Research Protocol for Patient Centered Medical Home Laws

Prepared by the Policy Surveillance Program Staff

May 2016
Patient Centered Medical Home Laws

I. Date of Protocol: May 2016

II. Scope: Compile state statutes and regulations implementing the patient centered medical home (“PCMH”) health care delivery model. This cross-sectional dataset includes coding questions on PCMH state law recognition, PCMH insurance type eligibility or incorporation, and the establishment, membership and duties of PCMH advisory councils. This dataset also covers PCMH state legislature reporting requirements and the different funding sources available to governing bodies implementing the model.

   a. Initial Returns and Additional Inclusion or Exclusion Criteria: Included laws recognizing the PCMH model, on PCMH insurance type eligibility or incorporation, and on the role and membership of PCMH advisory councils. Laws were also included on PCMH state legislature reporting requirements and on different funding sources available to governing bodies for implementation. Excluded areas of law include:

      - Laws on general health innovation, reform, or care coordination initiatives that did not explicitly require, authorize or encourage use of the PCMH model.
      - Laws on home health and respite care services regulating the delivery of healthcare to seniors and/or special medical needs populations within their homes and/or in residential healthcare and/or nursing facilities.

III. Project Team: David Presley, JD, Andrew Kunka, JD, Benjamin Hartung, JD

IV. Primary Data Collection

   a. Project Dates: Legal research was conducted between October 1, 2015 and May 1, 2016.

   b. Dates Covered in the Dataset: The effective date listed for each state is the date of the most recent version of the PCMH state law coded. If more than one PCMH law is included in the legal text for a state, the effective date reflects the date of the most
recently updated law. Since this dataset is cross-sectional, if the state did not have a PCMH law in effect on May 1, 2016, the effective and valid through date are listed as May 1, 2016.

c. **Data Collection Methods:** The *Policy Surveillance Program Team* ("Team") building this dataset consisted primarily of one legal Researcher and one Supervisor. Three additional Researchers assisted with collecting PCMH laws and an additional Researcher joined the team to assist with redundant coding. Researchers began by writing a background memorandum to understand the key policy components of PCMH healthcare delivery. Next, a five state memorandum was written by one Researcher, summarizing and identifying laws related to the key components identified in the background memorandum.

i. **Databases Used:** Searches were conducted using WestlawNext and state-specific legislature websites. Full text versions of the laws were collected and pulled from state legislature websites.

ii. **Search Terms:** The following searches were used in the current (Multistate Legislative Service - (LEGIS-ALL)) bill libraries of Westlaw(Next):

- **advanced (adv):** ("medical home" or "health home" or (centered +s home) or (patient +s centered) or (person +s centered)) & (board or commission or (advis! /s group) or (advis! /s body) or committee or association or stakeholder or council or "task force" or collaborative) % (criminal /s justice) or "sunset review" or "respite care" or (juvenile /s justice) or (civil /p procedure)
- **adv: "medical home"** or "health home" or (centered /s home) or (patient /s centered) or (person /s centered) and (board or commission or advisory or group or advising or committee or association or stakeholder or body or council or task force or collaborative)
- **adv: “Patient Centered Medical Home”**
- **adv: “PCMH”**
- **adv: “medical home”**
- **adv: “Primary Care Centered Medical Home”**
- **adv: “Primary Centered Medical Homes”**
- **adv: “Health home”**

Key word searches were supplemented by reviewing the table of contents chapters on PCMH laws and on related healthcare delivery and coordination initiative laws. All chapters were examined in their entirety for relevant law.
Discrepancies were reviewed by a supervising Researcher and resolved by further research.

V. Coding

a. Development of Coding Scheme: The Team worked in collaboration with Siobhan M. Gilchrist, JD, MPH, a Health Policy Analyst consultant for the United States Centers for Disease Control and Prevention, to determine the focus of the research and the key questions to be coded. A Researcher then conceptualized coding questions and circulated them for review by the Supervisor. When the questions were finalized, the Researcher entered the questions into the MonQcle, a software coding program.

Throughout the coding of state records, the Team frequently met as a group to narrow the scope of the dataset to direct indicators of PCMH recognition, insurance type incorporation, advisory council roles, legislature reporting requirements and available funding sources. As necessary, the coding scheme was altered to accommodate newly identified features of the data, and completed states were recoded.

b. Coding Rules: In order to alert the user of laws that did not have an explicit requirement, Researchers provided caution notes where the law authorized, encouraged or was unclear on the level of regulation imposed. Caution notes were also included where a law’s provision was contingent on the approval of a federal Medicaid waiver, other government action or the availability of funding.

