey results

Year 1: A fixed per patient per month (PPPM) payment for enhanced care coordination and practice transformation.
Year 2: A fixed PPPM plus possible additional incentives based on shared savings and quality improvements.
<table>
<thead>
<tr>
<th>State</th>
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<th>Ongoing/Care Coordination Incentives</th>
<th>Multi-Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York</td>
<td>NCQA Level 2; Level 3 within 12-18 months to continue receiving enhanced payments.</td>
<td>$84 PMPY</td>
<td>Payments are weighted based on practice size, practice share among Medicaid and private payers, and compliance with NCQA criteria; Practices earn incentive payments based on meeting quality targets. Practices will also have to meet certain utilization reduction thresholds in order to receive relevant incentive payments from meeting quality targets.</td>
<td>Yes</td>
</tr>
</tbody>
</table>
| Oregon    | NCQA, State defined • Tier 2 or Tier 3                                                    |                           | • A comprehensive website of resources  
• Monthly webinars on core practice transformation topics  
• A Learning Collaborative for selected practices  
• A train-the-trainer program for quality improvement professionals  
• Public Employee’s Benefit Board – PMPM incentive payment to tier 2 or tier 3 recognized primary care homes  
• Public Employee’s Benefit Board members have lower cost share for primary care services when access through a recognized primary care home – from 10% to 15%  
• Enhanced payments to selected practices from five private payers and Medicaid starting in November of 2012  
• Supplemental PMPM for certain chronic conditions – Tier 1 - $10; Tier 2 - $15; Tier 3 - $24 | Yes         |
Determining Per-Member Per-Month Payment Incentives

Despite the difficulties in determining the cost burden, many payers intend to offset the costs that practices incur in becoming a PCMH through enhanced payments. Naturally, these payments vary widely, with one 2009 study of 26 PCMH initiatives reporting a range of $0.50 to $9.00 PMPM among the initiatives assessed. In 2011, the Primary Care Collaborative further reviewed PMPM payment variations and the factors that may influence these among 12 PCMH initiatives that were selected to represent a diverse mix of single and multi-payer initiatives, some of which included the state Medicaid agency, as well as a range of payment models. Figure 3 displays these results.

Figure 5: PMPM Variation in 12 PCMH Initiatives

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Program Characteristics</th>
<th>Rates Adjusted For:</th>
<th>Other Payments Provided</th>
<th>PMPM Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorado: HealthTeamworks</td>
<td>Multi-payer; multi-state</td>
<td>Practice size (1-2 physicians vs. 3+); NCQA recognition level</td>
<td>FFS; P4P bonus</td>
<td>$4.00 - $8.50</td>
</tr>
<tr>
<td>Maryland</td>
<td>Multi-payer</td>
<td>Practice size; Population group (Medicaid, Commercial, Medicare); NCQA recognition level</td>
<td>FFS; Shared savings</td>
<td>$4.68 - $11.54</td>
</tr>
<tr>
<td>Minnesota: Health Homes</td>
<td>Medicaid program health homes for patients with chronic/complex needs</td>
<td>Condition group; primary language other than English; serious/persistent mental illness</td>
<td>NA</td>
<td>$10.14 - $60.81</td>
</tr>
<tr>
<td>New York: Capital District Physicians’ Health Plan</td>
<td>Single private payer</td>
<td>Patient panel risk profiles; performance</td>
<td>One-time payment of $35,000; FFS; quality bonus</td>
<td>Up to $4.05</td>
</tr>
<tr>
<td>New York: EmblemHealth</td>
<td>Single private payer</td>
<td>Care management; P4P</td>
<td>FFS; P4P</td>
<td>Up to $5.00</td>
</tr>
<tr>
<td>North Carolina: Community Care of North Carolina</td>
<td>State Medicaid program</td>
<td>Population (women and children vs. ABD)</td>
<td>FFS; payment to regional networks to support local care management activities</td>
<td>$2.50 - $5.00 (practice); $3.00-$8.00 (network)</td>
</tr>
</tbody>
</table>

