

Health Quality and Cost Council Primary Care Medical Home Workgroup Maryland Health Care Commission

Presented by:

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NASHP

- 21 year old non-profit, non-partisan organization
- Academy members
 - Peer-selected group of state health policy leaders
 - No dues—commitment to identify needs and guide work
- Working together across states, branches and agencies to advance, accelerate and implement workable policy solutions that address major health issues

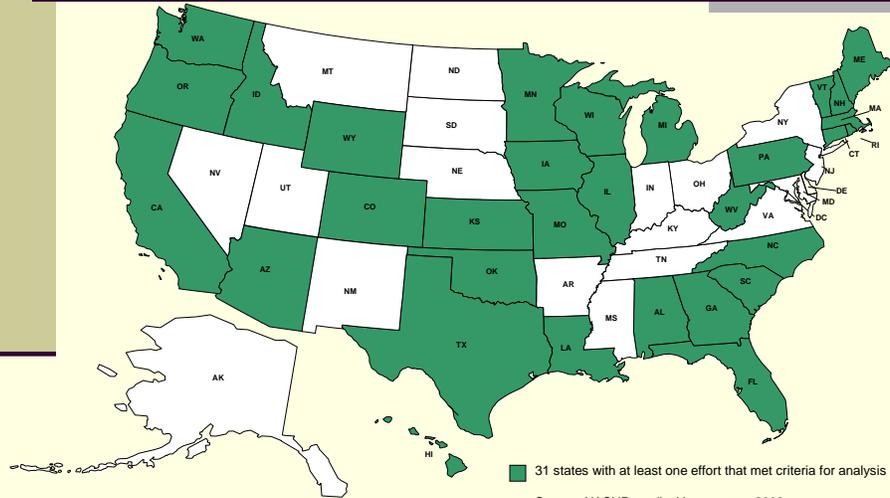
Advancing Medical Homes in State Medicaid and CHIP Programs

- One year project supported by The Commonwealth Fund
- Partnership between NASHP & Patient Centered Primary Care Collaborative (PCPCC)
- Focus on developing/disseminating state policy options and providing group technical assistance to states

Timing is right

- Creation of PCPCC: private sector resolve
- Burgeoning Medicaid budgets
- Groundwork has been laid in states
- New tools to recognize medical homes
- Opportunities to drive system change in state health benefits plans and private sector
- 15 states are considering health care reform

Since 2006, most states have engaged in an effort to advance medical homes in Medicaid and CHIP



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Medicaid medical home efforts vary widely

- Some start with children—some with roots in CSHCN and EPSDT
- Many target high costs populations
- Vermont focuses on general population
- Many plan to go state-wide
- Most have legislative or Governor support
- Several use state plan amendments or Medicaid waivers
- All delivery systems: FFS, PCCM, MCO

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Five Areas of Activity

- Forming Key Partnerships
- Defining and Recognizing a Medical Home
- Purchasing and Reimbursement
- Support for Changing Practices
- Measuring Results

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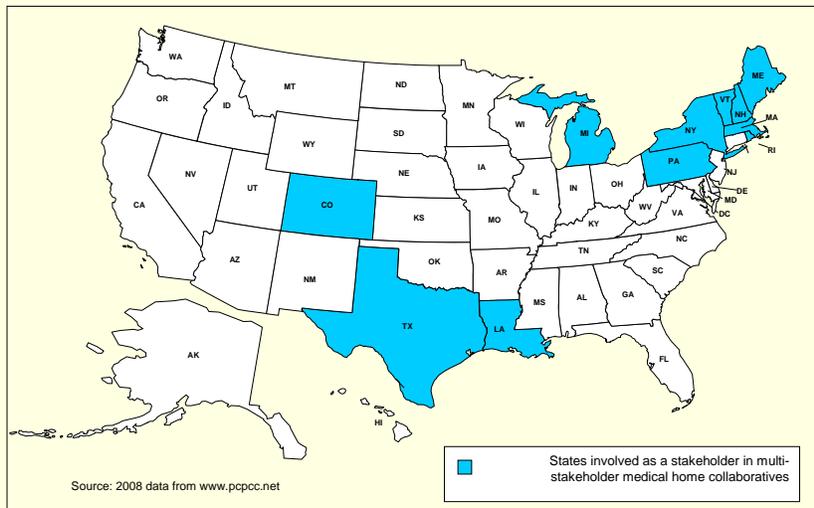
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Forming Key Partnerships



- Involving providers and consumers in planning
 - community health centers, Family Voices, AAFP
- Working with QI collaboratives
- Collaborating with other state agencies
 - DPH/Title V, DHS, Governor's Offices
- Partnering with other payers/purchasers
 - State and public employees: WA, OR
 - "All-in" via legislation: MN, OR, VT
 - Multi-payer medical home initiatives

States involved in multi-stakeholder medical home collaboratives



State-led multi-payer collaboratives

	Pennsylvania	Rhode Island	Vermont
Lead agency	Governor's Office of Health Care Reform	Office of Health Insurance Commissioner	Blueprint for Health of Department of Health
Authority	Executive Order	OHIC Statute	Legislation

