

## Small states, big progress

*Rhode Island, North Dakota lead way in promoting medical homes*

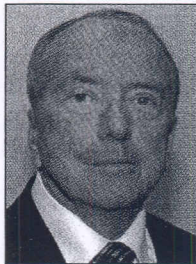
**A**s the smallest in size and fourth-least densely populated states, respectively, Rhode Island and North Dakota don't often find themselves leading the rest of the union. But both are in front of the pack when it comes to promoting the patient-centered medical home concept.

According to medical home advocates, the concept is designed to maximize chronic care, prevention and wellness while compensating primary-care physicians for care coordination and counseling and education done outside of the typical office visits, such as via telephone or e-mail. There are at least 22 medical home pilot projects in some stage of implementation, according to the Patient Centered Primary Care Collaborative, a coalition of providers, employers, consumer groups, unions and others, but officials in North Dakota and Rhode Island say their programs are the only ones that are statewide in scope.

In addition to being statewide, the Rhode Island Chronic Care Sustainability Initiative, which launched Oct. 1, stands out because it involves the state's Medicaid program as well as its three largest commercial payers. Rhode Island Health Insurance Commissioner Christopher Koller said that, because of a 2004

state law, health plans are now legislatively mandated to work toward improving health-care affordability, accessibility and quality.

"It creates a different conversation than in other places," Koller said. "The state holds insurance companies accountable for making efforts toward affordability, and that's what makes this effort possible."



**McGeeney: A practice must address all its patients for it to be considered a medical home.**

The big payers in the state—Blue Cross and Blue Shield of Rhode Island, Medicaid, Neighborhood Health Plan of Rhode Island and UnitedHealthcare of New England—have agreed to pay a \$3 per member per month fee for care coordination as well as pay for the services of a care-management nurse at the five practices participating in the pilot.

Insurance industry officials think the concept may be successful. "The main advantage is that, over the years, a lot of doctors have com-

plained about pay-for-performance programs that involve only one payer because they don't want to treat their patients with one plan different than the others," said Gus Manocchia, chief medical officer at the Rhode Island Blues.

"Overall, we're hoping doctor satisfaction will be better and their reimbursement will go up," said Neal Galinko, UnitedHealthcare of

New England senior medical director, who added that savings are expected from fewer hospital readmissions, shorter lengths of stay, and fewer emergency department visits. "We're pretty confident that, with more care coordination and integration, costs will go down."

Scheduled to last two years, the pilot includes five practices who agreed to conform to the standards required by the National Committee for Quality Assurance, receive special chronic-care training, educate patients on their condition and treatment, and do performance reporting on quality measures for coronary artery disease, diabetes and depression (See Commentary on p. 20, also Oct. 20, p. 36).

Galinko also said that measures were chosen because of the prevalence of the conditions and the wide acceptance of the standard treatment measurements for those conditions.

But while Rhode Island trumpets the start of its statewide pilot, North Dakota is set to launch its statewide program Jan. 1, 2009. "Everyone is just doing pilots, the difference in North Dakota is that they've already done a two-year pilot, so what they're launching is the full-fledged implementation," said Heather McLarney, vice president of marketing for MDdatacor, the company whose information technology products are being used by Blue Cross and Blue Shield of North Dakota to facilitate its MediQHome quality program.