20 Bailit, M. “Payment Rate Brief”, Patient-Centered Primary Care Collaborative, March 2011.
<table>
<thead>
<tr>
<th>Initiative</th>
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<th>Rates Adjusted For:</th>
<th>Other Payments Provided</th>
<th>PMPM Range</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ohio: The Health Improvement Collaborative of Greater Cincinnati</strong></td>
<td>Three private payers</td>
<td>NCQA recognition level</td>
<td>FFS; P4P</td>
<td>$2.50 - $6.00</td>
</tr>
<tr>
<td><strong>Oklahoma SoonerCare Choice</strong></td>
<td>State Medicaid program</td>
<td>Population (Children, adults); Level of PCMH recognition; Practice capability</td>
<td>One-time payment to some providers to switch to capitation; FFS; P4P</td>
<td>$3.03 - $9.24</td>
</tr>
<tr>
<td><strong>Pennsylvania Chronic Care Initiative</strong></td>
<td>Multi-payer</td>
<td>Practice support; Care management based on age</td>
<td>FFS; shared savings</td>
<td>$2.10 – $8.50</td>
</tr>
<tr>
<td><strong>Rhode Island Chronic Sustainability Initiative</strong></td>
<td>Multi-payer</td>
<td>Practice support; nurse care management</td>
<td>FFS</td>
<td>$4.16 (varies by practice)</td>
</tr>
<tr>
<td><strong>Vermont Blueprint for Health</strong></td>
<td>Multi-payer (5 including Medicare)</td>
<td>Number of NCQA PCMH recognition points earned</td>
<td>5 payers equally share the costs of a Community Health Team that supports the PCMH practices</td>
<td>Up to $2.39</td>
</tr>
<tr>
<td><strong>Washington</strong></td>
<td>Multi-payer</td>
<td>Year of operation</td>
<td>FFS; shared savings</td>
<td>$2.00 - $2.50</td>
</tr>
</tbody>
</table>

NA: Not available

Source: Bailit, M. “Payment Rate Brief”, Patient-Centered Primary Care Collaborative, March 2011.
THE EVIDENCE ABOUT THE MEDICAL HOME MODEL

Research is just beginning to emerge about the impact of the patient-centered medical home on quality, access, and costs. Most researchers agree that few rigorous evaluations have been done to date and evidence of the effectiveness of the model is not robust.\(^{21,22}\) There are good findings for people with major chronic illnesses such as asthma, and for older adults with multiple conditions; though even for these populations emerging results are not consistent, and more research is needed.\(^{23}\) Some studies have focused on limited network providers, such as closed panel HMOs, or for commercial populations, making it difficult to draw conclusions for Medicaid or Primary Care Case Management (PCCM) plans.

The Commonwealth Fund has convened a group of research methodologists called the Medical Home Evaluators’ Collaborative to create standard measures against which programs should be assessed to ensure that research findings can guide us in knowing the model’s real benefits.

Challenges to Rigorous, Independent Evaluation

There are several challenges to assessing the impact of medical homes. Often, medical home initiatives are small pilots and the small sample size means it is hard to detect changes in health care utilization except among the most frequent health care utilizers.\(^{24}\) Medical homes also are defined in varying ways, including variations in the associated care interventions, the degree of implementation, and included target populations.\(^{25}\) Another challenge is that the medical home model is often adapted to local conditions, such as practice size, workforce and community resources. Standardized implementation is not encouraged, and this variation makes outcomes measurement even harder. Without a rigorous research plan, practices are unlikely to keep track of the adaptations and implementation issues that would contribute to the findings.

