

Safety Net Medical Home Initiative

HEALTH REFORM AND THE PATIENT-CENTERED MEDICAL HOME: Policy Provisions and Expectations of the Patient Protection and Affordable Care Act

Introduction

In order for patient-centered medical home (PCMH) practice transformations to be sustainable, there must be payment reform to incentivize high-value, first-contact, primary care, and support medical home costs that are traditionally not reimbursed (e.g., non face-to-face encounters). This factsheet provides an overview of the recent health reform legislation and provides information on how this legislation will impact safety net providers, including new payment opportunities and support for innovation, access and care coordination. Together with [“Paying for the Medical Home: Payment Models to Support the Patient-Centered Medical Home in the Safety Net”](#) this publication serves as an introduction to a series of policy briefs focusing on payment reform opportunities to support and sustain the medical home.

The Patient Protection and Affordable Care Act

The Reconciliation Act of 2010 and the Patient Protection and Affordable Care Act (PPACA) are together considered the healthcare reform package and will be subsequently referred to as the “health reform law.” The law gives focus to the need for a strong primary care system to support the delivery of healthcare in the United States and has the potential to impact the delivery of healthcare and healthcare financing, now and in the future. It also lays the groundwork for payment reform, in part by supporting a wide range of primary care initiatives, including several provisions and demonstrations to support medical home transformation.

Policy Brief Issue 2

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The goal of the Safety Net Medical Home Initiative (SNMHI) is to help practices redesign their clinical and administrative systems to improve patient health by supporting effective and continuous relationships between patients and their care teams. In addition, the SNMHI seeks to sustain practice transformation by helping practices coordinate community resources and build capacity to advocate for improved reimbursement. The SNMHI is sponsored by The Commonwealth Fund and is administered by Qualis Health in partnership with the MacColl Center for Health Care Innovation at the Group Health Research Institute.



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Specifically, the law provides for increased FFS payments, expanded insurance access, expanded preventive care services, and provides support for a series of payment model demonstrations and pilot projects. Many of the payment models described in the separate policy brief on PCMH payment models ([link](#)) will be studied as demonstrations by the Center for Medicare and Medicaid Innovation (CMI), the new research and development arm of the Center for Medicare and Medicaid Services (CMS). These publically-sponsored demonstrations will augment our learning from the many private, multi-payer demonstrations taking place across the country.

The law can be broken down into three categories relevant to the Patient-Centered Medical Home (PCMH) including support for innovation, new payment opportunities, and access and care coordination payment demonstrations. All references refer to provisions within the PPACA unless otherwise noted.

Support for Innovation

CMS will administer a number of demonstration projects promoting quality primary care. These include medical home demonstrations administered through the new CMS Center for Innovation, as well as changes in the health care law, which will support medical home concepts. There is a mix of provisions, including:

- Expanded access.
- Streamlined CHIP/Medicaid enrollment procedures.
- Expanded coverage for preventive services.
- Excluded cost-sharing for preventive services.
- Expanded care coordination efforts.
- Increased mandatory funding to CHCs over five years.
- Increased support for primary care workforce development.
- Increased insurance benefits that require mental health and substance abuse treatment services.
- Expanded support for mental health and substance abuse disorders (screening, brief intervention, referral) in a primary care setting.
- Medicaid emergency psychiatric demonstration project.
- Medicaid quality measures reporting and comparative outcomes research.
- Established Center for Medicare and Medicaid Innovation (CMI) charged with assessing payment reform models.
- Payment and delivery system demonstration projects: bundled payment, global payment and “ACOs” (Accountable Care Organizations).



New Payment Opportunities

The payment reform components of the health care law are intended to improve quality and value and include increased FFS payment for primary care, enhanced support for preventive care, coverage and service expansion, workforce development and health center payment protections and improvements.

Increased Fee for Service Payment for Primary Care

- Increases the Medicaid and Medicare payment rate by 10% to primary care practitioners for primary care services, effective FY 2011-2016 (Section 5501).
- Requires that Medicaid payment rates to primary care physicians for furnishing primary care services be no less than 100% of the Medicare payment rates in 2013 and 2014 (Reconciliation Act, 1202).
- Provides 100% federal funding for the incremental costs to the states of meeting this Medicaid requirement (Reconciliation Act, 1202).

