

**Medicaid Health Plans of America**  
**White Paper: Role of Medicaid Health Plans in**  
**Patient-Centered Medical Homes**  
September 2010



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**EXECUTIVE SUMMARY**

Almost 47% of individuals in Medicaid are enrolled in a Medicaid health plan. Medicaid health plans have a long track record of providing quality care to beneficiaries and being accountable for access, cost, and quality. Plans have a mature infrastructure for data management and analytic capability and services needed to support high needs Medicaid populations, including transportation, care coordination, and translation services. Medicaid health plans have demonstrated their capability to improve services for Medicaid beneficiaries while controlling costs.

In spite of major successes in improving access and quality for Medicaid beneficiaries, there remain important challenges to high quality, coordinated care. These include:

- Limited participation of primary care providers in the Medicaid program
- Limited participation of specialists in the Medicaid program
- Higher than desired use of emergency services
- High enrollment turnover among Medicaid beneficiaries

Policy makers are increasingly interested in the use of patient-centered medical homes (PCMH) to improve access, care management and patient outcomes. Multiple pilot tests of the PCMH for Medicaid and commercial populations are under way. Medicaid plans are engaging with medical homes by collaborating in multi-payer pilot tests, providing enhanced fees, and offering data for analysis and evaluation.

There is growing evidence that by investing in coordinated, comprehensive primary care, the PCMH can reduce preventable hospitalizations and unnecessary specialty care, thereby controlling costs. Yet, the transformation of medical practices into medical homes is resource intensive and evaluation metrics are not standardized. This introduces questions such as, how many providers beyond “early adopters” will embrace medical homes, how much support will be needed to assist practices’ transformations, and how to measure the impact of the medical home in a standardized manner. These factors present challenges to the ability of the medical home model to unequivocally deliver the quality improvements and cost savings on a large scale.

Through decades of successful partnerships, State Medicaid programs have made important investments in a Medicaid health plan infrastructure that is accountable for delivering high quality care and managing costs across all inpatient and outpatient services. Medicaid health plans operate under regulation and oversight that is far more comprehensive than oversight of fee-for-service Medicaid or primary care case management (PCCM) programs. . Health plans:

- Organize, track and monitor health care services that are culturally and linguistically appropriate;
- Link members with primary care practitioners;
- Coordinate access to specialists;
- Offer enhanced benefits such as prenatal classes and diabetes education;
- Are accountable for facilitating access to care by providing language interpretation services and transportation;
- Manage enrollment and disenrollment information;
- Track cost, quality and utilization;
- Report publicly on cost, quality and access using standard definitions;
- Carry out fraud detection and prevention activities
- Are accountable to states and members for cost and quality management

These capabilities are essential for delivering high quality, cost-effective Medicaid services, and may not all be available at the provider level.

Medicaid health plans have a critical role in both the transformation process and in the ultimate accountability of the PCMH for improved outcomes and cost management. It is health plan data and care management capability that provides the needed analytics and human capital needed to support providers in making the transformation and evaluating the impact. Medicaid health plans have accountability for cost and quality management in both inpatient and outpatient services - which fee-for-service, PCMH and PCCM do not have - and have the data and infrastructure needed to evaluate the impact of medical homes.

This White Paper highlights the aligned goals of plans and medical homes. Table 1 illustrates this alignment. A close collaboration between providers and Medicaid health plans going forward will build on these synergies and promote more effective, measurable improvements in outcomes. MHPA concludes that PCMHs cannot effectively be implemented in the Medicaid population without the expertise and support of Medicaid Health Plans. MHPA recommends that States promote collaborations with Medicaid health plans and providers to develop and maximize the effectiveness of PCMH models, and should explicitly include Medicaid health plans in state strategies to implement PCMHs. MHPA also believes it essential for states to establish performance and evaluation metrics to assess effectiveness of the PCMH in improving health outcomes of Medicaid beneficiaries.

## **INTRODUCTION**

### **About MHPA**

Medicaid Health Plans of America (MHPA) is the leading trade association representing Medicaid managed health plans. MHPA is a national nonprofit organization representing 23 health plans dedicated to serving the low income population's medical, health, and social/economic needs. MHPA's member plans serve more than 13 million beneficiaries, a number that continues to grow with expansions in state Medicaid and Children's Health Insurance Programs.