Emerging Evidence Suggests Reduction in Emergency Department Visits for Older Adults and/or Populations with Multiple Chronic Conditions

One systematic review of published PCMH studies highlights such difficulties, reporting on the inconsistency in the definitions and nomenclature for PCMH.\(^{26}\) In 19 comparative studies, this review found that PCMH interventions had a small positive effect on patient experiences and small to moderate positive effects on the delivery of preventive care services. A low strength of evidence was found for an


improvement in staff experiences by a small to moderate degree. While the evidence suggested a reduction in emergency department visits in older adults, no reduction was found for hospital admissions. No evidence for overall cost savings was found. The review concludes that evidence is not yet sufficient to determine whether there are improvements in chronic illness care processes, clinical outcomes, hospital admissions, or the costs of care as a result of PCMH implementation, and that more research is needed to determine whether improvements translate into improved outcomes and lower costs.

A recent study of five independent primary care practices in the Rhode Island Chronic Care Sustainability Initiative found that a pilot program of a multi-payer PCMH was associated with substantial improvements in PCMH scores on NCQA’s self-assessment online tool and a significant reduction in ambulatory sensitive emergency department visits (11.6 percent) over two years. No significant differences, but a downward trend, were found in emergency department visits overall and inpatient admissions, and no changes were found in quality measures assessed.

A Colorado multi-stakeholder PCMH pilot that has been in place since 2009 is currently being evaluated by the Harvard School of Public Health and results are pending; however, preliminary results show significantly reduced emergency department visits and hospital admissions, particularly for patients with multiple chronic conditions. In addition, improvements on measures of infrastructure (use of team-based care, health information systems, evidence-based guidelines, self-management support, and care coordination), quality (screening for tobacco use, depression, and breast and colorectal cancer), and intermediate outcomes (reduction of lipids and blood pressure levels for patients with diabetes and cardiovascular disease) were also noted. One payer reported a 250-400 percent return on investment during the pilot. These positive results were noted despite numerous obstacles encountered, including lack of payment for PCMH services provided to a large number of patients. The full evaluation based on claims data, as well as satisfaction information obtained from patient surveys, will provide greater clarity.

**Early Evidence on Cost Reduction Also Focuses on Older Adults and Populations with Chronic Conditions**

Medical homes are believed to have the capacity to reduce health care costs, namely through reduced emergency department visits, inpatient hospitalizations and readmissions for people who are at high risk for these services, as a result of improving chronic care management and care coordination. While rigorous research has yet to demonstrate consistent cost benefits, the evidence that is available is largely focused on older adults with multiple chronic conditions. A recent study of a Michigan PMCH program with more than 2,500 primary care practices found the program achieved improvements in use

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of preventive care by children, but savings of $155 million were entirely for adults. The report concludes that this finding is consistent with the underlying PCMH principles of improving chronic care management and care coordination, benefits that would largely accrue to an older population with higher disease burden rather than to a relatively healthy child population. Correspondingly, the few studies that did focus on and find decreases in emergency department visits for children were for children with complex or special health care needs. As this kind of research is conducted on a larger scale over longer periods of time, we expect to see more conclusive evidence on the cost effects of the medical home model.

Self-Reported Evaluations of Medical Home Projects Appears Promising

While numerous other emerging studies also point to the promise of medical homes, they are conducted or funded by the organizations being studied, small in scale and lack the rigor of full, independent evaluations. The experiences of a few mature and controlled systems of care such as Geisinger Health System, Group Health Cooperative of Puget Sound and the North Carolina’s Primary Care Case Management program aresuggestive that PCMH may be improving care and reducing costs. A less mature effort, the Colorado Medical Home Initiative, a statewide program for children in Medicaid and CHIP, self-reports improvements in access to care, with significant increases in the number of providers accepting Medicaid, increased well care visits and decreased median costs since the program’s inception. The Pediatric Alliance for Coordinated Care in Boston funded a small-scale demonstration project of 150 children with special health care needs also noted improvements in access as well as communication as a result of comprehensive care and integrated health and other services. The program also resulted in a significant reduction in work days missed by parents and reduced hospitalizations. A recent study of Minnesota’s Health Care Home Initiative also points to improved quality and reduced or equivalent costs for high need patients. Specifically, improvements were noted for health care home practices for colorectal cancer screening, asthma care, diabetes care, and

