Connecticut Health Policy Project

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Patient-centered medical homes in the Patient Protection and Affordable Care Act

Sec. 3502 – Establishing Community Health Teams to Support the Patient-Centered Medical Home

Summary: Creates a program to establish and fund the development of community health teams to support the development of medical homes by increasing access to comprehensive, community based, coordinated care.

- Grants or contracts with HHS to interdisciplinary, interprofessional teams to support primary care practices – regardless of payer source (VT model)
- Provide capitated payments to PCPs
- Defined by hospital service areas
- Grants can go to states or state-designated entity
- Must have a 3 year sustainability plan
- Must include prevention, patient education, care management into delivery of care, integrated with community-based prevention and treatment
- Interdisciplinary team member requirements set by HHS, may include
  - Specialists
  - Nurses
  - Pharmacists
  - Nutritionists
  - Dieticians
  - Social workers
  - Behavioral and mental health providers
  - Chiropractors
  - CAM practitioners
  - Pas
- To include Medicaid patients from Sec. 2703 (see below) (not necessarily exclusively)
- Establish contracts with PCPs to provide support services
- PCMH defined to include
  - Personal physician
  - Whole person orientation
  - Coordinated and integrated care
  - Safe and high-quality care through evidence-based medicine, HIT, continuous quality improvement

- Expanded access to care
  - Payment that recognizes components of patient-centered care
  - Collaborate with local providers
- Team must collaborate with PCPs and existing community resources to
  - Coordinate disease prevention
  - Chronic disease management
  - Transitioning between settings, including children, with priority to people with chronic conditions
- Teams must develop care plans – interdisciplinary, interprofessional, integrate clinical and community preventive and health promotion services
- Include patients, providers, caregivers in program design and oversight
- Teams support to include:
  - Care coordination
  - Access to preventive care and health promotion, specialty care, inpatient care
  - Quality-driven, cost-effective, culturally appropriate, patient- and family-centered care
  - Pharmacist medication management services
  - Coordination and appropriate use of CAM, to those who request it
  - Quality improvement coordination and to reduce duplication
  - Referrals to local care for most appropriate care setting, integrative health care practitioners
  - Evaluate patient outcomes including patient experience of care
  - System for early ID and referral for children at risk of developmental or behavioral problems
- Team must provide 24-hour care management and support during transitions in care including on-site visits, discharge plans, counseling, include medication management, referrals for behavioral health as needed, to include transition from adolescence to adult settings
- Team must serve as liaison to community prevention and treatment programs
- Team must implement and maintain interoperable HER
- PCPs must
  - Provide a care plan for each patient
  - Allow access to patient records
  - Meet regularly with the care team
- Definition of primary care – "provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community"

Sec. 2703 – State Option to Provide Health Homes for Enrollees with Chronic Conditions

Summary: Provide States the option of enrolling Medicaid beneficiaries with chronic conditions into a health home. Health homes would be composed of a team of health professionals and would provide a comprehensive set of medical services, including care coordination.
(Note that Medicaid population now includes 43,000 plus SAGA members, in 2014 will include all childless adults to 133% FPL except undocumented immigrants, adds 150,000 people)

- 90% Medicaid match for first 8 quarters of program – gets attention – for home health services to eligible patients
- State Plan Amendment – essentially just a letter, not the rigorous waiver process with cost neutrality requirements – doesn't require Congressional appropriation
- Starts Jan. 1, 2011
- Patients choose a PCP or team as their "health home"
- HHS defines requirements for designation as health home provider
- Payments may be risk adjusted by number and/or severity of chronic conditions
- Payment not limited to pmpm, may use alternative methods
- Jan. 1, 2011 HHS may give states planning grants to develop SPA, state must match at 50% (CT), total payments to all states not to exceed $25m
- Hospitals must refer appropriate patients from ED
- Must coordinate with SAMSHA and address behavioral health needs
- Must track readmissions (and resulting savings)
- Must include HIT, including wireless patient technology**
- Includes quality reporting to state
- Eligible patients – HHS can raise this bar
    - Medicaid recipient
    - At least 2 chronic conditions, or
    - One chronic condition and at risk of a second, or
    - One serious and persistent mental health condition
- Chronic condition definition
    - Mental health condition
    - Substance use disorder
    - Asthma
    - Diabetes
    - Heart disease
    - Overweight (BMI over 25)
- Health home services

    - Comprehensive care management
    - Care coordination and health promotion
    - Transitional care, with follow up, from inpatient to out
    - Patient and family support
    - Referral to community and social services
    - HIT to link services
- Designated provider includes
    - Physician
    - Clinical practice or group
    - Community health center
    - Community mental health center
    - Home health agency
    - Any other provider or entity designated by state and approved by HHS, including pediatricians, OB/GYN
- Team of providers may include
    - Physicians and others such as
        - Nurse care coordinators
        - Nutritionist
        - Social worker
        - Behavioral health professional
        - Any other designated by state
- Health team definition refers to Sec. 3502
- Independent evaluation by HHS
    - Reducing hospital admissions
    - Reducing ER visits
    - Reducing admissions to skilled nursing facilities
- Report to Congress on
    - Hospital admission rates
    - Chronic disease management
    - Coordination of care for people with chronic disease
    - Quality improvement and clinical outcomes

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