

# Reinventing Medicaid Through Medical Homes

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**Legislative Health And Human Services Committee**

**Silver City, New Mexico**

**August 17, 2011**

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Program Director

National Academy for State Health Policy

# NASHP

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- ❖ 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

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- ❖ 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 (AL, CO, MD, MA, MI, MN, **NM**, NY, NC, OK, OR, RI, VT, WA)
  
- ❖ Centers for Medicare and Medicaid Services
  - With RTI, evaluation for the multi-payer Medicare Advanced Primary Care Practice Demonstration
  
- ❖ Office of the Assistant Secretary for Planning & Evaluation in the US Department HHS
  - With RTI, evaluation design for *ACA Sec. 2703* Medicaid State Plan Option for Chronically Ill Health Homes

# Presentation goals

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- Briefly describe the role of primary care in our health system and Medicaid
- Discuss the role of medical homes in changing Medicaid's delivery of primary care
- Highlight resources that may help you reinvent your Medicaid primary care delivery system

# US Healthcare System Falls Behind

Country Rankings	
	1.00-2.33
	2.34-4.66
	4.67-7.00



	AUS	CAN	GER	NETH	NZ	UK	US
OVERALL RANKING (2010)	3	6	4	1	5	2	7
Quality Care	4	7	5	2	1	3	6
Effective Care	2	7	6	3	5	1	4
Safe Care	6	5	3	1	4	2	7
Coordinated Care	4	5	7	2	1	3	6
Patient-Centered Care	2	5	3	6	1	7	4
Access	6.5	5	3	1	4	2	6.5
Cost-Related Problem	6	3.5	3.5	2	5	1	7
Timeliness of Care	6	7	2	1	3	4	5
Efficiency	2	6	5	3	4	1	7
Equity	4	5	3	1	6	2	7
Long, Healthy, Productive Lives	1	2	3	4	5	6	7
Health Expenditures/Capita, 2007	\$3,357	\$3,895	\$3,588	\$3,837*	\$2,454	\$2,992	\$7,290

Note: \* Estimate. Expenditures shown in \$US PPP (purchasing power parity).

Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, OECD Health Data, 2009 (Paris: OECD, Nov. 2009).