Below are specific rules used when coding certain questions and answer choices in the dataset:

Question: “Is there a state law recognizing patient centered medical homes (PCMH)?”

- States were coded as “Yes” wherever the law explicitly identified “patient centered medical homes,” “PCMH,” “medical homes,” “health homes,” “behavioral health homes” or “primary care centered medical home” within any state statute or regulation. “Yes” was selected regardless of how frequently the PCMH model was referenced or whether the state’s law included a comprehensive regulatory scheme for implementing the model.

Question: “How is the PCMH model identified in the law?”
This question captures the different terms states used to identify the PCMH model. These terms frequently varied depending on the specific patient population receiving services. Certain terms were conceptualized, coded and/or consolidated into the following response categories:

- Medical home: Includes “patient centered medical home,” “primary care centered medical home” and “patient centered primary care home”.
- Health home: Only includes “health home”. This answer response was designed to specifically capture those states that may have received Section 2703 Medicaid waivers, which provide PCMH services to individuals suffering from chronic and/or behavioral health conditions.
- Behavioral health home: Includes “behavioral health homes” and/or was coded where the state’s description of PCMH services incorporates the provision of behavioral, mental and/or other psychological services.

**Question:** “What types of insurance providers incorporate the PCMH model?”

This question captures any insurance types that may cover PCMH services under their healthcare plans. Responses were selected where 1) the state required, authorized, encouraged or in any way referenced a specific insurance provider offering PCMH services to their members; and/or 2) the law indicated PCMH practices would be eligible for reimbursement or some other form(s) of payment for services provided by that insurance type.

Researchers also coded incorporation where the PCMH model was defined and/or regulated within an insurance type’s specific state statute or regulation code chapter or section.

Where the law authorized or encouraged an insurance provider to incorporate the PCMH model, a caution note was provided. Caution notes were also included where incorporation was contingent on the approval of a federal Medicaid waiver and/or other government action or funding. Responses where further coded, conceptualized and/or consolidated as follows:

- Medicare: Includes “Medicare” and where the law indicates use of the PCMH model by all and/or public insurance providers broadly. Where coded based on the use of the model broadly, a caution note was provided.
- Medicaid: Includes the Child Health Insurance Program (“CHIP”) and any state health insurance program designed specifically for low-
income individuals and families that is funded through the federal government’s Medicaid program. Also coded where the law indicates use of the PCMH model by all and/or public insurance providers broadly. Where coded based on the use of the model broadly, a caution note was provided.

- Private health insurance: Includes private sector plans and/or plans provided under the health insurance exchanges established by the Affordable Care Act. Also coded where the law indicates use of the PCMH model by all insurance providers. Where coded based on the use of the model broadly, a caution note was provided.
- State employee health plans: Includes “state employee health plans” and coded where the law indicates use of the PCMH model by all and/or public insurance providers broadly. Where coded based on the use of the model broadly, a caution note was provided.
- Other: Coded where the healthcare plan or program covering PCMH services did not fall under one of the specific response categories. Where “other” was coded a caution note was provided.
- Law does not specify insurance type the PCMH model applies to: Coded where the law was silent on what insurance types used the PCMH model.

**Question:** “Does the law establish a PCMH demonstration project?”

- This question was answered “Yes” where the law establishes, authorizes or encourages the creation of a PCMH demonstration, pilot or any short term experimental project. “Yes” was also coded where establishment of a demonstration project was contingent on the approval of a federal Medicaid waiver and/or some other state program or funding. Where establishment was authorized, encouraged, unclear or contingent, a caution note was provided.

**Question:** “Does the law establish a PCMH advisory council(s)?”

- This question was answered “Yes” where the law establishes a council, task force, committee, collaborative, group or other body that advises on the implementation of the PCMH model as a whole or on some specific component(s) of implementation. Where establishment is authorized, encouraged, unclear or contingent, a caution note was provided.

**Question:** “What type of council(s) does the state have?”
This question captures the specific type(s) of PCMH advisory council(s) established by the state. Where the law included a combination of councils, all applicable council response types were selected. Responses were also coded, conceptualized and consolidated into the following categories:

- PCMH specific advisory body: Includes bodies specifically established to advise exclusively on the implementation of the PCMH model as a whole. These bodies were frequently identified as a “PCMH,” “medical home” or “health home” council, task force, committee or collaborative.
- Broad healthcare advisory body with PCMH duties: Includes bodies which advise on larger healthcare programs or initiatives, which include one or more components explicitly identified in the law as part of implementing the PCMH model. These bodies were frequently charged with improving a state healthcare systems’ quality, coordination, accessibility and affordability at large and across many different areas.
- Multiple healthcare specific councils with PCMH related duties: Includes multiple bodies which advise on one specific component of a state’s healthcare system, which are also explicitly identified as part of implementing the PCMH model. These bodies were frequently charged with developing new PCMH payment types and/or only evaluating a specific aspect of PCMH implementation.