MHPA's mission is to develop and advance public policy that improves access and delivery of quality health care to Medicaid members and improves efficiency of services. MHPA offers policy research, analysis, and educational forums that support the development of effective policy solutions to best provide for Medicaid individuals and families seeking quality healthcare from managed care organizations.

### **About this White Paper**

In this White Paper we discuss the aligned goals of Medicaid health plans and medical homes; we note where a close collaboration between providers and Medicaid health plans will promote more effective, measurable improvements in outcomes. Medicaid health plans have a track record of accountability for cost and quality of care for Medicaid beneficiaries, and have developed a critical infrastructure to measure cost and quality. This cost and quality tracking capability is not developed at the provider level and the PCMH impact on cost and quality is not fully understood. For these reasons MHPA concludes that state efforts to implement medical homes for Medicaid beneficiaries should be adopted judiciously, with the collaboration of health plans, and with clearly articulated performance and evaluation metrics for the medical homes.

### **The Impact of Medicaid Health Plans**

For the past decade States have increasingly turned to Medicaid health plans to manage benefits in Medicaid programs. Medicaid health plans also serve most of the children in the Children's Health Insurance Program (CHIP). About 47% of all Medicaid beneficiaries are now enrolled in a Medicaid health plan. When counting all types of Medicaid managed care arrangements almost 72% of the individuals in Medicaid are enrolled in some form of managed care. Managed care arrangements include "primary care case management," (PCCM) and Medicaid health plans (also called MCOs). Ten years ago just 55% of Medicaid beneficiaries were enrolled in some type of managed care arrangement.

According to the Kaiser Commission on Medicaid and the Uninsured, among states with Medicaid health plans, only 4 have less than half of their Medicaid beneficiaries in managed care. All other states have more than half of their beneficiaries in managed care, with 20 states having 81% or more members in managed care.<sup>1</sup> While growth in enrollment in the Medicaid program increased seven percent from June 2008 to June 2009, enrollment in Medicaid health

plans increased more than 11%. Projections show that Medicaid enrollment will grow from between 16 million and 24 million individuals beginning in 2014, when the Medicaid expansion in the new health care reform law takes effect.

Medicaid health plans are well-positioned to serve these new enrollees. Medicaid health plans have experience and expertise serving low-income women, children, disabled and senior populations around the country. Many enrollees reside in minority communities and have unique health and social needs. Health plans provide access to a medical home managed by a primary care provider and also offer a broad network of other providers that meet the cultural, medical and social needs of these populations. All Medicaid health plans participate in the Medicaid safety net and contract with other safety net providers including public hospitals and community health centers.

States recognize the benefits of health plans in coordinating care and improving quality. By contracting with health plans, states can provide Medicaid benefits at a lower, more predictable cost than traditional fee-for-service Medicaid. In addition to managing financial risk, plans are also accountable for delivering and reporting on access and availability of services and quality care. In addition to federal requirements for Medicaid, health plans to report quality measures and improvements in quality to the state. Most state reporting requirements go beyond federal standards, and many state requirements are tied to health plan incentive payments.

### **Challenges in the Medicaid Program**

Medicaid health plans have made important strides in improving primary care access for beneficiaries and out perform the fee-for-service sector on improving access and quality. Medicaid health plans link each member with a primary care practitioner and hold that practitioner accountable for care. Health plans also deploy care managers to support high needs individuals and offer “wrap around” services such as transportation to support patients’ access to services.

In spite of major successes improving access and quality for Medicaid beneficiaries, there remain important challenges to high quality, coordinated care. These include:

- Limited participation of primary care providers in the Medicaid program
- Limited participation of specialists in the Medicaid program
- Higher than desired use of emergency services
- High enrollment turnover among Medicaid beneficiaries

These underlying factors are why more primary care investment, care coordination and comprehensive care are still needed for Medicaid beneficiaries. However, these factors foreshadow the challenges that will be experienced by PCMH practices as they take on accountability for the challenging Medicaid population.

