

# Report to the Health and Human Services Appropriations Subcommittee

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## Medical Home Demonstration Project Feasibility

Prepared by the Division of Medicaid and Health Financing

December 2010



## EXECUTIVE SUMMARY

This report is submitted in response to the requirement in H.B. 397 passed by the 2010 Legislature:

“By December 31, 2010, the department shall: determine the feasibility of implementing a three year patient-centered medical home demonstration project in an area of the state using existing budget funds: and report the department’s findings and recommendations under Subsection (13)(a)(i) to the Health and Human Services Appropriations Subcommittee.”

### **Medical Home – Defined**

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child’s medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have since developed their own models for improving patient care called the “medical home” (AAFP, 2004) or “advanced medical home” (ACP, 2006). See Appendix A for a detailed definition.

### **Feasibility**

The question of the feasibility of implementing a patient-centered medical home within existing budget funds was presented to the Medical Care Advisory Committee (MCAC) in May, 2010. The committee consists of a variety of medical professionals, payers and medical service providers. At the direction of the MCAC a subcommittee was formed to study the issue. Staff from the Division of Medicaid and Health Financing worked with the group to determine a course of action. The group considered the fact that the Centers for Medicare and Medicaid Services (CMS) is funding demonstration projects under the Medicare program to determine the cost effectiveness of the medical home model. The group determined that without additional funding, and given the many components of a medical home, it would not be feasible to launch a medical home demonstration within existing funding. Rather, it would be most effective for Medicaid to participate in the Children’s Medical Home Demonstration Project that is funded through the Children’s Health Insurance Program Reauthorization Act (CHIPRA).

### **Utah Children’s Medical Home Demonstration**

Utah is one of ten states to receive a quality demonstration grant under section 401(d) of the Children’s Health Insurance Program Reauthorization Act (CHIPRA). The total 5-year funding award is \$10,277,361. The Utah Children’s Medical Home Demonstration is a key grant activity. The project description is included in Appendix B.

## **Accountable Care Organizations**

The Division has been working closely with legislators to develop a plan to implement payment reform by moving away from the current structure to a model where care is delivered through Accountable Care Organizations (ACO.) The medical home construct is a key component of the Accountable Care Organization model. The only way that a medical home demonstration would be feasible would be in a scenario in which payment reform would be involved.

### **Course of Action:**

- The Division of Medicaid and Health Financing will support the Utah Children’s Medical Home Demonstration and report the findings to the Legislature.
- The Division of Medicaid and Health Financing will continue to work with legislators on payment reform efforts that have a medical home component.

## Introduction

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child's medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have since developed their own models for improving patient care called the "medical home" (AAFP, 2004) or "advanced medical home" (ACP, 2006). See Appendix A for additional information.

The Patient Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

The AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PC-MH.

### ***Principles***

***Personal physician*** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

***Physician directed medical practice*** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

***Whole person orientation*** – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

***Care is coordinated and/or integrated*** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

***Quality and safety*** are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
- Evidence-based medicine and clinical decision-support tools guide decision making
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met

- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.

**Enhanced access** to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

**Payment** appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement;
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation;
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
- It should recognize case mix differences in the patient population being treated within the practice.
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

### **Feasibility**

Since 1996 Utah has required all Medicaid recipients in Salt Lake, Weber, Davis and Utah counties to enroll in a managed care organization. Only those living in a nursing facility or hospital are excluded from this requirement. Medicaid operates a voluntary primary care case management program in the remaining twenty-five counties. The Medicaid agency contracts with local health departments to educate Medicaid clients on the importance of having a regular source of medical care rather than relying on emergency departments. The local health departments enroll Medicaid clients with a medical provider willing to act as their primary care provider. In some rural counties, 87 percent of Medicaid clients are enrolled with a primary care provider. Other counties have few providers willing to accept Medicaid and enrollment is much lower. On average, 60 percent of rural Medicaid clients are enrolled with a primary care provider.

While some states claim huge savings from changing from a fee-for-service program to a medical home model the same saving would not be available in Utah's program because most Medicaid clients are enrolled in a managed care arrangement. The savings were realized when the model shifted from fee-for-service to managed care in 1996. Utah demographics are very different as well. Other states have higher smoking rates – Utah has the lowest smoking rate in the nation. Utah's population is the youngest in the nation. The vast majority of Utah Medicaid clients are children. All these differences must be taken into account when determining the feasibility of implementing a medical home approach. The area that offers the most possibility is to focus on children – and in particular children with special health care needs. Ensuring that children with chronic health care conditions have a true medical home where necessary care is provided and coordinated to eliminate unnecessary care may result in better quality care and reduced costs.

The question of the feasibility of implementing a three year patient-centered medical home demonstration project within existing budget funds was presented to the Medical Care Advisory Committee (MCAC) in May, 2010. The committee consists of a variety of medical professionals, payers and medical service providers. At the direction of the MCAC a subcommittee was formed to study the issue. Staff from the Division of Medicaid and Health Financing worked with the group to determine a course of action.