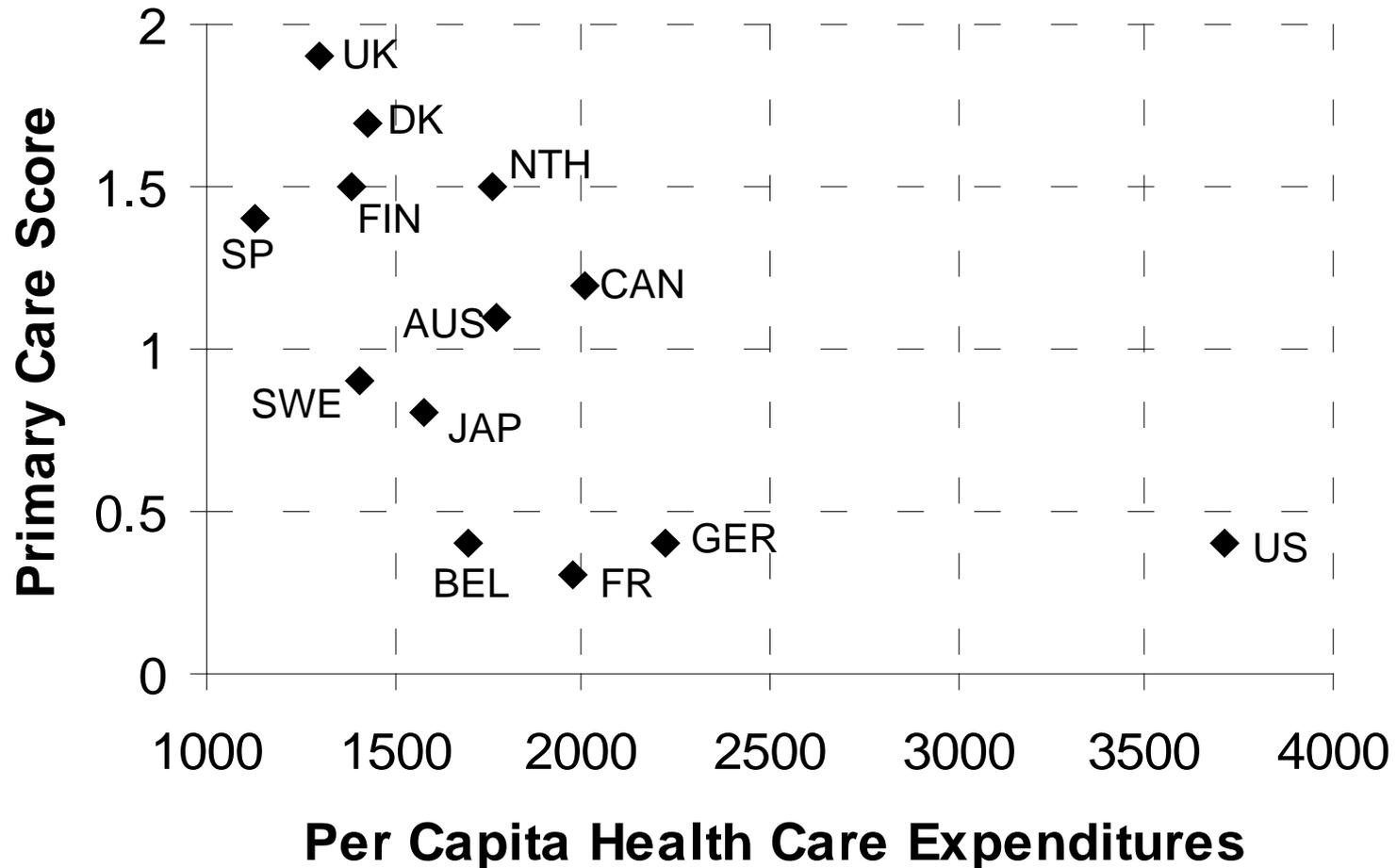
Source: Karen Davis et al. *Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally 2010 Update*. The Commonwealth Fund. June 2010.