## **HEALTH PLANS AND THE PATIENT-CENTERED MEDICAL HOME**

### **Patient-Centered Medical Home Policy Developments**

Once of the most commonly used descriptions of the patient-centered medical home was developed and endorsed by prominent physician organizations. These “Joint Principles,” are outlined in Table 1, which also shows the many Medicaid health plan capabilities that align with or are supportive of the objectives outlined in the Joint Principles. Other organizations, including states and accrediting organizations, have developed their own definitions and criteria.

According to the National Academy for State Health Policy, since 2006 at least 30 states have implemented programs or pilots to implement medical homes in Medicaid managed care programs.<sup>2</sup> Development of PCMH models in Medicaid appear likely to accelerate.

Under the recently enacted Patient Protection and Affordable Care Act (PPACA), States have the option to provide health homes for enrollees with chronic conditions. Under this program, states would receive an increased federal funding match to provide payments to designated providers for health home services provided to eligible individuals who have selected a health home. Eligible individuals are defined in the legislation, and providers must be designated as health homes based on qualifications and ability to provide coordinated, comprehensive care. States participating in the health homes program receive a 90% FMAP for these services for 2011 and 2012, and the program can be implemented with a state plan amendment. States will determine the methodologies for enhanced payments, which do not need to be on a per member per month basis.

The PPACA also makes \$25 million available for planning grants, and states must match the federal grant amounts under their regular FMAP rate. As a condition for pilot funding, states must track hospital readmissions, propose use of HIT, and collect quality measures from eligible providers. Also of note, the PPACA may accelerate the development of Accountable Care Organizations (ACOs). ACOs are local systems of care intended to be accountable for all health care services along a continuum, based on a strong foundation of primary care.

The Patient-Centered Primary Care Collaborative (PCPCC), a national organization dedicated to promulgating the medical home, has catalogued pilot tests of the medical home and evidence supporting adoption.<sup>3,4</sup> The literature on the PCMH shows a strong underpinning of support for the PCMH concept for a number of factors. Provider and provider organizations tend to favor adoption of medical homes as a strategy to reverse economic and practice-related disincentives to practice primary care.<sup>5</sup> Policy-makers have been intrigued by reports of substantial cost savings and the potential to improve care quality.<sup>6,7</sup> Patient advocacy groups are encouraged by the potential for more patient-centered care that includes better coordination of services, and more appropriate care.<sup>8</sup>

There is also evidence supporting use of medical homes to promote better primary care, leading to better patient outcomes: a number of individual studies show that medical homes can improve patient satisfaction, rehospitalizations rates, and sometimes, cost.<sup>9,10</sup> An examination of four primary care sites in one study found a 15-20% reduction in costs without reductions in quality.<sup>11</sup>

Yet there are also warning signs of uncertainty in the effectiveness of medical homes. A 2010 study that conducted detailed examinations of 26 PCMH demonstration projects across the U.S.<sup>12</sup> found tremendous diversity in what was described as a “medical home.” The authors also found that 60% of the demonstration projects had not yet developed plans for evaluating the impact of the medical home, and many did not have specific performance measures by which they would assess their impact. The authors concluded that there is an urgent need to incorporate evaluation into the design of medical home pilot tests.

**Table 1: Alignment of Medicaid Health Plan Capability with Joint Principles of the Patient-Centered Medical Home**

<b>Element of the Patient-Centered Medical Home</b>	<b>Description from Joint Principles</b>	<b>Medicaid Plan Activities that Align With PCMH</b>
Personal physician	<i>Patient has ongoing relationship for comprehensive care</i>	Medicaid plans require members to have a personal physician and assist them in choosing one.
Physician directed medical practice	<i>Team care with collective responsibility</i>	Medicaid plans provide a team to support the primary care practice including physicians, pharmacists, nurses, informatics experts, education specialists and outreach workers. Services include dental and vision care.
Whole person orientation	<i>Health care team is responsible for providing or arranging care</i>	Health plans address the total health of plan members through risk assessment, prevention, health education and outreach and by coordinating care through case managers.
Care is coordinated and / or integrated	<i>Physician and other care (home health, hospital) is coordinated through information technology and information exchange</i>	Medicaid plan case managers support members with complex health needs and coordinate medical and ancillary providers and benefits across all settings. Health plan data systems integrate data from claims, laboratory and pharmacy services for quality improvement, performance reporting, and care management.
Quality and safety	<i>Practices use evidence based medicine and decision support, care quality is evaluated and continuously improved</i>	Medicaid plans assess and report HEDIS quality indicators and CAHPS patient experience measures; plans are accredited by NCQA and comply with state and federal quality mandates. Health plan data systems identify quality and safety concerns such as duplicate medications.
Enhanced access	<i>Expanded hours, technologically supported visits (email, web)</i>	Medicaid plans are required by federal regulations and NCQA standards to ensure access. They offer nurse support lines, assist members in accessing urgent care and contract with physicians who will meet specific accessibility standards
Payment	<i>Payment method recognizes added value services, new modes of delivering care and need for infrastructure development, and should reflect shared savings resulting from care improvement</i>	Medicaid plans are accountable to states for managing all costs of comprehensive care including inpatient and outpatient. Plans manage capitated payments from state and administer payments to providers and can innovate payment to reward value added services such as the PCMH, when permitted by states.

