

## Medical Homes

### Cost Containment Strategy and Logic

“Medical home” describes a way of organizing and delivering health care that is coordinated, comprehensive, efficient and personalized (Table 1). Health care practices and clinics that meet medical home criteria manage all aspects of a patient’s care, not just treatment. The main purpose of medical homes is to improve quality of care,<sup>1</sup> especially for people with high medical needs, and potentially reduce health care costs.

The premise of the medical home model is that, by providing coordinated, comprehensive, efficient personal care, medical homes will improve patient health and satisfaction, reduce emergency room use, decrease hospital admissions and readmissions, shorten the average length of a hospital stay, and eliminate unnecessary tests and procedures, all of which contribute to overall cost savings.

Medical home practices differ from traditional primary care practices in several ways. In a medical home, a physician-led team—not the patient—coordinates care (e.g., finds specialists, arranges for services after hospital discharge). Medical home physicians use evidence-based care standards in addition to their knowledge and experience. Medical homes use various means to ensure easy patient access to care (e.g., 24/7 access to care and advice) instead of waiting for the next available appointment. In a medical home, provider teams emphasize and work with patients

to improve self-management skills, unlike traditional practices that focus on physician-delivered treatment.

Medical homes are also known as health homes, primary care medical homes, patient-centered medical homes and advanced primary care.

**Some studies show significant medical home savings. Others have found minimal or no overall savings but report other benefits, such as improved quality of care, fewer medical errors and enhanced health care access.**

Depending on the initiative, medical homes operate in several ways. Some provide care for certain target populations only (e.g., patients with chronic conditions, people with disabilities, children); others serve a broader population (e.g., all Medicaid patients or all private plan enrollees). Some medical home initiatives involve only one payer (e.g., Medicaid or a private health plan); others involve several payers. Others include all medical home components of a fully developed model, or only a few.

### Target of Cost Containment

Medical homes are designed to address several shortcomings in the current health care system, especially uncoordinated care (Figure 1 on next page). Poor care coordination is associated with duplicate procedures, conflicting treatment recommendations, unnecessary hospitalizations and nursing home placements, and adverse drug reactions. In addition to uncoordinated care, medical homes are designed to address lack of patient access to a primary care doctor, inadequate physician payment for primary care services, use of more expensive services where less expensive care would be as effective, and poor care management for patients with chronic conditions.

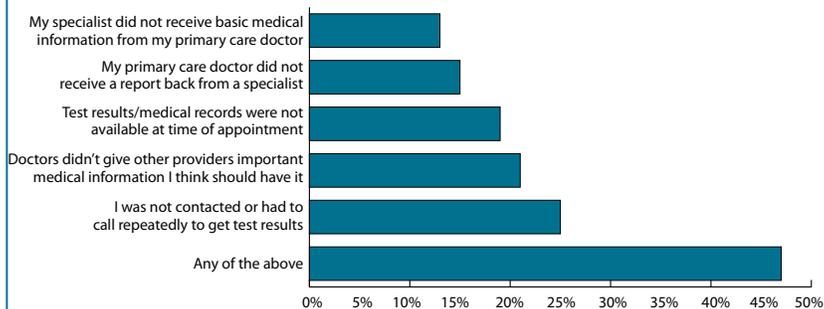
### Federal Health Reform

The Patient Protection and Affordable Care Act, signed March 23, 2010, includes several medical home provisions. The act defines patient-centered medical homes (section 3502) and authorizes tests of innovative Medicaid and Medicare service delivery models in federal fiscal years 2010 to 2019, “to reduce program expenditures while preserving or enhancing patient quality of care” (section 3021). Innovative models include patient-centered medical homes for high-need patients and medical homes that address women’s unique health care needs. The act also makes available state grants to establish community-based interdisciplinary teams to support medical homes (section 3502) and help primary care providers implement them in federal fiscal years 2011 and 2012 (section 5405).

