

Advancing Medical Homes in Medicaid and SCHIP

Presented by:

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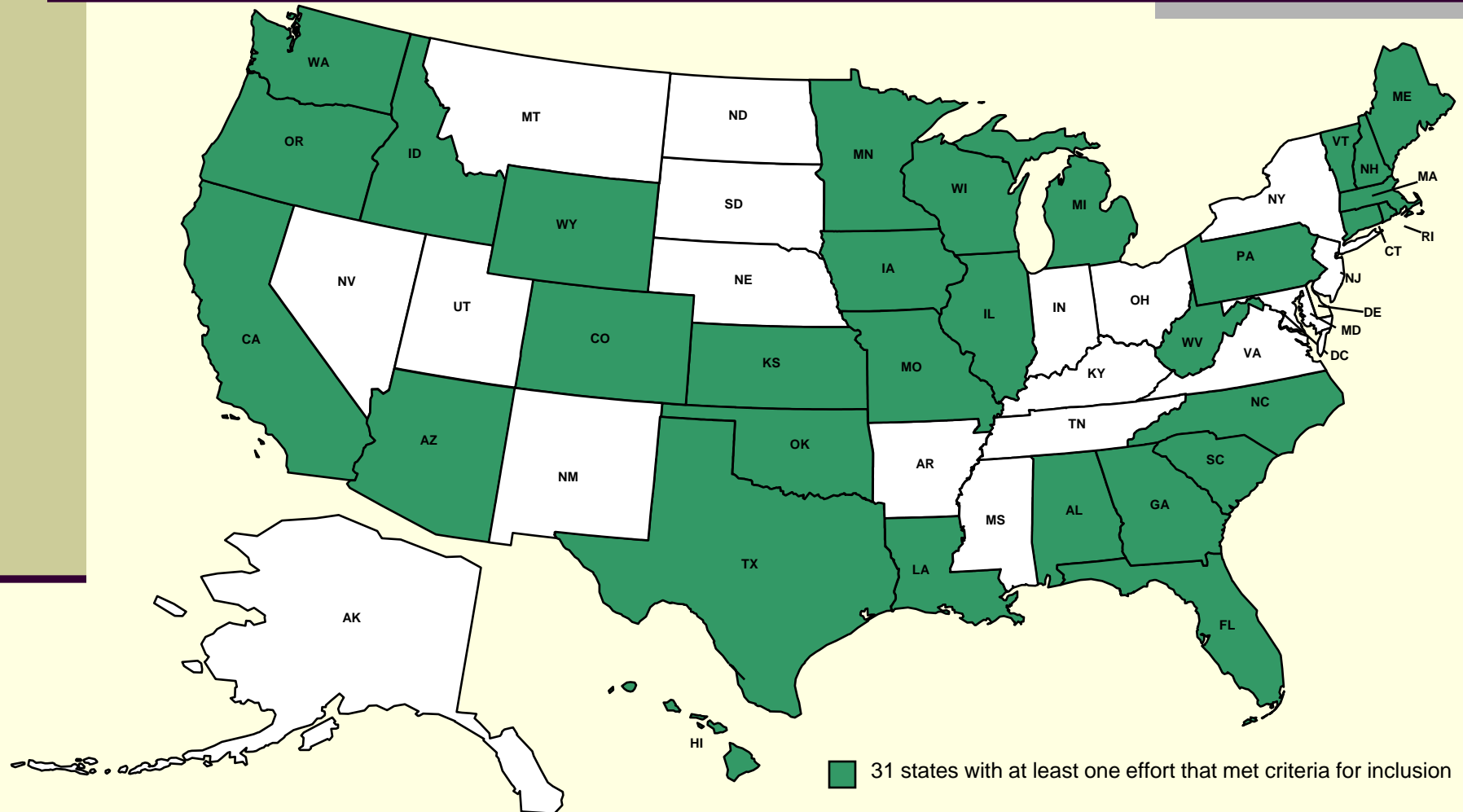
NASHP

- 22 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

Sources of Information

- 50 state scan
 - E-mail
 - Internet
 - State listserve
- Detailed information from selected states
 - State Summit faculty/advisors and participants: CO, ID, LA, MN, NC, NH, OK, OR, PA, RI, WA
 - Pre- and Post- Summit survey
 - Post-Summit conference call
 - Review of draft paper

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



Source: NASHP medical home scan, 2008

Medicaid medical home efforts vary widely

- Most start with sub-populations
 - Children: roots in CSHCN and EPSDT
 - Complex adults or children
- Some plan to go state-wide: “All in”
- Most have legislative or governor support
- Several use state plan amendments or Medicaid waivers
- All delivery systems: FFS, PCCM, MCO

Five Strategies for States

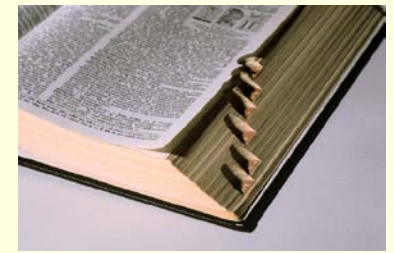
- Forming Key Partnerships
- Defining and Recognizing a Medical Home
- Purchasing and Reimbursement
- Support for Changing Practices
- Measuring Results

Forming Key Partnerships



- Involving providers and consumers
 - Community health centers, provider associations, Family Voices
- 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
 - Multi-payer medical home initiatives

Defining Medical Homes



- PCMH Joint Principles
 - personal physician, physician directed, whole person, coordinated / integrated care, quality focus, enhanced access, payment recognizes value
 - CO (adults), ID, LA, NH, PA, OK, RI
- State-developed
 - CO (children), MN, NC, OR, WA

Recognizing Medical Homes



- NCQA/PPC-PCMH: CO (adults), LA, NH, RI
- State-developed process: CO (child), MN, NC, OK, OR, WA
 - Colorado PCPs: NCQA *or* annual Medicaid certification
 - Minnesota's 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

Purchasing & Reimbursement



- Two major reimbursement models for ‘medical home administration’
 - Fee-for-service + separate administration payment (PMPM or lump sum): ID, NH, NC, OK, RI, others
 - Enhanced visit rates for certain visits: MN, CO (children)
 - Both often vary based on patient or practice characteristics
 - Both often come with performance requirements

- Other innovations
 - Pay for performance/shared savings
 - Managed care purchasing process
 - Consumer incentives

Support for Changing Practices



- Within practices
 - First contact care
 - Team-based care
 - Information to support provision of care and change
 - On-site technical assistance
- Wrap-around practices
 - Payment to networks that support practices: NC, OK
 - Off-site care coordination staff: CO, OK
 - HIT: HIE, registries, EHR, eRx: CO, ID, PA, LA
- Patient support
 - Increasing patient knowledge, expectations, and engagement: LA, RI, WA
 - Patient incentives: LA, others considering
 - Personal Health Records: WA



Measuring results

- Louisiana
 - HEDIS
 - ED/hospitalizations rates for ambulatory care sensitive conditions
- New Hampshire
 - Measures consistent with Medicare's (PQRI) program
- Washington
 - PCP ability: structural measures/adherence to clinical practice guidelines
 - ED/hospitalizations for ambulatory care sensitive conditions
 - Patient experience: parent & patient surveys
- Multi-payer pilots (PA, RI, VT)
 - Clinical outcomes
 - Costs
 - NCQA score
 - Patient/provider satisfaction

For More Information

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Building Medical Homes in State Medicaid and SCHIP Programs

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