NATIONAL COALITION ON HEALTH CARE

Working Together for an Affordable Future

POLICY BRIEF

Addressing America's Health Care Value Crisis

America's health costs are extraordinarily high and rising. Total national health expenditures represented 17 percent of the Gross National Product in 2010 and are projected to reach nearly 20 percent by 2020 and more than 40 percent by 2050. Yet according to the Institute of Medicine, approximately one third of this enormous investment is poised to be spent on goods and services that improve no one's health. Clearly America's health system faces a crisis of value. This National Coalition on Health Care Policy Brief is part of a series, designed to explore issues and priorities related to addressing this crisis.

This series examines a range of options including some policies on which the National Coalition on Health Care has yet to take a formal position. Discussion of any particular policy in this document implies neither support nor opposition by NCHC or its member organizations.

Curbing Health Costs, Improving Quality: Integrating Care through Medical Homes and Community Health Teams

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According to the Institute of Medicine, the United States lost $315 billion in health care expenditures to inefficient delivery and overuse of health care services in 2009 alone. If that pattern continues over the next decade, overuse and inefficient delivery can be expected to drain well over three trillion dollars from our health system.

Many of these wasted resources are attributable to fragmented and poorly coordinated delivery of health care. In today's American health system, providers are often unaware of what care patients are receiving from other providers or of recent developments in the patient's health condition. As a result, patients often do not receive the optimum care at the right time and are subjected to unnecessary tests and procedures. In some cases, patients go without care entirely or are harmed by the care they do receive.

A team of health care experts from the Dartmouth Institute for Health Policy and Clinical Practice has stated the problem this way:

> *Many of the deficiencies in U.S. health care are reflections of the disjointed and poorly coordinated care that patients receive as they move across settings and among providers: more frequent and flawed care transitions, failures of communication, and errors.*[1]

These challenges can dramatically affect the care of anyone whose health needs go beyond a single provider, setting or episode of care. But fragmentation has an even greater impact when dealing with the highest-cost, highest-need patients, particularly those facing chronic conditions and/or functional limitations.

Policymakers, providers, and health plans alike are experimenting with a wide array of solutions designed to meet this challenge. This paper focuses on two specific strategies for addressing this fragmentation of care - the patient-centered medical home and the community health team – as well as policy options to promote those strategies. Both of these approaches are designed to improve value for the highest-cost, highest-need patients, and broader patient populations. Other briefs in the series will spotlight care coordination efforts that target smaller sub-populations of high-cost, high-need enrollees.

Strategy: The Patient-Centered Medical Home

The patient-centered medical home (PCMH) is a leading model for improving care coordination. This approach seeks to achieve higher quality, better coordinated care through a team-based approach designed around the needs of the patient, emphasizing health information technology, patient involvement in care decisions, management of chronic conditions and prevention.

Efforts to implement the PCMH model have yielded improvements in quality of care, reductions in readmissions, and in many cases, overall cost reductions.[2] However, initial results from the American Academy of Family Physician's National Demonstration Project show that the process of transforming practices into patient-centered medical homes demands substantial resources and

[1] Fisher, E et.al. (2006, Dec 5). "Creating Accountable Care Organizations: The Extended Hospital Medical Staff," *Health Affairs.* Retrieved from http://content.healthaffairs.org/content/26/1/w44.full.pdf.

[2] Grumbach, K, et.al. The Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence on Quality, Access and Costs from Recent Prospective Evaluation Studies Patient-Centered Primary Care Collaborative. Retrieved from http://www.pcpcc.net/files/pcmh_evidence_outcomes_2009.pdf.

time.[3] One analysis by the Urban Institute critiques the model's potential to achieve short-term savings given the cost of implementation over a broad population.[4]

Nonetheless, in 2011, under the Center for Medicare and Medicaid Innovation (CMMI) Comprehensive Primary Care Initiatives, Medicare began participating in eight state initiatives to implement medical homes. In Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota, Medicare is joining with Medicaid and major private payers in a coordinated approach to implement medical homes. In each of these initiatives, selected primary care providers will be offered funding and support needed to upgrade their practices to medical homes which can provide the care coordination services called for in the PCMH model.

Policy Options: Use Existing Legal Authorities to Expand PCMH in Medicare

Expansion of the Comprehensive Primary Care Initiative could be possible without further Congressional action. If the Advance Primary Care Demonstration generates savings to Medicare while preserving or maintaining quality (as certified by CMS' Office of the Actuary), current law gives the Secretary of HHS the authority to extend the program more broadly - even nationwide. However, this policy option would require waiting until the completion of the Demonstration, scheduled for mid-2014, before even considering program expansion. Further, given that this demonstration is limited to states with multi-payer initiatives, the Actuary could conclude that savings would not necessarily accrue in states without cooperation from multiple payers, which might restrict the Secretary's ability to expand that program.

