PATIENT CENTERED MEDICAL HOMES & THE AFFORDABLE CARE ACT

Fewer than 4% of Medicaid beneficiaries drive nearly 50% of Medicaid costs.[1] These beneficiaries require patient-centered medical homes that address all health determinants,[2] including behavioral health and social services needs, and so act more as "health homes" with a holistic approach to improving outcomes.

- Half of beneficiaries with serious mental illness do not receive mental health care, and fewer access primary care, despite the prevalence of chronic medical conditions among the population.[3]
- Homeless frequent users assigned to medical homes *increase* their inpatient costs because they cannot obtain sufficient rest, follow a healthy diet, store medications, or regularly attend appointments.[4]
- Among high-cost beneficiaries, over half live alone, half are homeless, and those who are not homeless are often unstably housed.[5]

Research on Medical Home Models that Offer Traditional Care Coordination

A review of 15 care coordination studies revealed medical homes offered through Medicare that did not include a strong face-to-face component are unlikely to improve care or yield Medicare savings.[6] Interventions have greatest potential for improved health when directed to those who are or are expected to be frequent hospital users[7] identified through predictive modeling tools.[8]

- A New York pilot identified likely high-cost Medicaid beneficiaries using an algorithm to identify patients in real-time while the beneficiary was hospitalized.[9]

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[1] A. Sommers. "Medicaid's High Cost Enrollees: How Much Do They Drive Program Spending?" *The Kaiser Commission on Medicaid and the Uninsured.* 2006.
[2] C.J. Peek. "Report on the Current 'State of the Art' for Medical/Health Care Home." *Institute for Clinical Systems Improvement, Minnesota Department of Health* (Dec. 2008).
[3] RC Kessler, PA Berglund, et al. "The Prevalence and Correlates of Untreated Serious Mental Illness." *Health Services Research.* 36:987–1007, 2001.
[4] Linkins, *supra.*
[5] John Billings. "Predictive Modeling for High-Cost Medicaid Patients in New York." August 2008.
[6] Deborah Peikes, Arnold Chen, Jennifer Schore, Randall Brown. "Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries: 15 Randomized Trials." *Journal of American Medical Association.* (Sept. 1, 2010). See also Thomas Bodenheimer, Rachel Berry-Millet. "Care Management of Patients with Complex Health Needs." Robert Wood Johnson Foundation Research Synthesis Report. No. 19. (Dec. 2009).
[7] Debra Peikes D, A. Chen A, et. al. "Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries: 15 Randomized Trials." *Journal Am. Medical Assoc.* 2009. 301:603-18.
[8] Melanie Bella, Chad Shearer, Karen Llanos, Stephen Somers. "Purchasing Strategies to Improve Care Management for Complex Populations: A National Scan of State Purchasers." *Center for Health Care Strategies.* March 2008.
[9] Maria Raven, Kelly Doran, Shannon Kostrowski, et. al. "An Intervention to Improve Care and Reduce Costs for High-Risk Patients with Frequent Hospital Admissions: A Pilot Study." *BioMed Central Health Services Research.*11; 270 (2011).

- The total number of hospitalizations for all participants decreased by 37.5%. Considering inpatient, ED, and clinic costs, the pilot resulted in an average annual Medicaid cost reduction of $5,080 per patient.[10]

- Other studies repeat these findings:
  - Medi-Cal beneficiaries participating in foundation-funded frequent user programs improved outcomes and reduced Medi-Cal hospital costs by $7,519 per beneficiary per year after two years over the costs of these programs.[11]
  - A Washington study showed homeless chronic inebriates connected to intensive case management incurred $2,449 less in Medicaid costs per person, per month than control group participants after six months beyond program costs.[12]
  - Two randomized studies of chronically homeless frequent users receiving health home services showed participants decreased hospital inpatient days by 46% after 18 months, and decreased nursing home days by over 60% within a year, compared to a usual care group.[13]

ACA Opportunities

The Affordable Care Act (ACA) offers multiple opportunities to fund comprehensive care coordination.

- The most promising opportunity is for Health Homes for People with Chronic Conditions, as this option is intended to fund whole-person oriented care coordination, discharge planning, integrating care, and connecting participants to community services.[14]
  - 90% federal funding for two years, and 50% funding thereafter.
  - Beneficiaries with two chronic conditions or a mental illness are eligible.
  - California can access with minimal state contribution.
  - AB 2266 in 2012: Assemblymember Mitchell legislation authorizing the state to take advantage of this option, and to ensure chronically homeless and frequent hospital users are included in the target population. Bill will be reintroduced in 2013.