Enhanced Support for Preventive Care

- Improving access to preventive services in Medicaid and Medicare including (Sections 4104-6):
 - Any clinical preventive service recommended with a grade A or B by the U.S. Preventive Services Task Force (USPSTF).
 - Adult immunizations recommended by the Advisory Committee on Immunization Practices (ACIP).
- Incentives for chronic disease prevention for Medicaid beneficiaries (Section 4108).

Health Center Payment Protections and Improvements

Private insurers that offer plans through the new health insurance exchanges:

- must contract with health centers; and
- cannot pay less than the Medicaid PPS rate.

Coverage and Service Expansion

Medicaid will be expanded to all citizens under age 65 with incomes of up to 133% of the federal poverty level (FPL) in FY 2014 (Section 2001). This change will result in coverage for approximately 16 million Americans who were previously uninsured.

Health centers are projected to serve a total of 40 million patients in the next 5 years.

- \$11 Billion in new funding over 5 years for Health Center Program Expansion beginning in FY 2011.
 - \$9.5 billion to expand operational capacity:
 - Operations funds may be used for base grant adjustments; expanded medical capacity and service expansions (oral, behavioral, and pharmacy); new access points, including new starts and new sites; and enabling services.
 - \$1.5 billion will be allocated to allow health centers to expand and improve existing facilities and construct new sites.

Workforce Development

The PPACA reauthorizes and expands workforce education and training programs under title VII and VIII of the Public Health Service Act.

- \$1.5 billion of new dedicated funding for the National Health Service Corps to place an estimated 15,000 primary care providers (including medical, nursing, and dental providers) in healthcare provider shortage areas (HPSAs).
- National Health Service Corps members may count up to 50% of their time spent teaching towards their service obligation.
- Authorizes the development of residency programs at health centers and provides payments to community-based entities (CHCs) that operate teaching programs (Section 5508).

Access and Care Coordination Payment Demonstrations

Payment Delivery

- ACOs: ACOs manage the full continuum of patient care and will share in the cost-savings they achieve for Medicare and Medicaid programs.
 - A five-year Medicaid pediatric demonstration with incentive payments based on quality and shared savings (Section 2706).
 - Medicare providers will be eligible for an ACO demonstration, provided they serve a minimum of 5,000 Medicare beneficiaries and will share in the savings they accrue for the Medicare program (Section 3022).
- The CMS Innovation Center (CMI) has been charged with testing innovative payment and service delivery models. Successful models can be expanded nationally (Section 3021).
 - Global Payment: Up to five states can create a global, capitated, bundled payment system for a large safety-net hospital system to evaluate changes in health care spending and outcomes, including continuing care hospitals (Section 2705).
 - Bundled Payments: The CMS Innovations Center would establish a bundled payment demonstration project under Medicaid in up to 8 states for a Medicaid beneficiary (Section 2704):
 - For an episode of care that includes a hospitalization.
 - For concurrent physicians services provided during a hospitalization.
- Medicaid State Plan Option with enhanced FMAP to promote health homes and integrated care. Enrollees with two chronic conditions, or one chronic condition and risk of a second, can designate a qualified health provider as their health home. Services include comprehensive care management, care coordination and health promotion, comprehensive transitional care and community and social support services (Section 2703):
 - Requires hospitals to establish procedures to refer eligible individuals with chronic conditions to designated providers;
 - Includes a methodology for tracking avoidable hospital readmissions and cost savings realized from improved chronic care coordination; and
 - Includes a proposal for use of health information technology in providing home health services.
- Community health teams to support the development of medical homes for persons with chronic conditions by increasing access to comprehensive, community-based, coordinated care (Section 3502).
- Grants for medication therapy management (MTM) services provided by licensed pharmacists as part of a collaborative approach to the treatment of chronic diseases (Section 3503).
- Grants for a consortium of health care providers under a joint governance structure to create Community Based Collaborative Care Networks comprised of a hospital and an FQHC (where available) to provide comprehensive coordinated and integrated health care services for low-income populations (Section 10333). Grant funds may be used to:
 - Assist low-income individuals to enroll in health coverage programs, obtain a primary care provider and access health services;
 - Provide case management and care management;
 - Perform health outreach using neighborhood health workers;
 - Provide transportation;
 - Expand capacity through telehealth, after hours services or urgent care; and
 - Provide direct patient care services.