Policy Option: Enact Legislation expanding PCMH across Medicare

Alternatively, rather than waiting for the outcome of this round of demonstrations, Congress could craft legislation that would rapidly implement the medical home model across Medicare.

CBO is unwilling to attribute substantial budgetary savings to medical home initiatives, estimating that establishment of medical homes for enrollees with two or more chronic conditions could actually cost the federal government $5.6 billion over ten years. However, many experts predict robust implementation of medical homes could be a powerful cost-saver over the longer term. Dr. Ken Thorpe of Emory University has estimated that expansion of the PCMH model and associated activities could yield budgetary savings upwards of $100 billion over ten years.[5] Robust, nationwide implementation of medical homes could prove worthwhile. Policymakers should strongly consider making this investment.

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[3] Stange, K, et.al. (2010, May 1). Context for Understanding the National Demonstration Project and the Patient-Centered Medical Home. Supplement, *Annals of Family Medicine*. Retrieved from http://www.annfammed.org/content/8/Suppl_1/S2.abstract.

[4] Berenson, R. (2011, Aug). *Will the Patient-Centered Medical Home Transform the Delivery of HealthCare.* The Urban Institute. Retrieved from http://www.urban.org/uploadedpdf/412373-will-patient-centered-medical-home-transform-delivery-health-care.pdf.

[5] Thorpe, KE. (2011, Sep 28). Potential Savings Associated with the Blue Cross and Blue Shield Association's Building Tomorrow's Healthcare System The Pathway to High-Quality, Affordable Care in America. Retrieved from http://www.bcbs.com/why-bcbs/health-reform/economic-analysis.pdf.

Strategy: Community Health Teams

Community health teams are teams of health professionals designed to support medical homes with a range of services needed to manage population health. These teams are usually led by registered nurse case managers and include dieticians, public health specialists and educators, pharmacists, behavioral health specialists, and community health workers. They enable communities that depend on small provider practices to provide the same robust case management, patient education and other services which larger physician groups provide.

Community Care of North Carolina is a leading example of this model. This organization's networks of medical homes and health teams care for more than one million Medicaid and CHIP enrollees across all of North Carolina's 100 counties. Initial estimates show statewide savings of $1.5 billion over a three year period and significant reduction in ER use, while showing remarkable improvement in care outcomes for patients with chronic conditions.[6] CCNC is now expanding participation to certain Medicare patients as well as private payers in the Raleigh-Durham regions.

Vermont has also implemented a program where community health teams work in support of patients' medical homes. After an initial test of the program found savings between 8.9% and 11.6% per patient, the state is currently implementing the program statewide across both public and private payers.[7]

Policy Option: Discretionary Appropriations for Community Health Teams
Inspired in part by the success of community health teams in North Carolina, the Affordable Care Act's Section 3502 established a new program within HHS to support community health teams and authorized funding for the program. In the current political climate, however, securing discretionary funding for any portion of the ACA has been extremely challenging, and Section 3502 has yet to receive any appropriated funding. In another blow to the feasibility of funding this program through discretionary sources, CBO has not scored community health teams as yielding budgetary savings.

Policy Option: Direct Medicaid Funding for Community Health Team
Another alternative would be to implement community health teams as part of state Medicaid programs. The Affordable Care Act offers state Medicaid programs the option of enrolling Medicaid patients with chronic conditions in health homes, supported by community health teams, and offers enhanced federal matching funds for states that do so. CMS has approved health

[6] Hewson, DL. (2011, Jun 21). Dual Eligibles: Understanding This Vulnerable Population and How to Improve Their Care. Testimony before the U.S. House of Representatives Energy and Commerce Subcommittee on Health. Retrieved from http://www.communitycarenc.org/elements/media/related-downloads/levis-hewson-testimony-to-congress.pdf.
[7] Bielaszaka-DuVernay, C. (2011, Mar). "Vermont's Blueprint For Medical Homes, Community Health Teams, and Better Health at Lower Cost," *Health Affairs 30(3):*383–86.

home programs in four states, Rhode Island, Missouri, New York, and Oregon. Six additional states are also seeking to avail themselves of this option.

However, under current law, the state health home initiatives are responsible for serving both Medicaid-only beneficiaries as well as dual eligibles whose ongoing medical services are paid by Medicare. Medicare is not required to participate in funding these health home services.

To accelerate implementation of the community health team model, Congress could consider legislation directing some Medicare funds to cover some of the cost of treating dual eligibles under this option. Congress might also consider increasing the federal matching funds (FMAP) to state Medicaid programs which implement CHTs. Even a small increase, perhaps a fraction of one percent, could potentially spur state action that would be worth the budgetary investment.