# What we already know about primary care

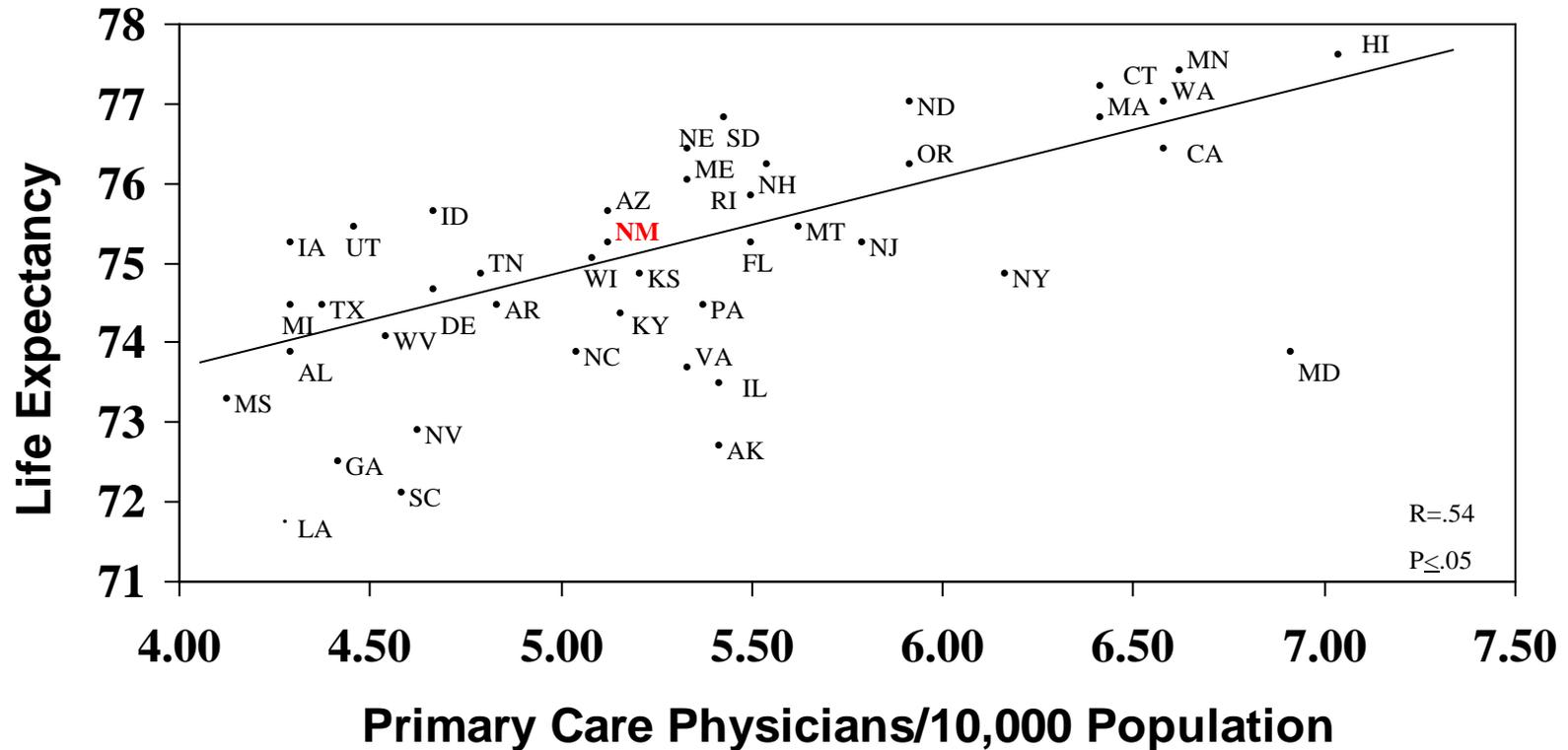
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- ❖ Primary care oriented systems:
  - Improve health (improving effectiveness)
  - Keep costs manageable (improving efficiency)
  - Reduces racial disparities