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31 Klitzner TS, Rabbitt LA, Chang RKR. “Benefits of Care Coordination for Children with Complex Disease: A Pilot Medical Home Project in a Resident Teaching Clinic.” The Journal of Pediatrics, 156.6 (2010): 1006-10.
33 Domino, ME. “Enhancing the Medical Homes Model for Children with Asthma.” Medical Care, 47.11 (2009): 1113-20.
37 Takach, M. “Reinventing Medicaid: State Innovations To Qualify and Pay For Patient-Centered Medical Homes Show Promising Results.” Health Affairs, 30.7 (2011): 1325-34.
depression follow-up compared to control practices, with overall Medicaid expenditures of 9.2 percent less than control practices by the third year of the study. While this evaluation was focused on the initial phases of health care home transformation in the studied practices, a deeper evaluation of the initiative, including additional years of data, is forthcoming.

While few independent studies directly evaluate the medical home and the evolving approaches to designing and implementing the model suggest that evidence to support PCMH is preliminary, efforts to evaluate the medical home continue. We can expect to see more evidence emerge on the medical home as a whole, as well as its individual components, as this capacity grows.

EXISTING MEDICAL HOME IN ILLINOIS

Medical Home Adoption in Publicly Financed Programs

The medical home model has been promoted in Illinois’ Department of Healthcare and Family Services (HFS) publicly financed health care since 2007. Beginning with Illinois Health Connect (IHC), the state’s primary care case management (PCCM) program, key features of the medical home were included as minimal requirements for participating primary care providers (PCPs) and a blended payment model was introduced that includes per member per month care management fees and bonus pay for performance components in addition to the traditional fee-for-service payments. As HFS’ largest quasi-managed care program, IHC currently includes over 5,600 IHC medical homes serving over 1.7 million clients. Due to the program’s size and statewide reach, the focus on medical home components within the program has been the state’s most substantial spread of medical home in publicly or privately financed health care.

The program has demonstrated success, with over 90 percent of providers receiving bonus payments in 2008, for a total of $2.8 million distributed, increasing to $5 million in 2012. Over a two-year period, IHC saved $500 million compared to expected expenses, and an HFS report to the General Assembly showed four-year savings of $997 million. Moreover, the most recent satisfaction surveys indicate that satisfaction is high among providers and patients, with over 95 percent of IHC medical homes reporting that IHC is beneficial to their patients and 92 percent reporting that it is well administered, and more

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41 As of June 30, 2013.
43 These figures report the combined savings of Illinois Health Connect and Your Healthcare Plus.
44 An unpublished update to this report estimates savings could be as high as $2 billion. Findings were presented to the AAFP Family Medicine Congressional Conference, May 14, 2012, Washington, D.C.
46 Illinois Health Connect PCCM 2013 Provider Satisfaction Survey
than 95 percent of urban and rural patients rating their experience with IHC as satisfactory or very satisfactory.\footnote{Illinois Health Connect 2010 Enrollee Satisfaction Survey.}

While the medical home spread and positive results in IHC is a significant achievement, the design of the PCCM program has not advanced medical home transformation as much as in other states, and the sheer size of the program has limited what it has been able to accomplish. IHC was not authorized to push medical homes beyond minimal requirements, has offered only limited incentives primarily focused on increasing targeted clinical services and not on practice transformation or care coordination and has not included compliance and enforcement provisions. Increased access to PCPs during office hours, 24/7 availability of triage services, and connecting patient records and sharing information with practices were hard to benchmark and measure due to the size and breadth of the program. Clinical benchmarks were successful in raising clinical quality measures from below average to meet national average performance, but has not advanced beyond that.

Since their introduction through IHC, medical home elements have been included, in varying degrees, in other HFS program contracts. While these efforts have encouraged growth in the medical home model and the number of HFS individuals served by a medical home, the requirements across contracts lack uniform requirements and language (see Figure 6 below). The end result has been an inconsistent encouragement of medical home adoption across contracts.