**Question:** “Who may be members of the council(s)?”

This question captures members that the law requires serve on any of the PCMH advisory council types selected in the question “What type of council(s) does the state have?” Certain members were coded, conceptualized and/or consolidated into the following response categories:

- State health agencies: Includes any state health commissioner, department, secretary, director, superintendent, chief, public health insurance provider or the identification of any individual or group directly representing a state health agency. This responses was also coded where the law broadly identified membership from “public health agencies.” Where coded based only on this broad group identification, a caution note was provided.
- Private health insurance providers: Includes any stakeholder, member, representative or other individual representing a private health insurer or private health insurers group and/or association. This response was also
coded where the law broadly identified membership from “health insurance providers.” Where coded based only on this broad groups identification, a caution note was provided.

- Managed Care Organizations: Coded only where law explicitly included “Managed Care Organizations.”
- Local government agencies: Includes local, municipal, city, county or regional government agencies. This response was coded in addition to “state health agencies” where the law broadly identified membership from “public health agencies.” Where coded based only on this broad group identification, a caution note was provided.
- Hospital representatives: Includes any individual(s) representing a hospital, hospital group and/or association.
- Physicians: Includes “Doctor,” any licensed “Medical Doctor,” “MD,” “Osteopathic Physician” or “OP” or any physician specialist, such as gynecologists, pediatricians and psychiatrists and/or any individual(s) representing a physician specific group or association. This response was also coded where the law broadly identified membership to include “healthcare providers,” primary care providers and/or healthcare provider groups, associations, etc. Where coded based only on a broad group identification, a caution note was provided.
- Physician assistants: Includes “PA” or any individual(s) representing a physician assistant specific group or association. This response was also coded where the law broadly identified membership to include “healthcare providers,” primary care providers and/or healthcare provider groups, associations, etc. Where coded based only on a broad group identification, a caution note was provided.
- Pediatric specialist: Includes any individual healthcare provider or group specialized in providing medical treatment to newborns, toddlers, children and/or adolescents.
- Advanced practice registered nurse (Non-NP): Includes all non-NP APRNs such as clinical nurse specialists, certified nurse midwives, or certified registered nurse anesthetists and any individual(s) representing a non-specific nursing group and/or association. This response was coded in addition to “Nurse Practitioners” when the law broadly identified all APRNs as members and/or when membership included “healthcare providers,” primary care providers and/or healthcare provider groups, associations, etc. Where coded based only on a broad group identification, a caution note was provided.
- Nurse practitioners: “Nurse Practitioner” was also coded where the law identified Advanced Practice Registered Nurses (APRNs) as a group,
which include NPs and any individual(s) representing a non-specific nursing group and/or association. This response was also coded where the law broadly identified membership to include “healthcare providers,” primary care providers and/or healthcare provider groups, associations, etc. Where coded based only on a broad group identification, a caution note was provided.

- Registered nurses (RN): Includes non-advanced registered nurses and any individual(s) representing a non-specific nurse professional group and where the law broadly identified membership to include “healthcare providers” and/or healthcare provider groups, associations, etc. without indicating any specific type(s) of healthcare professional(s). Where coded based only on a broad group identification, a caution note was provided.

- Pharmacists: Includes any pharmacist professional group and/or association and where the law broadly identified membership to include “healthcare providers” and/or healthcare provider groups, associations, etc. Where coded based only on a broad group identification, a caution note was provided.

- Health care consumers: Includes any type of patient population and/or patients’ family members.

- Senior care specialists: Includes any individual healthcare provider or group specialized in geriatric medicine and/or providing medical treatment to seniors and elderly populations.

- Behavioral/mental health specialists: Includes any individual healthcare provider or group specialized in providing treatment for mental, behavioral and/or substance abuse health issues, including but not limited to psychiatrists, psychologists and clinical social workers.

- Healthcare finance specialist: Includes any individual or group with expertise in healthcare financing, payment, reimbursement and/or funding.

- Disability specialists: Includes any individual or group that specializes in providing services to individuals with physical, mental and/or developmental disabilities.

- Labor Groups: Includes any individual or group representing the interests of the labor force, workers or employees.

- Other: Coded where member type did not fall under one of the above response categories. Where “other” was coded, a caution note was provided.

