Exploring the Patient Centered Medical Home

Arizona Association of Community Health Centers Annual Meeting

February 9, 2011

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National Academy for State Health Policy
NASHP

- 24-year-old non-profit, non-partisan organization
- Offices in Portland, Maine and Washington, D.C.
- 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
NASHP Medical Home Projects

- The Commonwealth Fund: Advancing Medical Homes in Medicaid
  - Round I 2007-2009 (CO, ID, LA, MN, NH, OK, OR, WA)
  - Round II 2009-2010 (AL, IA, KS, MD, MT NE, TX, VA)
  - Round III 2011-2012 (RFA released 1/2011)

- Office of the Assistant Secretary for Planning & Evaluation in the US Department HHS
  - With RTI, evaluation design for Medicaid State Plan Option for Chronically Ill Health Homes (Section 2703 Affordable Care Act)

- Federal HRSA Bureau of Primary Health Care
  - Informing state policymaking as it affects health centers through a National Cooperative Agreement

- Federal HRSA Maternal Child Health Bureau
  - Coordinating medical home policies between State Title V & Medicaid
Presentation goals

- Describe how state policy makers are using the medical home model to transform primary care delivery systems
- Describe the roles that health centers & state primary care associations are playing in these efforts
- Discuss how federal health care reform might accelerate these efforts
# What’s so new about medical homes?

<table>
<thead>
<tr>
<th>Today’s Care</th>
<th>Health Care Homes</th>
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<tbody>
<tr>
<td>Patients are recipients of services by providers and clinics.</td>
<td>Patients and families are partners in the provision and planning of care.</td>
</tr>
<tr>
<td>My patients are those who make appointments to see me.</td>
<td>Our patients are those who have agreed to participate in our HCH and understand how to contact our HCH.</td>
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<td>Care is determined by today’s problem and time available today.</td>
<td>Proactive care planning is developed with the patient / family to anticipate patients needs.</td>
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<td>Care varies by memory or skill of the provider.</td>
<td>Care is standardized with evidence-based guidelines and planned visits.</td>
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<td>Patients are responsible to coordinate their own care.</td>
<td>A team, including the care coordinator, coordinates care with patients and families.</td>
</tr>
<tr>
<td>I know I deliver high quality care because I’m well trained.</td>
<td>We measure our quality and outcomes and make ongoing changes to improve it. We include patients / families in our quality work.</td>
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<tr>
<td>It’s up to the patient to tell us what happened to them.</td>
<td>We use a registry to track visits and tests and we do follow-up after ED visits and hospital admissions.</td>
</tr>
<tr>
<td>Clinical operations center on meeting the doctor’s needs.</td>
<td>A multidisciplinary team works at the top of our licenses to serve patients.</td>
</tr>
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Slide courtesy of Minnesota Department of Health/ Minnesota Department of Human Services
Since 2006, most states have new Medicaid or CHIP medical home initiatives

States with at least one effort that met criteria for analysis

SOURCE: NASHP analysis
Medicaid medical home efforts vary widely

- Some start with sub populations
- Most target high cost populations...
- ...then plan to go state-wide
- Most have legislative or Governor support
- Many have state funding, most do not
- 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

- Planning with providers & consumers
  - health centers, provider & consumer associations
- Working with QI collaboratives
- Collaborating with other state agencies
  - Public health/Title V, Mental Health, Governor’s Offices, legislators
- Partnering with foundations & universities
- Joining forces with other payers/purchasers
  - State & public employees
  - Multi-payer medical home initiatives
17 States are Participating (or Plan to Participate) in Multi-payer Initiatives
## Defining Medical Homes

### Joint Principles
- Colorado (adults)
- Idaho
- Louisiana*
- Maine
- Michigan
- New York
- Oklahoma*
- Pennsylvania
- Rhode Island
- Vermont

### State-grown definitions
- Colorado (children)
- Kansas
- Maryland
- Minnesota
- Montana
- Nebraska
- North Carolina
- Oregon
- Washington

*modified Joint Principles*
Recognizing medical homes

Why Recognize?