Despite these inconsistencies, the medical home model has grown steadily in Illinois. There were 140 NCQA-recognized PCMH practices including 569 clinicians in Illinois in December 2012, more than an eight-fold increase since 18 months prior. In addition, of the 120 FQHC sites in Illinois as of December 2013:

- 28 have received 2012 PCMH supplemental funding, and 9 have received 2011 PCMH supplemental funding;
- 6 health centers (which may encompass more than one site per center) have received TJC PCMH Certification, and an additional center is pending;
- 7 sites have achieved NCQA PCMH Recognition (Levels 1-3), 13 sites have applications pending, and 11 additional sites intend to submit applications in the next 6 months; and
- It is anticipated that 20-25 sites will have submitted applications for Level 3 NCQA PCMH Recognition by the fall of 2014.

Even with this growth, as Illinois’ Medicaid reform transitions over 50 percent of Medicaid clients into care coordination and managed care delivery systems, the importance of uniform medical home requirements across programs is even more apparent. As the state moves toward a more robust
coordinated managed care model, smaller local networks with more manageable populations will result, with additional resources/supports available to practices, including options to increase access/hours, 24-hour triage service with access to medical record and connection to practices, higher benchmarks and MCO support of medical homes from MCOs, Accountable Care Entities (ACEs) and Coordinated Care Entities (CCEs).
<table>
<thead>
<tr>
<th>Delivery System</th>
<th>Population Served</th>
<th>Contractual Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Case Management (PCCM)</td>
<td>Most Medicaid and All Kids (CHIP) enrollees, with certain exceptions</td>
<td>Medical homes are promoted in IHC’s PCCM contracts in several ways, both at the administrative and provider levels. The current PCCM program administrator, Automated Health Systems, Inc., is contractually obligated to expediently secure medical homes for newborns, provide medical home education to enrollees, and monitor enrollment in a medical home to ensure access to care. IHC providers are required to maintain adequate office hours and access and availability requirements based on acuity, provide direct access to a provider 24/7 (not including automatic referral to an ER), maintain hospital admitting and/or delivery privileges or arrangements for admission, institute care plans for patients with chronic disease, participate in the Centers for Disease Control and Prevention’s (CDC) Vaccines for Children (VFC) program to provide no-cost vaccinations to children whose families would be otherwise unable to pay, provide all required EPSDT services, make medically necessary referrals to HFS enrolled providers including specialists, as needed, and participate in IHC’s Quality Assurance (QA) program.</td>
</tr>
<tr>
<td>Integrated Care Program (ICP)</td>
<td>Older adults and adults with disabilities who are eligible for Medicaid but not eligible for Medicare</td>
<td>The ICP contractually obligates its participating MCOs to include medical homes in their provider networks with a patient-centered approach to care, including the provision and coordination of high quality, planned, family-centered health promotion; Wellness Programs; acute illness care; and chronic disease management. In addition to PCP services, the medical homes must support the integration of physical and behavioral health and provide care through an integrated care team, supported by health information technology. The MCO must also provide medical home education to its affiliated providers.</td>
</tr>
<tr>
<td>Medicare Medicaid Alignment Initiative (MMAI)</td>
<td>Dual eligibles</td>
<td>MMAI MCOs have similar requirements to ICP MCOs. These MCOs have the same contractual provision to provide patient-centered medical homes in their provider networks with integrated physical and behavioral health, health information technology and medical home education. Unlike ICP MCOs, however, MMAI MCOs are also required to have a</td>
</tr>
</tbody>
</table>