Table 1. Medical Home Model

- Each patient has a personal physician who is responsible for coordinating and providing or arranging all of his/her care.
- Care is coordinated across all settings and practitioners (e.g., specialists, mental health professionals, nutritionists, hospitals, home health agencies, nursing homes) by a physician-led team of health care professionals.
- Patients have expanded health care access (e.g., e-mail access to their physician, after-hours care, 24-hour nurse advice line).
- Quality and safety are priorities, care is evidence-based, physicians rate themselves on efficiency and quality measures, and patients are involved in all care decisions.
- Physicians are paid a care coordination fee in addition to their regular office visit fee and may receive bonus payments for meeting or exceeding specified quality and efficiency targets. Care coordination fees may be adjusted based a patient’s health (e.g., higher fees for patients with several chronic conditions or children with special needs).

**Figure 1. Percent of U.S. Adults Reporting Care Coordination Failures in Past Two Years, 2007-2008**



Source: Commonwealth Fund Survey of Public Views in the U.S. Health Care System, 2008.

## State Examples

■ As of July 2010, at least 29 states had enacted medical home legislation<sup>2</sup> and 22 had one or more public, private or public-private medical home pilot programs.<sup>3</sup> Some Medicaid and state children's health insurance plan (CHIP) programs have implemented medical home programs without specific legislative authorization, relying on existing statutory authority to establish provider participation and reimbursement rules.

■ Several Medicaid and CHIP programs participate with private payers (e.g., health insurers and employers with self-insured health plans) in multi-payer medical home initiatives. As of December 2009, they included Colorado, Iowa, Maine, Massachusetts, Minnesota, New Hampshire, New York, Pennsylvania, Rhode Island, Vermont and West Virginia. Pennsylvania, for example, is working with 16 separate payers. Several multi-payer medical home initiatives include state employee health benefit plans (e.g., Colorado, Minnesota and West Virginia).

■ Community Care of **North Carolina** (CCNC) is one of the oldest coordinated-care primary practice medical home programs in the nation. It began as a Medicaid managed care pilot program in 1998. Since then, the legislature has expanded it to a statewide program that includes more Medicaid enrollees. Today, CCNC consists of 14 local nonprofit community networks across the state. The networks, which serve more than 950,000 Medicaid enrollees, are comprised of hospitals, health and social service departments, and 1,380 practices and clinics. Medicaid pays networks \$3 per member per month (\$8 for populations with complex medical conditions, such as the aged, blind and disabled) to coordinate care and hire local case managers. Medical home providers receive \$2.50 per member per month (\$5 for those with complex medical conditions) to implement evidence-based patient treatment plans and provide 24/7 access.

■ **Vermont** enacted legislation in 2007 (Act 71) and 2008 (Act 209) that established three integrated care pilot programs and required commercial insurers, and public medical care programs to participate in the pilots. The acts also required the director of Blueprint for Health, the state's comprehensive health reform initiative, to establish a medical home project for Medicaid beneficiaries, state employees health plan enrollees and those covered by the state's health care plan for the uninsured (Catamount Health). Blueprint for Health uses an inte-

grated health service model that has three key components: patient-centered medical homes; community health teams that support the medical homes in each community; and health information and evaluation systems. Vermont's three major health insurers (Blue Cross-Blue Shield, MVP Health Care and Cigna), Vermont Medicaid and the state budget share the cost of the community health care teams, as required by Act 204 of 2008.

■ **Minnesota's** 2008 health care reform act included a number of health care home provisions.<sup>4</sup> The act called for development and implementation of health care home certification standards for the state's publicly supported health plans. It authorized per-person care coordination payments to certified health care homes based on care complexity. It also required small employers and individual health plans to include health care homes in their provider networks and pay care coordination fees for members using certified health care homes. An unusual provision of the law requires that, in developing the criteria for setting care coordination payments, the commissioner of human services take into consideration the feasibility of including the additional time and resources needed by patients with limited English-language skills, cultural differences or other barriers to health care.