Data Reporting

To support quality improvement for Medicaid patients and providers, the health reform law directs the Secretary to:

- Identify a set of recommended adult quality health measures for Medicaid-eligible adults and establish a Medicaid Quality Measurement Program (Section 2701).
- Data collection and other public reporting requirements (Sections 3015, 10305).

In order to respond to these new opportunities, Health Centers should:

1. Develop medical home capabilities.
2. Prepare for changes in patient insurance status.
3. Pursue the Medicaid medical home state option for enrollees with two chronic conditions.
4. Pursue grants to establish community health teams supported by capitated payments to qualified providers.
5. Consider strategies for accepting global payment and forming or operating within an ACO.

What Should Health Centers Do to Respond to New Opportunities Related to the Medical Home?

- 1. Develop, demonstrate, and sustain medical home capabilities.** CHCs need to develop and demonstrate their medical home capabilities as other primary care practices begin to do so. Public and private payers will expect it, and strong performance will become important as payment systems become more performance-based.
- 2. Prepare for changes in patient insurance status.** Not only will Medicaid and other payers look for medical home capabilities from their contracted primary care practices, but they will need more capacity as Medicaid enrollment increases, quite dramatically in many states. In addition, people will be buying coverage through new health exchanges. As a result of these changes, CHCs will need to a) grow their medical home capacity, b) be a part of a sufficient number of health plan networks to gain access to those enrolling through exchanges, and c) prepare for changes in the source and composition of their funding stream.
- 3. Encourage and support state efforts to pursue the Medicaid medical home state option for enrollees with two chronic conditions.** States will find this opportunity, Section 2703, to be attractive as it offers 90% match for the first 8 calendar quarters. With many states interested in medical homes but lacking budget funds to support enhanced payments, this presents an opportunity to implement and evaluate a pilot at community health centers and other high-volume Medicaid providers at relatively modest cost to the state. States with existing medical home initiatives will also want explore the opportunity. There are restrictions however, including eligibility being limited to beneficiaries with at least two chronic conditions, or one chronic condition and at risk of a second, or one serious and persistent mental health condition.
- 4. Encourage and support state efforts to pursue grants to establish community health teams supported by capitated payments to qualified providers.** This grant opportunity, contained in Section 3502, is based on a model employed in Vermont as part of its medical home initiative, the Blueprint for Health. The law states that the teams shall be community-based, interdisciplinary teams, which may include medical specialists, nurses, nutritionists, dieticians, social workers, and physician assistants, to support primary care practices, within the hospital service areas served by the eligible entity. Community health centers are well-positioned to assume this role. CHCs should study the Vermont model to gain familiarity with one application of the concept, and develop proposals to bring to their state Medicaid and/or public health agencies.
- 5. Consider strategies for accepting global payment and forming or operating within an ACO.** Many believe that ACOs must have medical homes as their foundation in order to succeed, and CHCs are potentially well-positioned to serve as that foundation. Hospitals and physicians are furiously affiliating and planning their strategies to form ACOs and to contract under shared savings or global payment arrangements. Much of this is anticipatory activity, in advance of Medicare's testing of these models. While it is unclear at what pace these changes will take hold, CHCs should anticipate that Medicaid programs are likely to follow the lead of Medicare and commercial payers. CHCs do not want to be the last providers to plan for these possible changes.

Impact Discussion

The newly created Center for Medicare and Medicaid Innovation gives the Secretary of Health and Human Services authority to test models that promote broad payment and practice reform within Medicare, Medicaid, and Children's Health Insurance Program (CHIP). The Secretary is directed to give preference to models that promote coordination, quality, and efficiency, and to consider models that support reimbursement reform away from FFS payment and toward a comprehensive payment model. Projects under the new center have substantial funding and do not require the Secretary to obtain further legislative approval to implement successful aspects of the demonstration. The Secretary is authorized to extend successful payment models to providers who voluntarily choose to be paid by the new method instead of the FFS models. Further, under the Center for Innovation, projects are not required to be budget neutral.