48 Section 4.1.8.2 of AHS contract.  
49 Section 4.5.1.6 of AHS contract.  
50 Section 4.15.2.1 of AHS contract.  
51 Sections 5.5 and 5.9 of ICP contracts.  
52 Aetna Better Health has adopted more rigorous language in its provider contracts, as described below.
<table>
<thead>
<tr>
<th>Delivery System</th>
<th>Population Served</th>
<th>Contractual Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Coordination Entities (CCE)</td>
<td>Medicaid-eligible complex seniors and persons with disabilities</td>
<td>CCEs, provider-organized networks operating under the Care Coordination Innovations Project and serving Medicaid-eligible complex seniors and persons with disabilities, offer an alternative option to traditional MCOs. CCEs provide care coordination services and deliver care that is more patient-centered and focused on improved health outcomes, enhanced patient access, and patient safety. Macon County’s CCE, one of five in Illinois, is required to provide a patient-centered medical home to enrollees, including a PCP and a care coordination team. The plan must provide support for enrollees in selecting a medical home and connect providers through coordinated communication methods.</td>
</tr>
<tr>
<td>Voluntary Managed Care Organizations (VMCOs)</td>
<td>Medicaid and All Kids (CHIP) enrollees in certain counties who voluntarily chose to participate</td>
<td>VMCO contracts, while not requiring medical homes, do state in their marketing requirements that enrollees may select a medical home as their PCP.</td>
</tr>
</tbody>
</table>

53 Sections 2.8 and 2.7.4.3 of MMAI contracts.
54 Sections 5.5 and 5.73 of Macon County CCE contract.
Medical Home Adoption in Provider Organizations

Provider organizations in Illinois, including the Illinois Primary Health Care Association (IPHCA), the Illinois Chapter of the American Academy of Pediatrics (ICAAP) and the Illinois Academy of Family Physicians (IAFP), have been promoting and responding to the spread of medical home in Illinois through the development of practice expertise and providing direct support to practices as they move toward becoming medical homes.

IPHCA has hired transformation/facilitation staff and provided support to 32 federally qualified health centers (FQHCs) with federal Health Resources and Services Administration (HRSA) funding to achieve NCQA PCMH recognition. In addition, 23 FQHCs are participating in CMS’ Advance Primary Care Practice Demonstration to assess team-based care coordination. These practices receive a monthly care management fee through the program to help make investments in patient care and infrastructure. Through the demonstration, FQHCs are expected to achieve NCQA PCMH Level 3 recognition, actively coordinate care and assist patients in chronic disease management.

ICAAP and IAFP have likewise supported practices – ICAAP through its medical home, transition and CHIPRA projects, and IAFP through the Practice Improvement Network. These organizations have been monitoring medical home activity in other states and health systems and have provided guidance to HFS on ways to strengthen the medical homes provided in their programs.

Medical Home Adoption among Private Payers

While it is unknown the degree to which many private payers in Illinois are encouraging or supporting medical homes, Aetna and Blue Cross Blue Shield of Illinois (BCBS IL) have taken proactive strides to develop and promote medical homes among their providers.

Aetna Better Health

Aetna Better Health, one of the contracted MCOs for ICP, has included rigorous language within its provider contracts that requires a medical home self-assessment system for providers and a four-level ranking system for medical homes with accompanying incentives for achieving higher levels. The MCO supports medical homes through the establishment of a Medical Home Development Advisory Council, a medical home monitoring program, telephonic case management for high-risk members, data feeds on the population, and quality management tools.

Blue Cross Blue Shield of Illinois (BCBS IL)

BCBS IL is currently using an intensive health home approach based on the Boeing Model to target high cost patients. While this isn’t truly a medical home model, they currently have 11 medical homes

55 The following information was provided by Bill Patten, Senior Director at BCBS IL, Professional Provider Network Relations during a telephone conversation on June 14, 2013.
involved in this initiative. Through predictive modeling, BCBS IL has identified the 10 percent of covered individuals who are driving 65 percent or more of their costs for inclusion in the program.