■ In recent years, **Washington** expanded its medical home efforts from an initial focus on improving care for publicly insured children with special health care needs to improving care for people of all ages and abilities, including public and private health plan enrollees. The 2007 Child Health Care Act (SB 5093) authorized targeted provider rate increases to coordinate care for children enrolled in public health plans through medical homes. Other 2007 legislation (E2SSB 5930) called for design and implementation of medical homes for the state's aged, blind and disabled clients. Pursuant to 2009 legislation (ESSB 5491), the Washington Health Care Authority and Department of Social and Health Services are working with interested stakeholders to develop, implement and evaluate one or more multi-payer medical home provider reimbursement models. At least eight health insurers have committed to help the state test the models.<sup>5</sup>

■ Several states have estimated potential medical home savings. West Virginia, for example, engaged an actuarial consulting firm in 2009 to estimate the cost of and potential savings from a statewide medical home initiative.<sup>6</sup> The firm estimated that, by 2014, a statewide initiative could involve as many as 1,800 physicians and produce annual savings of \$57.3 million for the state, \$173.2 million for insurers, \$170.6 million for policyholders, \$199.3 million for the federal government and \$42.1 million in charity care. A report prepared for Massachusetts estimated widespread adoption of medical homes could reduce cumulative spending in the state by as much as \$5.7 billion or increase it by as much as \$2.8 billion between 2010 and 2020.<sup>7</sup>

## Non-State Examples

■ Several health insurers have medical home pilot projects. UnitedHealth Group, for example, is collaborating with IBM to test the medical home model at seven medical group practices in Arizona.

■ Large, fully integrated health care delivery systems<sup>8</sup> increasingly use the medical home model to deliver primary care. Examples include Group Health Cooperative, serving Oregon and Washington; Geisinger Health System, located in central rural Pennsylvania; and Intermountain Healthcare, serving Utah and southeastern Idaho.

■ Bridges to Excellence (BTE), a national nonprofit health care quality improvement organization, has mounted a multi-state, multiple employer Medical Home Program. Several large employers participate, including Ford, GE, Humana, P&G, UPS and Verizon. Several health plans also participate.

■ In September 2009, the U.S. Secretary of Health and Human Services announced Medicare will join selected state-based, multi-payer medical home initiatives in a three-year Advanced Primary Care Demonstration. The states had not been selected as of April 2010.

## Evidence of Effectiveness

Some studies show significant medical home savings; others have found minimal or no overall savings but report other benefits (e.g., improved care quality, reduced medical errors, higher patient satisfaction, enhanced health care access and fewer health disparities). Most studies that support medical homes' potential to reduce overall spending have not assessed a complete version of the approach. Instead, they have looked at selected components, such as ensuring all patients have a primary care doctor or establishing care coordination programs for patients with diabetes or heart disease.

■ Several studies have examined the cost-effectiveness of the Community Care of North Carolina program described earlier. Mercer Human Resources Consulting Group, for example, found that, in every year examined (SFY 2003 to SFY 2007), CCNC achieved savings relative to an estimate of what the state would have spent under its previous primary care case management program. In SFY 2007, for example, estimated savings were between \$135 million and \$149 million.<sup>9</sup> This savings estimate did not, however, take into account enhanced payments to participating providers and network fees.

■ Several large, integrated health care delivery systems have reported medical home pilot program savings. Geisinger Health System, for example, calculated its medical home pilot practices reduced overall health care costs by 4 percent in 2006 (the first year of the pilot) and 7 percent in 2008. Group Health Cooperative compared the quality and costs of care for patients enrolled in a medical home pilot to a control group.<sup>10</sup> After 21 months, it reported increased costs for specialty care (\$5.80 more per member per month) and primary care (\$1.60

more) but reduced costs for emergency department and urgent care visits (\$4 less) and inpatient admissions (\$14.18 less). Adjusting for the severity of the health conditions of patients in the pilot and control groups, this produced overall net savings of \$10.30 per member per month—a result Group Health said “approached statistical significance.”