- Law does not specify member requirements: Coded where the law was unclear on membership or silent on the matter.
**Question:** “What are the duties of the council(s)?”

- This question captures the specific duties the law confers on any of the PCMH advisory council(s) types selected in the question “What type of council(s) does the state have?” Responses were further coded, conceptualized and/or consolidated as follows:
  - **PCMH stakeholders:** Includes convening, consulting and collaborating with individuals external from the council that are identified as “PCMH stakeholders” and/or other individuals involved in implementing the PCMH model, such as insurance companies, health care providers, patients, social service providers, community advocacy groups and other similar groups.
  - **Implementation of PCMH:** Includes advising on the general “implementation,” “provision” or “delivery” of the PCMH model.
  - **PCMH program performance:** Includes any duty involving the advising on or research, development, analysis, evaluation or reporting on the PCMH program and/or provider performance standards, indicators, metrics and measures.
  - **PCMH best practices:** Includes any duty involving the advising on or research, development, analysis, evaluation or reporting on the most efficient and/or proven and/or best practices, methods and/or systems for implementing the PCMH model.
  - **Broad health innovation initiatives:** Coded where the law only includes a non-PCMH specific advisory council that advises on a broad range of healthcare areas that includes one or more components of PCMH implementation identified in the law.
  - **PCMH payment types:** Includes any duty involving the advising on or research, development, analysis, evaluation and reporting on PCMH healthcare services reimbursement and/or different payment formulas, types and methods.
  - **PCMH certification standards:** Includes any duty involving the advising on or research, development, analysis, evaluation or reporting on PCMH certification, recognition and/or qualifying standards, criteria, metrics and measures.
  - **PCMH program design:** Includes any duty involving the advising on or research, development, analysis, evaluation or reporting on PCMH
scope of services, models of care and/or essential elements for PCMH healthcare services delivery.

- Community linkages: Includes any duty involving the advising on or research, development, analysis, evaluation, or reporting on PCMH community integration, coordination and/or collaboration with community members and/or social support services, programs, organizations and stakeholders.

- PCMH implementation barriers: Includes any duty involving the advising on and/or research, development, analysis, evaluation or reporting on any obstacles, problems, issues, challenges and/or barriers, etc. in implementing the PCMH model as a whole.

- Healthcare Information Technology: Includes any duty involving the advising on and/or research, development, analysis, evaluation or reporting on PCMH healthcare information technology, “HIT,” “electronic medical records,” “EMR” and/or any reference integrating PCMH services with technology.

- PCMH Training: Includes any duty involving the advising on and/or research, development, analysis, evaluation or reporting on PCMH services delivery training for healthcare providers, practices, insurance companies and/or other stakeholders using the PCMH model.

- Law indicates council must advise state health agency on all agency implementation duties: Coded where the law indicates the council will advise on all of the state health agency’s duties, either through cross-reference and/or by law section or chapter organization.

**Question:** “What is the state health agency’s role on the council?”

- This question captures the specific role of the state’s health agency on any of the council(s) identified in the question “What type of council(s) does the state have?” The state health agency was identified based on the terms used for the “state health agencies” response provided on Pg. 7 under the question “Who may be members of the council(s)?”

Language only requiring a state health agency to “consult” the PCMH council was scoped out based on Researchers’ determination that this did signify a specific role and was an assumed duty of the state’s health agency since the advisory councils by law were established to advise the state on implementing PCMH policy. Certain responses were further coded, conceptualized and/or consolidated as follows:
Research Protocol for Patient Centered Medical Homes – May 2016

- Convenes members of the council: Includes establishing the council and organizing a collective meeting(s) of the council for advisory purposes.
- Leads the council: Includes serving as the director, manager, chair and/or leader of the council.
- Participates in the advisory council: Coded wherever the law identifies the state health agency as a member of the council, as such this response was coded where “state health agencies” was selected as a response to the question “Who may be members of the council(s)?” and vice versa.
- Other: Coded where the state’s role did not fall under one of the other response categories. Where “other” was coded a caution note was provided.
- State’s role on the council not indicated in the law: Coded wherever the law was unclear or silent on the state health agencies role.