BCBS requires that each practice employ a nurse case manager (NCM), whom the MCO funds through care coordination payments. BCBS provides training to the NCMs to assist them in their responsibilities of outreach, enrollment into the model, development of a care coordination plan and ongoing care coordination. Each NCM has a caseload of 200 high-risk patients and monthly contact with each patient is required. Physician involvement in care coordination is also encouraged and the MCO has found that when providers engage in direct contact with the patient, engagement is more successful. In addition to the care coordination payments, participating practices are eligible for shared savings. These practices are compared to a control group of non-participating practices to determine the cost savings of the model.

The model began in May 2012, and results have been encouraging. As of June 2013, the MCO saw an engagement rate of 77 percent among targeted members, and increasing rates over time are anticipated.

Illinois’ Agenda for Health System Reform

With Federal funding, the State of Illinois and over 80 stakeholders who are engaged with the Illinois health system as providers, purchasers, or advocates, have created the Illinois Alliance for Health Innovation Plan. Based on achieving the Triple Aim of improved health, improved efficiency, and lower costs, the plan lays out numerous transformations that Illinois can undertake to achieve the Alliance’s goals. The first of these changes is to deliver care through comprehensive, integrated delivery systems, and reform payments to support them. Medical homes are named in the plan as a means of delivering integrated care, particularly to populations with complex health needs.
RECOMMENDATIONS

With the growing emphasis on medical homes as a means to improve quality and lower costs, the Medical Home Incentives Workgroup makes six recommendations for HFS to consider in implementing medical homes for children.

1. Define and Use the Term PCMH Consistently

The Incentives Workgroup recommends adopting a slightly modified version of the medical home definition developed by the Patient Centered Primary Care Collaborative (PCPCC), adding a focus on the family given their role in caring for children. They agreed that a medical home should be:

- **Patient and family-centered**: A partnership among practitioners, patients and their families ensures that decisions respect patients’ wants, needs, and preferences, and that patients have the education and support they need to make informed decisions and participate in their own care.

- **Comprehensive**: A team of care providers, led by a personal primary care provider, is wholly accountable for a patient’s physical and mental health care needs, including prevention and wellness, acute care, and chronic care.

- **Coordinated**: Care is organized across all elements of the broader health care system, including specialty care, hospitals, home health care, community services and other supports.

- **Accessible**: Patients are able to access same day/next day appointments as needed, evening and weekend appointment hours and 24/7 electronic or telephone access.

- **Committed to quality and safety**: Clinicians and staff enhance quality improvement through the use of health IT and other tools to ensure that patients and families make informed decisions about their health.

2. Use Nationally Recognized Medical Home Recognition Programs

The Incentives Workgroup recommends that HFS adopt a formal PCMH recognition process based on an existing national recognition or accreditation program. The workgroup does not recommend that HFS develop and adopt its own PCMH recognition standard. This has been done in some states (Minnesota, for example) causing great confusion in the provider marketplace as some public programs use the state PCMH standard, while some privately funded health plans use others.

NCQA’s PCMH is considered the “gold standard” and is well-suited for adoption by outpatient primary care practices as well as federally qualified health centers (FQHC). NCQA PCMH recognition reflects the essential elements of a medical home – care coordination, quality improvement, patient access,
evidence-based care, team-based care, community resources and population management. Additionally, the cost for applying for NCQA PCMH recognition is modest, and scaled by practice size.

The NCQA PCMH recognition program may be used by non-physician-led practices, such as Advanced Practice Nurses and Physician Assistants and specialty/subspecialty practices. Practices that function as medical homes, such as OB-GYN, oncology, cardiology, endocrinology and mental health clinics, and can demonstrate provision of whole person care and fulfillment of the other elements of the joint principles for at least 75 percent of its patients, can be eligible for PCMH recognition by NCQA even if it is not a traditional primary care practice. Flexibility and breadth in eligibility for NCQA PCMH recognition will enable inclusion of more providers who are already fulfilling a medical home role, helping to maintain continuity of care and better care for their patients.

