PAYMENT REFORM POLICY BRIEF:
Medical Homes

The general category of "medical homes" covers a number of similar initiatives, sometimes referred to as a Patient Centered Medical Home ("PCMH") or a Health Home ("HH"), that share the same elements:

- Small regular Per Member Per Month ("PMPM") payment.
- Covers coordination of needed care for patients with complex or chronic conditions.
- Care management services (sometimes called case management services) are "embedded" in primary care practice.
- Care management services may be provided directly by the practice, or by a separate Community Care Team ("CCT").
- Care managers need not be clinicians, but are usually nurses or social workers.

The medical home model not only has the potential to improve outcomes and reduce costs for patients, but also may serve as way for practices to ready themselves for *capitation* – that is, accepting a regular fixed payment for a defined set of services for each patient.[1] However, the PCMH model does not require the practice to become licensed by the Bureau of Insurance as an insurer, utilization review entity, or "downstream risk" provider.

The U.S. Department of Health and Human Services, Agency for Healthcare Reform and Quality, maintains an online *Patient Centered Medical Home Resource Center* at: http://pcmh.ahrq.gov/.

An overview of PCMH initiatives can be found on the Maine Quality Counts website: http://www.mainequalitycounts.org/page/2-659/patient-centered-medical-home.

Information about CCTs in Maine is available at: http://www.mainequalitycounts.org/page/2-654/community-care-teams.

Medicare

Under the Affordable Care Act and prior legislation, the Medicare program has sponsored a number of "primary care transformation" demonstration projects, including medical home models.

- Maine is a demonstration state for the Multi-Payer Advanced Primary Care Practice demonstration project, in which over 150 practices are participating: http://innovation.cms.gov/initiatives/Multi-Payer-Advanced-Primary-Care-Practice/.
- The ongoing FQHC Advanced Primary Care Practice Demonstration involves over 400 community health centers nationwide, including some in Maine: http://innovation.cms.gov/initiatives/FQHCs/.
- The Medicare Medical Home Demonstration was discontinued: http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Medicare-Demonstrations-Items/CMS1199247.html.

MaineCare

Primary Care Case Management

MaineCare has had a Primary Care Case Management ("PCCM") program for many years. Under PCCM, the primary care practice provides limited care management, and pre-authorizes specialist referrals. Information is available on the MaineCare website at: http://www.maine.gov/dhhs/oms/provider/pccm.html.

Health Homes

MaineCare's "Stage A" Health Home initiative enrolls eligible members with both the HH primary care practice and a CCT, which share data about enrolled members through a web portal.

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1 "*Partial*" or "*services only*" capitation: PMPM payment for all services performed for that patient by the practice.
"*Partial global*" capitation: PMPM payment for not only all services performed by the practice, but also all other services for which the practice has referred that patient.
"*Full*" or "global" capitation: PMPM payment for all needed health care services for the patient.

This Issue Brief was prepared by Benjamin P. Townsend, Esq., an attorney at Kozak & Gayer, P.A., under a grant from the Maine Health Access Foundation. Additional resources are available through the "Payment Reform" pages of MMA's website at: www.mainemed.com/cme-education-info/payment-reform-resources.

- Member eligibility:
  - Two qualifying chronic medical conditions, or
  - One qualifying chronic medical condition, and at risk for another.
- *Qualifying chronic medical conditions* include cardiac and circulatory abnormalities, chronic obstructive pulmonary disease, developmental disorders, diabetes, heart disease, hyperlipidemia, hypertension, obesity, substance abuse, tobacco use, acquired brain injury, asthma, seizure disorder, certain mental health conditions.

MaineCare Health Homes web page: http://www.maine.gov/dhhs/oms/vbp/health-homes/.

Other Payors

Many commercial payors and self-insured employee health plans are exploring the medical home model through a national Patient-Centered Primary Care Collaborative. Information about this model generally, as well as about specific payors' programs, is available at: http://www.pcpcc.org/about/medical-home

Anthem offers a *Patient-Centered Primary Care Program Provider Toolkit*, offering tools and resources for practices that wish to explore the medical home concept:

http://www.anthem.com/wps/portal/ca/provider?content_path=provider/f0/s0/t0/pw_e191353.htm&label=Patient-Centered%20Primary%20Care%20Program%20%E2%80%93%20Provider%20Toolkit&rootLevel=3.