■ Some evidence indicates a highly developed medical home focused on select conditions can produce savings.<sup>11</sup> Long-running, randomized trials demonstrate that care coordination programs targeting high-risk, high-severity patients with chronic illnesses generate savings.

■ Although most medical home programs report reductions in emergency room use and hospital admissions, several studies have found little or no evidence of overall reductions in health care expenditures. A 2008 report by Deloitte Center for Health Solutions, for example, found no documented evidence of a return on investment from medical home programs.<sup>12</sup> Another study reported evidence of downstream savings from the few existing rigorous evaluations that have been conducted “are not encouraging.”<sup>13</sup>

■ Some caution that the medical home model “has not yet proven scalable, lacks a universally accepted definition, and lacks sufficient evidence of its ability to yield significant cost savings.”<sup>14</sup> According to one researcher, “Most proponents admit the [medical home] model is, most likely at best, aspirational.”<sup>15</sup>

■ Researchers have suggested several reasons for the limited evidence of medical home savings. Full-fledged medical homes have not been implemented on a large enough scale or for long enough to demonstrate savings. Significant time, staffing, coordinated community support and up-to-date health information technology are needed to implement a medical home; experts estimate it takes two to five years to fully transform from a traditional practice to a medical home. The primary focus of medical homes is quality of care improvement, not cost containment. In most medical homes, the initial focus is on getting recommended care for people who have not had it.

■ Experience with the medical home model suggests that those most likely to generate savings are full-fledged programs that are part of an integrated delivery system, implemented on a large scale, and supported by strong health information technology, community and health professionals support systems.

## Challenges

Establishing a medical home program that can reduce or slow overall health care spending growth presents a number of challenges.

■ Financial incentives must be sufficient both to encourage primary care doctors to transform their practices into medical homes and to secure the collaboration of other providers (e.g., hospitals and specialists). Many consider adequate financial re-

muneration to be one of the most important design features of a successful medical home program.

■ To make it cost-effective for physicians to meet medical home standards, payers need to share savings with medical home practices from such things as reductions in hospital admissions and emergency room visits, and practices must have enough patients covered by health plans that support the medical home model.

■ States may initially find their overall costs actually increase as a result of enhanced payments, new care coordination costs, and more services delivered to patients who were previously underserved (e.g., immunizations were not up-to-date). It may take several years to realize cost savings, if any.

■ States may need to establish a state action exemption under anti-trust law that will permit payers and providers to collaborate to develop payment and performance measurement in medical homes. Maryland, for instance, included a medical home anti-trust exemption in 2010 legislation (SB 855).

■ Estimating potential medical home savings is difficult. The cost of setting up a medical home ranges from \$60 to \$1,800 per person per year, while gross savings have been estimated at \$250 per person per year.

## Complementary Strategies

The medical home model incorporates several strategies that offer the promise of a greater level of cost containment than could be achieved by implementing a single strategy (e.g., provider performance-based pay, care coordination, etc.). Other complementary strategies include accountable care organizations, expanded scope of practice laws and value-based benefit design, which are discussed in other briefs in this series.

## For More Information

Florida Agency for Health Care Administration, *Medicaid Medical Home Task Force Report, Recommendations for Designing and Implementing a Medical Home Pilot Project for Florida Medicaid* (Tallahassee, Fla.: FAHCA, February 2010); [http://ahca.myflorida.com/Medicaid/deputy\\_secretary/recent\\_presentations/medical\\_home\\_tf/medicaid\\_medical\\_home\\_task\\_force\\_report\\_020110.pdf](http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/medical_home_tf/medicaid_medical_home_task_force_report_020110.pdf).

### About this Project

NCSL's Health Cost Containment and Efficiency Series describes multiple alternative state policy approaches, with an emphasis on documented and fiscally calculated results. The project is housed at the NCSL Health Program in Denver, Colorado. It is led by Richard Cauchi, program director, and Martha King, group director, with Barbara Yondorf as lead researcher.