# Primary Care Score vs. Health Care Expenditures, 1997



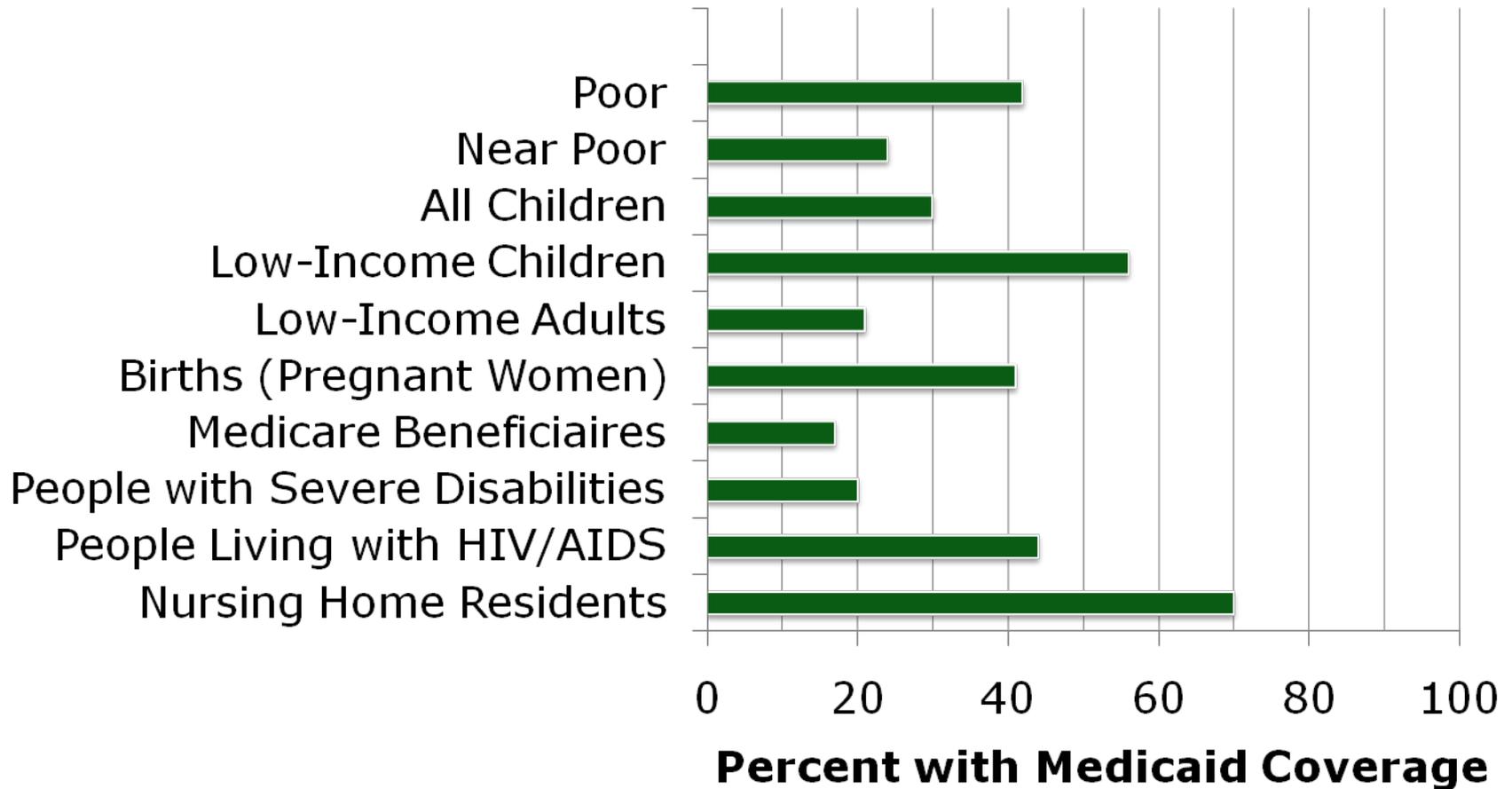
# State Level Analysis: Primary Care and Life Expectancy



Slide Source: Dr. Barbara Starfield; Presentation at the Blekinge Conference; Ronneby, Sweden; September 19, 2007

Data Source: Shi et al, J Fam Pract 1999; 48:275-84.

# What is the role of Medicaid?



**Source:** Kaiser Family Foundation. *Medicaid: A Primer*. June 2010. Report #7334-04. Available at: <http://kff.org/medicaid/upload/7334-04.pdf>

# Why is Medicaid so costly?

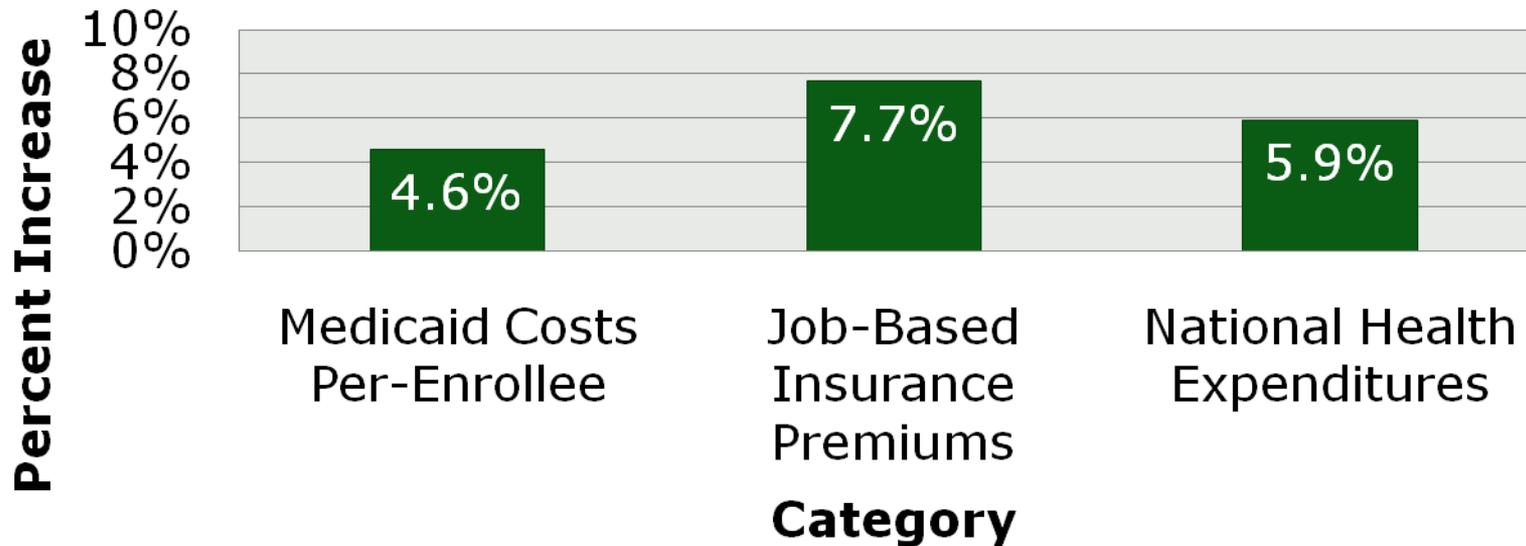
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- ❖ Enrollment is the main driver of Medicaid spending.
- ❖ Medicaid spending is concentrated in a small group of high-need beneficiaries.
- ❖ Health care cost inflation system-wide also affects Medicaid.