The Joint Statement is from: American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Osteopathic Association (AOA). March 2007. Available at: <http://www.medicalhomeinfo.org/downloads/pdfs/jointstatement.pdf>

Studies have shown that the “practice transformation,” underlying the medical home model is difficult to achieve, particularly in smaller or less integrated physician practices.<sup>13, 14</sup> Such transformation requires an investment in information technology and support staff, along with a philosophical transformation that the practice is accountable for all aspects of patient care.<sup>15</sup> Under the current financing system, there may or may not be capital investments available to support the practice transformation or to reimburse for enhanced services. Others have warned of the potential for providers to lose the element of patient-centeredness.<sup>16</sup> In particular, some experts warn that without common definitions and metrics for evaluating the medical home, it will be difficult to both implement and assess the impact of the new model.<sup>17</sup> There may also be some limits to the willingness of providers to fully adopt the medical home model without adequate supports and incentives.

Due to many of these considerations, experts studying the PCMH warn that financial and organizational aspects of the PCMH must be clearly defined, and that results of the medical home may take 5-10 years to materialize.<sup>18,19,20</sup> MHPA observes that the demonstration programs to date reporting massive savings have all used divergent definitions of medical homes, patient populations and cost savings. The transformation into a medical practice is challenging and at this point, far from universal. This introduces uncertainty as to whether medical homes will unequivocally deliver the access, quality improvements and cost savings on a large scale needed to serve expanding Medicaid populations, especially without providing adequate data support for providers to integrate and coordinate care.

### **Health Plan Accountability for Access, Quality and Cost**

Medicaid health plans typically operate under regulation and oversight that is far more comprehensive than oversight of fee-for-service Medicaid or PCCM programs. Through decades of successful partnership with states, Medicaid health plans:

- Organize, track and monitor health care services that are culturally and linguistically appropriate;
- Link member with primary care practitioners;
- Coordinate access to specialists;
- Offer enhanced benefits such as prenatal classes and diabetes education;
- Are accountable for facilitating access to care by providing language interpretation services and transportation;
- Manage enrollment and disenrollment information;
- Track cost, quality and utilization;
- Report publicly on cost, quality and access using standard definitions;
- Carry out fraud detection and prevention activities
- Are accountable to states and members for cost and quality management

It is critical for policy-makers to understand that traditional fee-for-service Medicaid programs have no accountability for cost control or quality improvement. Under fee-for-service arrangements providers are simply reimbursed for any services they deliver. There are no beneficiary protections to guard against under-use – such as may occur if there are access barriers, or over-use, when patients receive services they don't need or fraudulent services. Medicaid managed care plans are accountable for all aspects of care.

Medicaid health plans carry out essential care coordination functions to support better health care for beneficiaries and control costs. Medicaid health plans have more stringent beneficiary protections, quality measurement, and public accountability than fee-for-service or PCCM programs. Plans are required to implement and track access standards and quality improvement activities and to undergo external quality review. They must also abide by federal rules that offer enrollee protections for access to emergency care and specialty care and enrollee rights to appeal.<sup>21</sup>

Medicaid health plans are subject to both federal and state oversight and private oversight by accrediting organizations. Unlike fee-for-service providers, health plans typically report on their performance using a standardized data set established by the National Committee for Quality Assurance (NCQA), called the Healthcare Effectiveness Data and Information Set (HEDIS). The Kaiser Commission reports that 36 states use HEDIS to monitor quality in health plans and 34 states use a standard consumer satisfaction survey called CAHPS, compared to 18 states that use HEDIS quality indicators for PCCM and 17 that use CAHPS. Health plans also report to states on their fraud prevention and detection activities.