While the new health reform law provides expanded access to health care and new methods of payment, however, many of the policy provisions won't go into effect until 2014. Health centers have already experienced dramatic growth in the last year and ensuring adequate reimbursement for services will remain critically important during the transition period. The health reform bill requires new insurance products to include FQHCs in their provider network and aligns health center payment across private insurance plans with Medicaid payments to ensure that the new exchange-based insurance plans will not underpay FQHCs.

The law provides the largest increase in FQHC funding since its inception. The additional operating funds can support expanded operating hours or an increased number of clinics or programs. Additionally, the health reform bill adds preventive services to the FQHC Medicare payment rate and eliminates the Medicare payment cap on FQHCs. Historically, FQHC caps were designed as a mechanism to control health care costs by establishing a per-visit payment limit or cap. Currently, over 75% of FQHCs serving Medicare beneficiaries are at or exceed the payment cap, which results in a net loss for the FQHC. FQHCs have been using funds intended to cover the uninsured and other revenue streams to make up for their Medicare shortfalls. The health reform law will eliminate these caps.

FQHCs also will see a change in Medicare payment due to the pending implementation of the FQHC Prospective Payment System (PPS). Currently, FQHCs are reimbursed on a reasonable cost basis, with a per visit limit. The new PPS will eliminate the Medicare FQHC all-inclusive payment rate, upper payment limits, and productivity guidelines. Under the new PPS, FQHC payment rates will be based on estimated reasonable costs for services. The PPS is required to include a process for describing FQHC services, and establish payment rates for specific payment codes based on descriptions of services including type, intensity, and duration of services (Section 4105). The new PPS methodology will be implemented in 2014, but the Secretary may require FQHCs to submit information deemed necessary to develop in the PPS, including submitting HCPCS codes. Across practices participating in the Safety Net Medical Home Initiative, an estimated 12% of patients are covered under Medicare. This estimate varies by region, ranging from 8% in Massachusetts to 18% in Idaho.

While it is difficult to predict how the law will impact the entire health system, it is possible to identify some infrastructure support for a change in payment. The health reform bill includes increased primary care funds, support for care coordination team grants, and medical home demonstrations to support medical system transformation. The legislation also includes demonstrations to test new payment models beyond FFS.

Health Reform Law Timeline Related to Medical Home Provisions⁷

2010

- Pediatric Medicaid ACO demonstration initiated.
- Medication management demonstration targeted for patients with multiple chronic illnesses established.
- High-risk pool to provide health coverage for individuals with pre-existing medical conditions launched.
- Private new group and individual health plans to cover certain preventive services and immunizations without cost-sharing required.
- Dependent coverage for children up to age 26 in all individual and group policies established.
- Payment protections for rural low-volume Medicare providers extended.
- Medicaid state early expansion option scaling up to 133% of FPL initiated.

2011

- CMS Innovation Center to test innovative payment and service delivery models with a focus on reducing cost and improving quality launched.
- Medicaid medical home state option with enhanced FMAP where enrollees with two or more chronic conditions can designate a health home established.
- Community Collaborative Care Network established.
- Increased funding for state demonstration programs to evaluate alternative reform models over five years initiated.
- Medicare wellness and preventive care services covered.
- Preventive services and elimination of cost-sharing in Medicaid enacted.
- Increased reimbursement for Medicare with 10% bonus payment for primary care physicians and general surgeons initiated.

2012

- Medicare ACO medical home demonstration with physician and nurse practitioner directed home-based primary care teams incentive payment based on shared savings launched.
- Hospital value-based purchasing program to incentivize enhanced quality outcomes for acute care hospitals established.

2013

- Incentives for state Medicaid to cover evidence-based preventive services without cost-sharing enacted.
- Public reporting of physician performance enacted.
- Qualified health plans required to offer essential health benefits package.
- States that eliminate cost-sharing for recommended preventive services and immunizations are eligible to receive a 1% increase in their FMAP for those services.
- National pilot on payment bundling to increase collaboration and improve coordination of care enacted.
- Medicaid primary care payment rate increased to Medicare rate.
- Community health teams demonstration enacted.