**Source:** Kaiser Family Foundation. *Medicaid Matters: Understanding Medicaid's Role in Our Health Care System*. March 2011. Publication#8165. Available at:  
<http://www.kff.org/medicaid/upload/8165.pdf>

# Closer look at inflation

## Increase in Health Care Costs Over the Last Decade

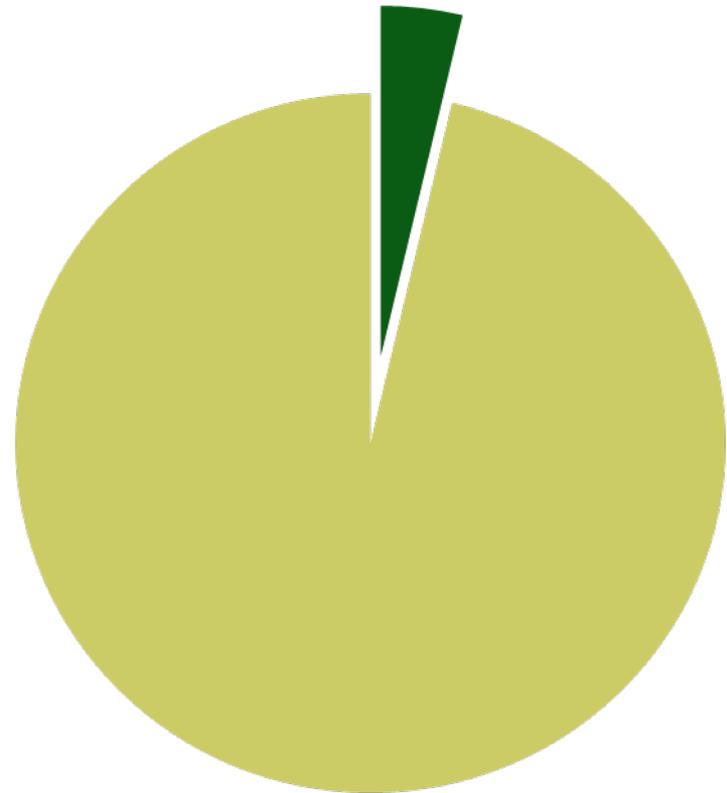


**Source:** Kaiser Family Foundation. *Medicaid Matters: Understanding Medicaid's Role in Our Health Care System*. March 2011. Publication# 8165. Available at: <http://www.kff.org/medicaid/upload/8165.pdf>