In addition to state oversight, many Medicaid health plans also undergo external quality evaluation by NCQA. NCQA has established rigorous standards by involving consumer advocacy organizations, health plans, state regulators, and other experts in Medicaid. These standards require plans to develop policies and procedures that protect beneficiaries and clearly articulate how health plans operate. The standards also protect beneficiaries by requiring processes of grievances and appeals and use of consumer satisfaction surveys. Accredited health plans ensure that physicians practicing in the network have appropriate credentials to practice and are willing to accept Medicaid clients, an important element of both access and quality management.

Importantly, Medicaid health plans are also accountable for all health care costs associated with enrollee care. In contrast to the PCMH, which has accountability for outpatient services, health plans are accountable for both inpatient and outpatient care costs. Health plans are generally capitated for the cost of care, which means that state costs are capped and predictable. A 2009 Study by the Lewin group that examined results from 24 studies on the cost-effectiveness of Medicaid managed care found consistent cost-savings attributable to managed care, with the percent of savings ranging from 1 to 20%.<sup>22</sup>

## **THE FUTURE: COLLABORATION BETWEEN STATES, PLANS, MEDICAL HOMES**

### **Medicaid Health Plan alignment with PCMH**

Medicaid health plans have a track record working with Medicaid beneficiaries and being accountable for care. Patient-centered medical homes show potential for improving care and managing costs, but existing research on the PCMH shows that the transition from ordinary medical practice to PCMH requires great transformation and intensive work. This suggests that some provider sites may not currently be equipped to become PCMH's, that incentives may be needed to promote the transformation, and that providers will need support in redesigning practices to promote truly patient-centered care.

Health plans have a critical role in both the transformation process and in the ultimate accountability of the PCMH for improved outcomes and cost management. It is health plan data and care management capability that provides the needed analytics and human capital needed to successfully make the transformation and evaluate the impact. Health plans bring the following elements to the table to support the work of medical homes:

- Standardized quality management and measurement approaches
- Transparency of quality and financial results
- Capability to aggregate and analyze data from all sources, including pharmacy, laboratory, inpatient claims and outpatient claims
- Relationships with providers and understanding of which sites are high volume
- Expertise and leverage negotiating best prices from specialists and acute care facilities;
- Capability to manage inpatient stays, which the PCMH may not
- Financial systems capable of tracking costs across providers and facilities
- Accountability for cost and quality management in both inpatient and outpatient services, which fee for service, PCMH and PCCM do not
- Data on outcomes and costs from all sources

In addition to the accountability plans offer to states, Medicaid health plans have capability to support providers in developing and enhancing the provider-driven PCMH.

For example, two of Pennsylvania's Medicaid health plans are active participants in the State's Chronic Care Commission medical home pilot. Keystone Mercy and AmeriHealth Mercy Health Plans contributed seed monies to a three year PCMH pilot in Southeast and Central Pennsylvania in partnership with commercial health plans. The pilot is supporting the development of medical homes, and will assess the impact of the PCMH on chronic disease care (specifically targeting asthma in children and diabetes in adults). Participating Medicaid plans leverage technology to deliver point of care information to improve provider-level quality and HEDIS measures. The physician's office enters the members' identification number when they check eligibility, which is then matched to preventive services needed by the patient such as mammography or hemoglobin A1C testing. A reminder will pop up on the screen to advise the physician that the patients need these tests. Sharing actionable information in this manner is critical to the success of medical home initiatives.

Going forward, Medicaid health plan support to develop and assist medical home sites may come in the following areas:

**Data:** Medicaid health plans have access to claims data from primary care and specialists providers, along with hospitals and other acute care settings. This enables plans to understand *cost and performance trends*, and to provide valuable feedback to the PCMH. Through data on provider practices, plans can help the PCMH identify high performing practices needed to make *evidence based referrals*. Plan data and health risk assessment processes also help *to identify high risk members*, including those most in need of a medical home for chronic care management. Medicaid health plans' provider data also enables plans to help members *select a medical home* as a primary care provider (PCP).