NCQA also has extended medical home concepts to specialists that do not act in a primary care capacity – the NCQA Patient-Centered Specialty Practice (PCSP) Recognition. Now, specialty practices committed to access, communication and care coordination can earn accolades as the “neighbors” that surround and inform the medical home and colleagues in primary care. Practices that become recognized will demonstrate patient-centered care and clinical quality through: streamlined referral processes and care coordination with referring clinicians, timely patient and caregiver-focused care management and continuous clinical quality improvement.

The Workgroup further recommends the acceptance of other nationally recognized programs, as well. Providers could make the case that their clinical setting, such as hospital affiliated clinics, outpatient departments or FQHCs, are better suited for recognition through an acceptable alternative program, such as The Joint Commission. In these instances, this accreditation could be accepted.

3. Provide Financial and Non-Financial Support for Practice Transformation to Achieve PCMH Standards

The CHIPRA Incentives Workgroup recommends that HFS provide financial and non-financial incentives to promote achievement of PCMH recognition, support transformation, and reward practices that serve as medical homes. Consistent with the health system redesign called for by the Illinois Alliance for Health Innovation, there should be three parts to the support that HFS and other payers provide:

a. Transformation support: a one-time payment upon commitment to implementing a PCMH program leading to recognition to support practice transformation, including practice facilitation through the recognition process.

b. Care coordination support: a care coordination fee on a per member per month basis during and after transformation. This fee should be scaled to align with higher levels of achievement of NCQA medical home recognition (i.e., Level 1, Level 2 and Level 3).
c. Quality improvement support: add to the existing pay-for-performance incentive payments to reflect achievement of quality, safety and efficiency goals in a medical home context. The initial transition and adjustment period of implementing PCMH may cause per capita patient costs to rise and utilization, especially of primary care, to increase; therefore it is beneficial to structure the metrics and incentives accordingly. HFS might find it more useful to focus on process or patient satisfaction metrics initially and shift to health outcomes and cost measures in years two or three.\(^{56}\)

Moreover, the workgroup recommends HFS provide the following non-financial incentives to providers to become medical homes:

a. Acknowledgement and public relations around medical home achievement. Illinois should formally adopt a way of publicizing medical homes’ accomplishments for patients and payers such as a certificate that can be hung in the office, a listing posted on the HFS website, and identification as a medical home during the client enrollment process.

b. Promote the existing training programs for case managers and care coordinators, including community health workers, nurse care managers, social work case managers and unlicensed care coordinators/community health workers that support PCMH precepts and processes.

c. Help practices identify the components of an electronic health record that support medical home attributes and make such software and support available.

4. Develop the Processes, Policies and Oversight Needed to Promote and Sustain PCMH, including Aligning Medical Home Incentives across HFS Programs and Involving Private Payers in Spreading and Sustaining Medical Homes

The workgroup recommends that HFS provide ongoing oversight of PCMH work, and adopt policies to promote its expansion and sustainability.

a. Illinois should create a PCMH advisory body in HFS to oversee this work to include patients/families.

b. Illinois should pursue a multi-payer collaboration via the Alliance to assure care is integrated and coordinated.

c. Illinois should adopt standard language in MCO contract requirements that align with the goals of PCMH.

Alignment of medical home standards with quality measures, contracting requirements, and other rules promulgated by HFS would concentrate providers’ resources on the most critical objectives.

Additionally, promoting the alignment of public and private sector initiatives would further focus attention and resources on priority health improvements. HFS and private payers could share the burden and expense of medical home transformation in the state.

5. Evaluate and Report on the Impact of PCMH Recognition

Illinois should measure medical home costs and utilization to assess the value of PCMH to contributing to health system reform goals. The Workgroup would like HFS to track the number of practices who achieve recognition, the cost of financial and non-financial incentives, any subsequent improvement in quality and/or reduction in emergency room or hospital-based care, and patient and provider satisfaction in order to understand how best to support practice transformation in the future.
APPENDIX 1: CHIPRA PCMH Incentives Workgroup

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APPENDIX 2: SELECTED PCMH RESOURCES

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