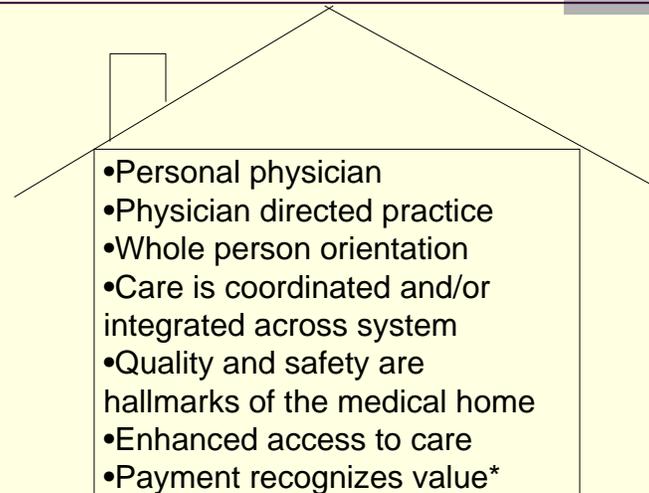
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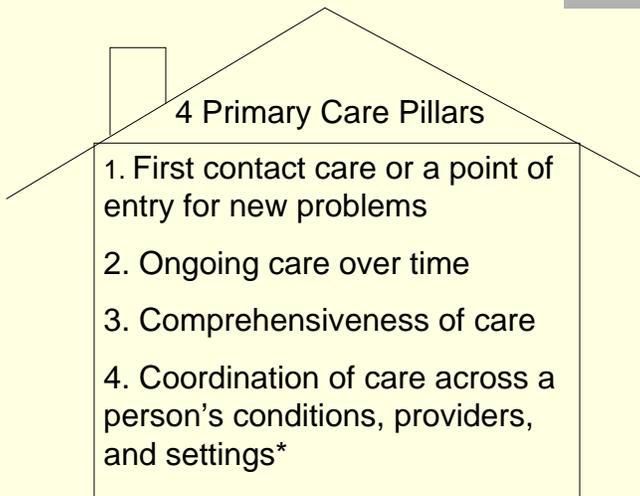
Defining a medical home: AAP

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- accessible
 - continuous
 - comprehensive
 - family centered
 - coordinated
 - compassionate
 - culturally effective*

Defining a medical home: Joint Principles

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- Personal physician
 - Physician directed practice
 - Whole person orientation
 - Care is coordinated and/or integrated across system
 - Quality and safety are hallmarks of the medical home
 - Enhanced access to care
 - Payment recognizes value*

Defining a medical home: variety of approaches; all reflect core values



Recognizing Medical Homes

- NCQA/PPC-PCMH: CO (adults), LA, NH, PA, RI, VT
- Colorado (adults) PCPs: NCQA or annual Medicaid certification
- OR to use Common Measures
- Minnesota's proposed criteria include:
 - Learning collaborative
 - Registry for population management
 - Updated care plans
 - Patient/parent on care teams
- Oklahoma PCPs use self audit to place in 1 of 3 tiers
- Provider & beneficiary handbooks (NC, AL)

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Themes in payment policies



- Most pay FFS + PMPM
- Many have or are developing P4P
- Five considering multiple structures, capitation, global fees, risk adjustment (LA, MN, NH, OR, WA)
- Use Medicaid managed care plans to increase access to medical homes (CO, OR, MN)
- Many are considering consumer incentives

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Support for Changing Practices

- Provider adoption of good practices
 - Learning collaboratives for practices
 - Practice coaches / TA
 - Registry or EHR
- \$ / TA for HIT/HIE
- Info to providers about their performance and patient needs/ utilization
- Support patients with self-management tools

Care Coordination



- RI and VT multi-stakeholder provides practices with on-site care coordinators
- NC and VT link on site care coordinators with community/public health resources
- CO (children) uses EPSDT Outreach and Case Management staff
- OK Medicaid Care Management Department uses RNs & LPNs for complex cases

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Measures under consideration

- Louisiana
 - HEDIS
 - Hospitalizations rates for ambulatory care sensitive conditions
- New Hampshire
 - Practice level structure and process measures, consistent with Medicare's (PQRI) program
- Washington
 - PCP ability: structural measures/adherence to clinical practice guidelines
 - Utilization measures: ED/hospitalizations for ambulatory care sensitive conditions
 - Patient experience: parent & patient surveys

Three state-led multi-stakeholder pilot evaluations

Pennsylvania	Rhode Island	Vermont
■ Engaged providers	■ NCQA score	■ NCQA score
■ Health status	■ Health outcomes	■ Health status
■ Costs	■ Costs	■ Costs
■ Clinical quality of care	■ Clinical quality of care	■ Clinical quality of care
■ Provider satisfaction	■ Patient experience	
■ Pt self-care knowledge		

For More Information

E-mail mtakach@nashp.org

Check www.nashp.org

this spring for the following publications:

Report of: ***The Role of FQHCs in State-led Multi-payer Medical Home Collaboratives****

Report of: ***Building Medical Homes Through State Medicaid and SCHIP Programs*****

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