The group discussed the fact that in order to launch a three year medical home project the Division would need to find providers that would be willing to take on the additional responsibilities and services required to serve patients in a medical home model. The group reviewed the principles of the medical home model including the expectation that each patient has a personal physician, the physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients, care is coordinated and integrated and quality and safety are woven through all aspects of care. The cost of delivering care within these principles is not reimbursed through the current fee for service model and is not included in the current Medicaid budget. Physicians want support for the cost of implementing a medical home model as demonstrated by the fact that some physicians groups are approaching commercial payers to make the case that it is in the best interest of payers to fund the upfront additional practice costs because ultimately medical expenses will be reduced. The key question considered by the group was would it be feasible to add the services integral to a medical home model and have that effort result in medical expense savings?

Although early evidence indicates that over time medical homes reduce hospital admissions, and therefore medical expense, there is no assurance the medical home model would produce guaranteed savings within three years. An additional consideration is that since 60 percent of Utah Medicaid clients in rural counties are enrolled with a primary care provider and most clients in urban counties are enrolled with a managed care organization the savings opportunity from implementing a medical home model might not be as great as if there were no existing medical expense reduction efforts in place.

However, the workgroup acknowledged the great value in the medical home model and continued to consider how the Medicaid program could participate in a medical home demonstration project. Several workgroup members were aware that work is underway in Utah to develop and evaluate

medical homes for children with special health care needs. That is, Utah is one of ten states to receive a quality demonstration grant under section 401(d) of the Children's Health Insurance Program Reauthorization Act (CHIPRA.) The total five year funding award is \$10,277,361. The Utah Children's Medical Home Demonstration is a key grant activity. The five year grant will fund the expense of transforming twelve primary care practices by adding the care coordination and other services necessary to function as a medical home. The grant will also pay for evaluation of the entire effort. The project includes commercial payers and Medicaid is a key participant in the project.

Based on review of all these factors the MCAC workgroup concluded it would not be prudent to assume there would be sufficient medical expense savings to fund the expense of adding the services necessary for a medical home demonstration project within current budget limits. It also would not be likely providers would be willing to take on the burden of establishing a medical home model without additional reimbursement for their efforts. Therefore it would not be feasible to launch a three year medical home demonstration project within existing budget funds.

However, the group recognized that funding does exist to test the medical home concept for children with special health care needs. The group recommend that Medicaid focus efforts on supporting the activities of the Utah Children's Medical Home Demonstration.

### **Utah Children's Medical Home Demonstration (UCMHD)**

*Can we improve the health of Utah's children while spending less on their healthcare? Can providers, payers, and families work together to meet the dual challenges of healthcare that is too expensive and outcomes that reflect gaps in quality, equity, and engagement?*

The **Children's Healthcare Improvement Collaboration (CHIC)** is a four year demonstration of the medical home model of care and innovative approaches to compensating clinicians and supporting quality improvement and care coordination. The demonstration will be supported by the Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstrations grant and funding from insurers of children in Utah through the multi-payer demonstrations group established by the Utah Legislature's Health Reform Task Force. For a complete description of the project see Appendix B.

### **Accountable Care Organizations**

What would be the circumstances in which it would be possible to include the medical home construct within existing budget funds? The answer likely resides with the Accountable Care Organization (ACO) concept. The Division has been working closely with legislators to develop a plan to implement payment reform by moving away from the current structure to a model where care is delivered through Accountable Care Organizations. A report issued by the Deloitte Center for Health Solutions states "accountable care organizations (ACOs), a method for integrating local physicians with other members

of the health care system and rewarding them for controlling costs and improving quality, have the potential to drive payment reform in the public and private health care sectors.”

According to the New England Journal of Medicine “an ACO will not succeed without a strong foundation of high-performance primary care.” In other words medical homes are a necessary component of a successful ACO.

The ACO provides the opportunity for providers to deliver care in a manner that is not tied to fee-for-service reimbursement. This means that providers may choose to alter the service delivery model to include items such as telehealth visits and case management services while also developing other innovative, cost-effective and efficient ways to deliver care. The ACO reimbursement method will reward providers for eliminating unnecessary care and meeting quality objectives. If implementation of the medical home construct occurs within the overall payment reform effort it is the most likely scenario where the model will be successfully implemented.

#### **Course of Action:**

- **The Division of Medicaid and Health Financing will support the Utah Children’s Medical Home Demonstration Project and report the findings to the Legislature.** As evidenced by the Utah Children’s Medical Home Demonstration Project implementing and evaluating medical homes for children with special health care needs is expensive and resource intensive. The Division of Medicaid and Health Financing should support the project and provide periodic reports to the Legislature on the progress and ultimate outcomes.
- **The Division of Medicaid and Health Financing will continue to work with legislators on payment reform efforts that have a medical home component.** The medical home concept is a key component of Accountable Care Organizations. The Division should continue to work with legislators to restructure the way Medicaid pays for health care by moving to a model where care is delivered through Accountable Care Organizations.