**Member engagement:** Medicaid health plans have the critical mass of enrollees needed to develop and deploy *educational websites*, culturally and linguistically appropriate *educational materials* and member support services such as *nurse advice lines*. Plans also track enrollment, conduct *outreach* to new Medicaid enrollees, and help members to select a medical home. Medicaid health plans also develop and promote *health risk assessment* tools to identify high risk members. They also offer transportable *personal health records (PHR)*, and are using health plan data to *populate the PHR with data* that might not be available to the PCP in real time.

**Practitioner engagement and support:** Health plans offer providers *performance feedback, support in using evidence based guidelines*, and can participate in collaboratives that offer *technical assistance on office redesign and practice transformation*. Many Medicaid health plans are offering incentives, direct purchase, or technical assistance for providers to *adopt health information technology* such as electronic health records, and the vast majority have also implemented electronic claims transactions to reduce *administrative inefficiency*. Plans are also collaborating with physicians to *support physician level care coordination* activities through such mechanisms as funding care coordinators on site.

**Financing:** Many health plans are collaborating with physicians to *create incentives for practice transformation* into a PCMH. Some financial transactions include reimbursing or rewarding physicians for costs of *becoming designated as a PCMH*, paying a *care coordination fee* for practices designated as a PCMH, providing indirect support by *funding ancillary personnel* to perform PCMH functions, or paying an enhanced case rate. Plans have the potential to support physician efforts to increase access through non-traditional visits *by reimbursing for telephonic, web, and group visits*, if permitted by state Medicaid regulations. As noted above, plans can support the efforts of the PCMH to achieve global cost savings *by tracking both inpatient and outpatient costs*.

MHPA believes that health plans have an important role in promoting development of PCMH practitioner sites. However, there are some barriers to both plan and physician engagement. Some of the physician barriers were identified earlier. Medicaid health plan barriers to fully engaging in effective PCMH development include:

- **Antitrust regulations:** Development of PCMH model necessitates that providers transform their practices for all patients with all types of insurance and plans. This means that health plans (payers) must be permitted to collaboratively work with providers and each other to determine common expectations and rewards that will enable the practice to deliver uniform services using uniform administrative practices.
- **Physician payment reform barriers:** Medicaid plans need flexibility from the State Medicaid agency to develop innovative reimbursement strategies, including enhanced payments and payment for non-traditional services. Where investment costs are expected, health plans need to be granted authority and appropriate financing to invest in PCMH development. States should also consider supporting the costs of consultation with physician practices that support practice transformation into a PCMH and practice recognition by NCQA or other external entities. As accountable care organizations develop, health plan activities that support ACOs or the PCMHs participating in ACO arrangements should also be authorized and encouraged by states.
- **Administrative cost and incentive restrictions:** The health care system is undergoing rapid evolution, particularly in the area of patient and physician incentives. Plans need flexibility to offer member engagement incentives within the PCMH (financial or otherwise) that are not subject to the same restrictions applicable to member marketing activities. Plans also need authorization to account for physician payment innovations, value added payments, and member engagement incentives as medical costs, not health plan administrative costs.

## Future directions

MHPA and its member Medicaid health plans applaud the dual focus of reform in the health care system to both improve coverage and increase access to patient-centered, coordinated and comprehensive care. MHPA recognizes that federal pilot programs enacted in the PPACA and state initiatives underway look to patient-centered medical homes as a core solution in this effort. Medicaid health plans must also be part of the solution.

Medicaid Health Plans of America and its member health plans believe that health plans must be an integral part of state efforts to develop medical homes, and that plans are best positioned to interface directly with providers to maintain accountability for fiscal and clinical outcomes under Medicaid. Health plans have an established track record of driving dramatic quality and access improvements for Medicaid beneficiaries. They are also transparent and accountable to states for the cost of care, and allow states to predict costs for the full range of services required by Medicaid beneficiaries. Medicaid health plans bring important capabilities to the PCMH table: data, member engagement, provider engagement, and payment strategies.

MHPA members ask for and look forward to ongoing collaboration with states, patient advocacy organizations, and provider organizations in implementing truly patient-centered medical homes with accountability for quality and outcomes improvement.

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