**Question:** “What bodies are required to report to the legislature on PCMH implementation?”

- This question captures whether certain councils, agencies or other bodies are required to report on one or more components of PCMH implementation. A body was also selected where their reporting requirement was contingent on the approval of a federal Medicaid waiver and/or approval of a state program or funding source. Where contingent, a caution note was provided. Responses were further coder, conceptualized and/or consolidated as follows:
  - State health agency: Coded based on the same terms used for the “state health agencies” response provided on pg. 7 under the question “Who may be members of the council(s)?”
  - PCMH specific advisory council: Coded based on the same terms used for “PCMH specific advisory body” response on pg. 6 under the question “What type of council(s) does the state have?”
  - Non-PCMH specific advisory council: Coded based on the same terms used for the “Broad healthcare advisory body with PCMH duties” and/or “Multiple healthcare specific councils with PCMH related duties” responses on pg. 6 under the question “What type of council(s) does the state have?”
  - Law does not include reporting requirement: Coded wherever the law was unclear or silent on whether any council, agency or other body was required to report to the legislature on PCMH implementation.
Question: “What information must be reported?”

- This question was only answered where one or more specific bodies was selected for the previous question (“What bodies are required to report to the legislature on PCMH implementation?”). This question captures the specific information that must be reported to the legislature. Responses were further coded, consolidated and/or conceptualized as follows:
  - PCMH use: Includes the number of patients enrolled in PCMHs and PCMH services used.
  - PCMH service costs: Includes any costs incurred statewide and/or by PCMH practices implementing the PCMH model.
  - Number of PCMH providers: Includes the number of practices and/or healthcare facilities operating as a PCMH within the state.
  - Effectiveness of PCMH funding: Includes evaluation of whether current federal, state, local and/or private funding adequately supports implementation of the PCMH model.
  - Healthcare costs savings: Includes any healthcare costs savings derived from implementing the PCMH model, including reduced emergency room visits, lower hospitalization rates and improved overall patient(s) health.
  - Impact on health outcomes: Includes the impact of PCMH use on health disparities and/or any research evaluating the difference in the health of patients before and after becoming a patient of a PCMH.
  - PCMH providers’ performance: Includes evaluation of the quality of care provided by PCMH practices as measured by specific performance standards, metrics, goals or other performance criteria.
  - Consumer satisfaction: Includes evaluation of patient’s satisfaction with the delivery of care under the PCMH model.
  - Local involvement: Includes evaluation of the level of outreach and/or integration of local governments, social service providers, advocacy groups and other local stakeholders when delivering care under the PCMH model.
  - Other: Coded where the type of information that is reported does not fall under one of the other response categories. Where coded, a caution note was provided.
  - No specific required information in the law: Coded where the law does not indicate any specific information that must be reported to the legislature.

Question: “Where may PCMH governing bodies seek funding for implementation?”
This question captures specific funding sources that the law indicates governing bodies may use to implement the PCMH model. Governing bodies include any of the PCMH advisory council type responses provided on pg. 6 for the question “What type of council(s) does the state have?” and the same terms used to identify the “state health agencies” and “local government agencies” responses provided on pg. 7 under the question “Who may be members of the council(s)?” Responses were further coded, consolidated and/or conceptualized as follows:

- Local governments: Includes any funds derived from the same terms used to identify the “local government agencies” response provided on pg. 7 under the question “Who may be members of the council(s)?”
- State government: Includes funds derived from any state government agency, fund or appropriation.
- Federal government: Includes funds derived from any federal government agency, fund or appropriation.
- Private donors: Includes funding from foundations, corporations, non-profits and other non-public sources.
- No sources of funding are specified in the law: Coded where the law does not include any funding sources that PCMH governing bodies may use for implementation.

VI. Quality Control

a. Quality Control – Background Research: States were redundantly researched for PCMH laws to ensure all relevant laws were collected for coding purposes. All redundant research was reviewed by the Supervisor and any missing laws were added to the collection of laws used to complete coding.

b. Quality Control – Coding:
   i. Redundant Coding: 49% of records from jurisdictions that recognized the PCMH model were redundantly coded by the Team throughout the development of the dataset (21 of 43 records with PCMH laws, 8 states had no laws related to PCMH of 51 total records coded). The Supervisor assigned 100% redundant coding of the first 10 jurisdictions on June 20, 2016. The rate of divergence was 17%. The Supervisor then assigned 33% redundant coding for the remaining 33 jurisdictions with PCMH laws (11 of 33) on August 26, 2016 and the rate of divergence fell to 7.6%. All divergences and caution notes were discussed and resolved by the Supervisor and Researchers. Divergences were then recoded to the agreed upon response.
ii. **Visual Data Inspection**: Following each round of coding, the Supervisor performed quality control by downloading all coding data into Microsoft Excel and examined the data for any missing answers, incorrect citations, and caution notes. Prior to publication, the Supervisor also downloaded all coding data into Microsoft Excel to do a final review of coding answers, statutory and regulatory citations and caution notes. All unnecessary caution notes were deleted and all necessary caution notes were edited for publication.