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

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National Academy for State Health Policy
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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

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
Five Areas of Activity

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

Source: 2008 data from www.pcpcc.net
### State-led multi-payer collaboratives

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<th>Pennsylvania</th>
<th>Rhode Island</th>
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<tr>
<td>Lead agency</td>
<td>Governor’s Office of Health Care Reform</td>
<td>Office of Health Insurance Commissioner</td>
<td>Blueprint for Health of Department of Health</td>
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<td>Authority</td>
<td>Executive Order</td>
<td>OHIC Statute</td>
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### Five Areas of Activity

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Defining a medical home: AAP

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

Defining a medical home: Joint Principles

- 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*

*www.aap.org
*www.pcpcc.net/content/joint-principles-patient-centered-medical-home
Defining a medical home: variety of approaches; all reflect core values

1. First contact care or a point of entry for new problems
2. Ongoing care over time
3. Comprehensiveness of care
4. Coordination of care across a person’s conditions, providers, and settings*

*Barbara Starfield and Leiyu Shi

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

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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**

*Work is funded through a National Cooperative Agreement with the federal HRSA Bureau of Primary Health Care

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