- Other sections of the ACA bolster existing programs that offer funding for care coordination.
  - Home- and community-based services as a Medi-Cal benefit.
    - Changes to Section 1915(i) state plan amendment option:[15]

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[10] This is likely a conservative estimate, as this is pilot work and our intervention costs are not necessarily to scale. Maria Raven. *BioMed Central Health Services Research.*

[11] Linkins, *supra.* The calculated costs avoided are based on average reductions in ED visits and inpatient days for Medi-Cal patients at rates the Office of Statewide Health Planning and Development (OSHPD) reported as costs for hospitals connected to frequent user programs. Rates averaged $305 per ED visit and $2,161 per inpatient day. OSHPD 2006 data. www.OSHPD.gov.

[12] Mary Larimer, Daniel Malone. "Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems." *Journal Am. Medical Assoc.* 2009; 301(13):1349-1357 (2009).

[13] David Buchanon, Romina Kee. "The Health Impact of Supportive Housing for HIV-Positive Homeless Patients: A Randomized Controlled Trial." *Journal Am. Medical Assoc.* (June. 2009) 99;6; David Buchanan, Romina Kee, Lisa Sadowski, et. al. "Effect of a Housing & Case Management Program on Emergency Department visits and Hospitalizations Among Chronically Ill Homeless Adults: A Randomized Controlled Trial." *Am. Journal Public Health. (May* 2009) 301;17.

[14] Patient Protection & Affordable Care Act (ACA), § 2703. 2010.

[15] ACA, § 2402(b).

        - States can access 1915(i) through a state plan amendment.
        - States can specify services to be provided to specific populations, and those services can vary depending on beneficiary need.
        - No need to show targeted populations are at risk of institutionalization.
    - Other home- and community-based services programs:[16]
        - States can extend programs to additional populations through a state plan amendment.
        - States can match specific services to specific target populations.
  - Increased funding for community health clinics.[17]

- The ACA identifies multiple grant and demonstration programs that promote innovation.
  - Five-year demonstration program for people eligible for both Medicare and Medicaid:[18]
    - California is participating as part of the Coordinated Care Initiative.
    - The demonstration is an opportunity to establish health homes that address complex health needs of targeted dual-eligible beneficiaries.
  - Eight-state five-year demonstration program to improve hospital discharge planning.[19]
  - Grant program to help hospitals establish community-based, multi-disciplinary teams that link participants to patient-centered medical homes.[20]
  - Grants from the Center for Medicare and Medicaid Innovation, or CMMI.[21]
    - CMMI has awarded hundreds of grants to test care coordination models.
    - Some CMMI grants are creating accountable care organizations.
        - Patient-centered teams of providers, hospitals, and mental health professionals that coordinate a beneficiary's care.
        - The ACA allows ACOs to access savings incurred to Medicaid.[22]
        - The Camden, New Jersey, ACO has been highlighted for targeting "hot spots" of high costs and poor health within the City, and then using care managers to address whole needs of individuals incurring those costs.[23]

Recommendations

California could take a number of steps to fund the care coordination services that make health homes truly "patient-centered" for Medicaid beneficiaries:

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[16] ACA, § 2402(b).
[17] ACA, § 10503.
[18] ACA, §§ 2601, 2602.
[19] ACA, § 2704.
[20] ACA, § 3502.
[21] ACA, § 3021.
[22] ACA, § 3022.
[23] Atul Gewande. "The Hot Spotters." *The New Yorker.* Jan. 24, 2011.

- Risk adjust capitated and care coordination rates, depending on the needs of beneficiaries to provide incentives for addressing health disparities, like homelessness, in medical or health homes.
- Use predictive modeling tools to identify high-cost, highly vulnerable beneficiaries.
- Take advantage of ACA options to help California fund comprehensive care management, including the Health Home option.

For more information, contact:

Sharon Rapport
Associate Director, California Policy
Corporation for Supportive Housing
800 S. Figueroa, Ste. 810
Los Angeles, CA 90017
C: (323) 243-7424
O: (213) 623-4342, ext. 18
mailto:sharon.rapport@csh.org