NCSL gratefully acknowledges the financial support for this publication series from The Colorado Health Foundation and Rose Community Foundation of Denver, Colorado.

National Academy for State Health Policy, Medical Home & Patient-Centered Care web site, <http://www.nashp.org/medical-home/28>.

National Conference of State Legislatures Medical Home Model of Care web page, <http://www.ncsl.org/?tabid=17723>.

Patient-Centered Primary Care Collaborative website, <http://www.pccpc.net/>.

The latest information on this topic is available in an NCSL online supplement at [www.ncsl.org/?tabid=19936](http://www.ncsl.org/?tabid=19936)

## Notes

1. Quality of care measures the degree to which various inputs, processes and standards of care meet patient needs and increase the likelihood of improved patient health.

2. National Conference of State Legislatures, Medical Home Model of Care Web page, <http://www.ncsl.org/?tabid=17723>.

3. Patient-Centered Primary Care Collaborative, Pilots and Demonstrations Web page, <http://www.pccpc.net/pccpc-pilot-projects>.

4. 2008 Minn. Laws, Chap. 358.

5. Washington State Medical Home website, <http://www.medicalhome.org/about/medhomeplan.cfm>.

6. CCRC Actuaries, *Health Care Financing in the State of West Virginia: An Analysis and Projection of the Current System and Potential Transformations* (Charleston, W.V.: West Virginia Health Care Authority, August 2009); <http://www.hcawv.org/Support/Health%20Care%20Financing%20in%20the%20State%20of%20West%20Virginia%20DRAFT%20v3.pdf>.

7. Christine Eibner et al. *Controlling Health Care Spending in Massachusetts: An Analysis of Options*, Option #6, "Create Medical Homes to Enhance Primary Care" (Santa Monica: RAND Health, August 2009); [http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/control\\_health\\_care\\_spending\\_rand\\_08-07-09.pdf](http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/control_health_care_spending_rand_08-07-09.pdf).

8. A fully integrated health care delivery system includes the full range of providers (e.g., primary care physicians, specialists and hospitals) needed to care for a population of patients; the providers are part of a single organization that has a common bottom line.

9. Mercer Government Human Services Consulting, *CCNC/ACCESS Cost Savings—State Fiscal Year 2007 Analysis* (Atlanta: Mercer, February 26, 2009); <http://www.communitycarenc.com/PDFDocs/Mercer%20SFY07.pdf>.

10. Robert J. Reid et al., "The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers," *Health Affairs* 29, no. 5 (2010); <http://content.healthaffairs.org/cgi/content/full/29/5/835>.

11. Congressional Budget Office, "Option 39: Pay for a Medical Home for Chronically Ill Beneficiaries in Fee-for-Service Medicare," *Budget Options, Volume 1: Health Care* (Washington, D.C.: CBO, December 2008); <http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf>.

12. Paul H. Keckley and Howard R. Underwood, *The Medical Home: Disruptive Innovation for a New Primary Care Model* (Washington, D.C.: Deloitte Center for Health Solutions, 2008); <http://www.dhcs.ca.gov/provgovpart/Documents/Deloitte%20-%20Financial%20Model%20for%20Medical%20Home.pdf>.

13. Arnold Milstein and Elizabeth Gilbertson, "American Medical Home Runs," *Health Affairs*, 28, no. 5 (2009); <http://content.healthaffairs.org/cgi/content/abstract/28/5/1317>.

14. Elena Conis, "The Geisinger Medical Home Initiative," *Health Policy Monitor* (April 2009); <http://www.hpm.org/survey/us/a13/1>.

15. Gary Scott Davis and Julie Brillman, "Innovative Approaches to Health Care," (Washington, D.C.: American Health Lawyers Association, 2009); <http://www.healthlawyers.org/Events/Programs/Materials/Documents/PPMC09/davis.pdf>.



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