## Appendix A

### Joint Principles of the Patient Centered Medical Home

American Academy of Family Physicians (AAFP)  
American Academy of Pediatrics (AAP)  
American College of Physicians (ACP)  
American Osteopathic Association (AOA)

February 2007

#### ***Introduction***

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### **Background of the Medical Home Concept**

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child's medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

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**For More Information:**

American Academy of Family Physicians

<http://www.futurefamilymed.org>

American Academy of Pediatrics:

[http://aappolicy.aappublications.org/policy\\_statement/index.dtl#M](http://aappolicy.aappublications.org/policy_statement/index.dtl#M)

American College of Physicians:

<http://www.acponline.org/advocacy/?hp>

American Osteopathic Association

<http://www.osteopathic.org>

## Appendix B

### Proposal for a Utah Children's Medical Home Demonstration from the Children's Healthcare Improvement Collaboration (CHIC)

#### CHIC's Utah partners include:

- Utah Department of Health
  - Division of Medicaid and Health Financing
  - Office of Healthcare Statistics
- University of Utah
  - Department of Pediatrics
    - Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ)
    - Medical Home Portal ([www.medicalhomeportal.org](http://www.medicalhomeportal.org))
  - Department of Biomedical Informatics
- Intermountain Healthcare
  - Primary Children's Medical Center's Pediatric Continuum of Care Managers program
  - Institute for Health Care Delivery Research
- *HealthInsight*
- Utah Family Voices

#### Executive Summary – Utah Children's Medical Home Demonstration

*Can we improve the health of Utah's children while spending less on their healthcare?*

The **Children's Healthcare Improvement Collaboration (CHIC)\*** proposes collaborating with insurers and the Utah Health Reform Task Force on a 4-year multi-payer demonstration of quality improvement (QI), the medical home model, and innovative payment strategies, aimed at improving children's healthcare and outcomes and decreasing overall costs. The demonstration will involve 30-40 primary care pediatricians and four pediatric subspecialty practices. Interventions will include:

- Central support for measurement-driven practice-based QI and care coordination (CC)
  - Medical Home Coordinators 'embedded' in pediatric practices to develop and support practice teams in QI, CC, and implementing other elements of medical home and family-centered care
  - Practice coaches to guide and support QI efforts and share lessons learned across practices
  - Parent Partners in each practice to advise on policies/processes and assist other families to connect with needed services and supports
- Practice compensation to enable practices to build QI infrastructure and systems, support needed incremental staff, improve access to care, and provide services that are not currently compensated, such as electronic visits, care conferences, and population management

A 5-year CHIPRA Quality Demonstrations grant, awarded to Utah Medicaid in 2010, will cover most of the central support and project evaluation costs. Practice compensation and remaining central costs will be supported by the multi-payer demonstration. The practice compensation will enable both primary care and subspecialty practices to make needed investments and experiment with novel approaches to care. These costs will be split among payers by market share of insured children – see *Projected Costs* on page 8 for detail. Practices will budget these funds and be accountable for their appropriate use and for performance and outcomes measures. In years 3- 4, a portion of documented savings in overall costs of care (formula to be developed) will be shared with participating practices.

Evaluation measures will be developed with payers, participating practices, and the Task Force. They will address access, utilization/costs, quality of care, clinical outcomes, and patient/family experience. A robust evaluation will be supported by a set of resources that is unique to this project, including:

- Utah All-Payer Claims Database (APCD), enabling comparisons to ‘virtual’ control practices
- Independent evaluation by the Institute for Healthcare Delivery Research
- National evaluation supported by the grant agency<sup>†</sup>
- *HealthInsight’s* EHR Measure Calculator, to extract clinical/quality data from practice EHRs
- QI TeamSpace, a quality improvement project collaboration and data reporting system
- Potential to use prospectively recruited control practices to compare a range of measures

Practices will be selected in December 2010 from among those that respond to a ‘request for applications,’ using criteria<sup>‡</sup> that will include level of commitment and proportion of patients insured by Medicaid. Project staff will be hired and trained to enable implementation in March 2011. Periodic data and interim evaluation reports will guide ongoing adjustments in project strategies and practice compensation. The interventions will continue through November 2014 (3½ years).

Lessons learned in the demonstration and its evaluation will inform ongoing healthcare reform in Utah and may guide insurers in compensation design and provider contracting. Sustainability of this approach to QI and medical home will depend on the balance between the costs of a mature practice support system and demonstrated improvements in healthcare cost, access, quality, and outcomes. We expect that systems like this will be critical to the success of evolving healthcare delivery/payment structures, such as accountable care organizations (ACO).

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\* CHIC’s major partners include the Utah Medicaid program, the University of Utah’s Utah Department of Pediatrics and Pediatric Partnership to Improve Healthcare Quality, *HealthInsight*, Intermountain Healthcare’s Institute for Healthcare Delivery Research and Pediatric Continuum of Care Managers program, and Utah Family Voices.