- Establishes concrete expectations for practices & patients
- Reassures payers that extra payment translates to extra services
- Reassures providers that improved care translates to improved payment
- Motivates medical practices to change
Recognizing Medical Homes

**NCQA PPC-PCMH**
- Colorado (adults)
- Iowa
- Louisiana
- Maine*
- Maryland*
- Massachusetts*
- Michigan**
- New York
- Pennsylvania*
- Rhode Island
- Vermont

*modified NCQA

**NCQA or BCBS

**State-grown standards**
- Colorado (children)
- Kansas
- Minnesota
- Nebraska
- North Carolina
- Oklahoma
- Oregon
- Texas
- Washington
Payments for ongoing medical home costs

- Monthly care management payments
  - Do all health centers receive monthly care management payments?
  - Can health centers receive payments to provide care management for other practices?

- Lump sum payments

- Enhanced Fee For Service payments for certain visits
Purchasing & Reimbursement

- Payments for ongoing medical home costs (cont.)
  - Payments for new visit codes (i.e. behavioral health and after hour visit codes)
    - Can health centers provide these services for other practices/patients?
    - Can health centers provide after hours care for other practices/patients?
  - Payments to community networks
    - Can a health center be a community network?
- Payment incentives for performance
  - Are health centers able to take on risk?
- Managed care contracts
Support for Changing Practices

- **Provider adoption of good practices**
  - Learning collaboratives
  - Practice coaches/on-site technical assistance
  - Conference calls/check-ins

- **Info to providers on performance/patients**

- **$$ / technical assistance for HIT/HIE**
  - Registry, EHR, eRx

- **Care coordination**
  - Practice-based: PA, MN, RI, VT
  - Community-based: MT, NC, OK, VT
  - State-based: CO, OK
  - Patient/family-based: ME, MN, NE
# Measuring results

## Outcomes of interests in a few multi-payer pilots

<table>
<thead>
<tr>
<th>Pennsylvania</th>
<th>Rhode Island</th>
<th>Vermont</th>
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<tbody>
<tr>
<td>Engaged providers</td>
<td>NCQA score</td>
<td>NCQA score</td>
</tr>
<tr>
<td>Health status</td>
<td>Health outcomes</td>
<td>Health status</td>
</tr>
<tr>
<td>Costs</td>
<td>Costs</td>
<td>Costs</td>
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<tr>
<td>Clinical quality of care</td>
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<tr>
<td>Provider satisfaction</td>
<td>Patient experience</td>
<td></td>
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<td>Pt self-care knowledge</td>
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2014 is tomorrow
If you build it (medical home system),

1. **Increase primary care payments**
   - Section 1202 (Reconciliation Bill): Increased Primary Care Medicaid Reimbursement for Primary Care Providers
   - Section 4106: Improving access to preventive services for eligible adults in Medicaid
   - Section 5501: Increased Primary Care Medicare Reimbursement for Primary Care Providers
   - Section 5502. Medicare FQHC Improvements

2. **Increase system capacity**
   - Section 4101. $50 million School Based Health Clinics
   - Section 5507. $425 million Health Workforce Demonstrations
   - Section 5508. $230 million Teaching Health Centers for primary care residency programs
   - Section 10503. $11 billion CHC & NHSC Fund
3. Provide better infrastructure support
   - Section 3502: Community Health Teams
   - Section 5405: Primary Care Extension Program

4. Provide new models of care
   - Section 2703: State Option to Provide Health Homes for Enrollees with Chronic Conditions
   - Section 2706. Pediatric ACO Demonstration Project
   - Section 3021: $10 billion Center for Medicare and Medicaid Innovation in CMS
   - Section 4108. $100 million Incentives for Prevention of Chronic Disease in Medicaid
Other sources of funding to build your “dream home”

- Federal ARRA funding
  - Meaningful use & PCMH standards
- Public/private partnerships:
  - Multi-payer initiatives: Medicare Multi-payer Advanced Primary Care (APC) demo
  - Foundation grants
  - Pharma, commercial plans, provider associations
- Federal FQHC APC demo
Opportunities for health centers

- Federal support is unprecedented
- Partner! Partner!
- Do your homework. Know your state, know other states
  - [http://www.nashp.org/med-home-map](http://www.nashp.org/med-home-map)
- Go big: Align operations with PCMH goals
- Go bigger: Break down walls
- Go biggest: Break down ceiling
- Partner! Partner!
For More Information on Medical Homes....

- Please visit: www.nashp.org
- www.pcpcc.net

- Contact: mtakach@nashp.org