2014

- Medicaid expanded to all individuals under age 65 with incomes up to 133% of FPL.
- Exclusions based on pre-existing conditions prohibited.
- Discrimination based on health status prohibited.
- Individuals required to carry health insurance.

2015

- Physician Quality Reporting Initiative penalties are implemented at 1.5 % in 2015 and 2% in 2016 and beyond.

Glossary

ACOs

Accountable Care Organizations (ACOs) will be comprised of providers who voluntarily meet specified criteria, including reporting quality measures. ACOs will share in or fully retain the cost-savings they achieve for Medicare and Medicaid programs depending on the adopted payment model. ACOs are expected to manage the full continuum of patient care and are held accountable for overall costs and quality of care for a defined population. ACOs may be comprised of a variety of networks, from large integrated delivery systems to physician-led hospital groups, multispecialty practice groups, group physician practices or health center networks. ACOs may receive bundled or global payments for services, or contract on a shared savings basis.

Bundled Payments

Bundled payments occur at the chronic care condition or episode of care level. They make a single payment for all services related to a treatment or condition, potentially spanning multiple providers in multiple settings and may be adjusted for case severity. Providers assume financial risk for the cost of services associated with a particular condition or treatment as well as costs associated with preventable complications, but not for the occurrence of the medical conditions (insurance risk). Bundled payment supports coordination of care by sharing payment for treatment/ condition across multiple providers in multiple settings. Financial risk is mitigated by reinsurance or other ways to limit or cap risk. Bundled payments are seen as the middle ground between fee for service and global payment for all services.

Global Payment

Global payments, or capitation, bundle the payment at the patient level and are fixed dollar payments for the care received during a time period (month, year). Partial global payments cover primary care and/or specialty services. Full global payments cover primary, specialty, hospital, and other covered services. Global payments place providers at some risk for the occurrence of medical conditions (insurance risk) as well as management of occurring conditions (clinical risk). Providers are protected from the total insurance risk by risk adjustment of payments, reinsurance and other models which limit or cap risk. Global payments are designed to contain costs, encourage integration and coordination and reduce unnecessary services. Global payments may include added incentives for improving the quality of care. Global payment systems can be administratively complex for providers and require additional infrastructure to help manage financial risk. The risk and administrative burden in global payment potentially excludes small provider groups or solo practitioners.

Shared Savings

Shared savings arrangements are similar to global payment arrangements, except that the provider entity bears no risk for financial losses should expenditures exceed what was budgeted or targeted. Also, rather than have the provider entity retain all of the savings that it might generate through its efforts, those savings are shared with the payer. The extent to which savings are shared is often dependent upon performance on metrics that can assess access, patient experience, clinical quality and/or efficiency. Finally, shared savings arrangements are more likely than global payment arrangements to exclude some services (e.g., mental health).

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The Safety Net Medical Home Initiative will provide updates on health reform and other policy initiatives pertinent to medical home transformation in the safety net. For updates and additional information, refer to: www.safetynetmedicalhome.org.

Resources

The following are websites and journal articles that provide more information health reform and the Patient-Centered Medical Home.

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Terms

ACO: Accountable care organization

FFS: Fee-for-service

P4P: Pay for performance

PMPM: Per member per month payment

PMPY: Per member per year payment

PPACA: Patient Protection and Affordable Care Act

PPS: Prospective payment system, a reimbursement mechanism where providers are paid a flat rate per case

PQRI: Physician Quality Reporting Initiative

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¹The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148 124 Stat. 119), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, 124 Stat. 1029). Federal Register. [click here](#). Accessed August, 2010.

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Safety Net Medical Home Initiative

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The objective of the Safety Net Medical Home Initiative is to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centered medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative is administered by Qualis Health and conducted in partnership with the MacColl Center for Health Care Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado, Idaho, Massachusetts, Oregon and Pittsburgh), representing 65 safety net practices across the U.S. For more information about the Safety Net Medical Home Initiative, refer to: www.safetynetmedicalhome.org.



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