# Primary Care Spending in Medicaid: North Carolina example

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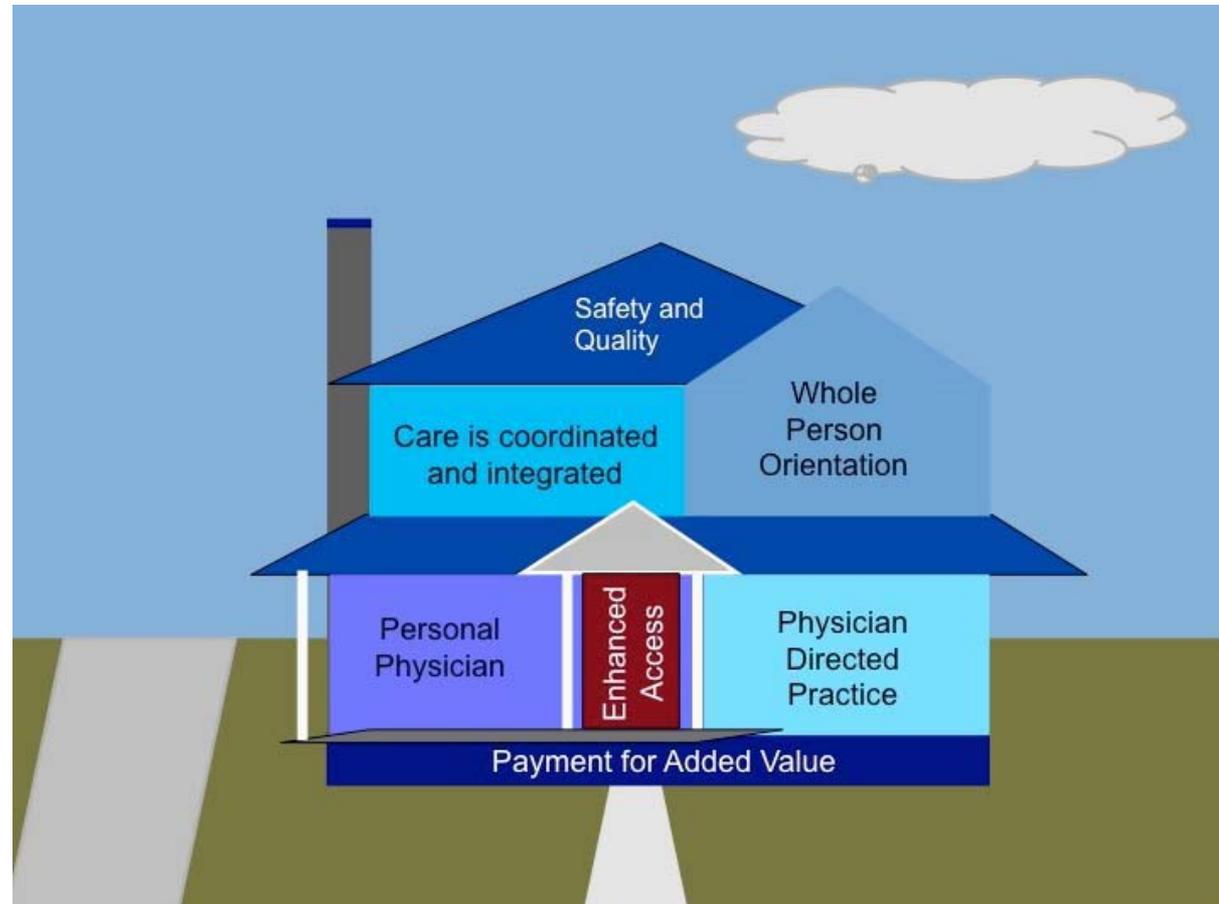
Primary Care Office  
Visits as a Proportion  
of Total Medicaid  
Spending\*



\*Based on SFY11 North Carolina Medicaid Spending

Source: Annette DuBard; Presentation entitled “Making the Case and Spreading Innovations” presented at NASHP/CMWF 3<sup>rd</sup> State Consortium to Advance Medical Homes in Medicaid and CHIP Meeting; Burlington, VT; July 19, 2011.

# Joint Principles of a Patient Centered Medical Home



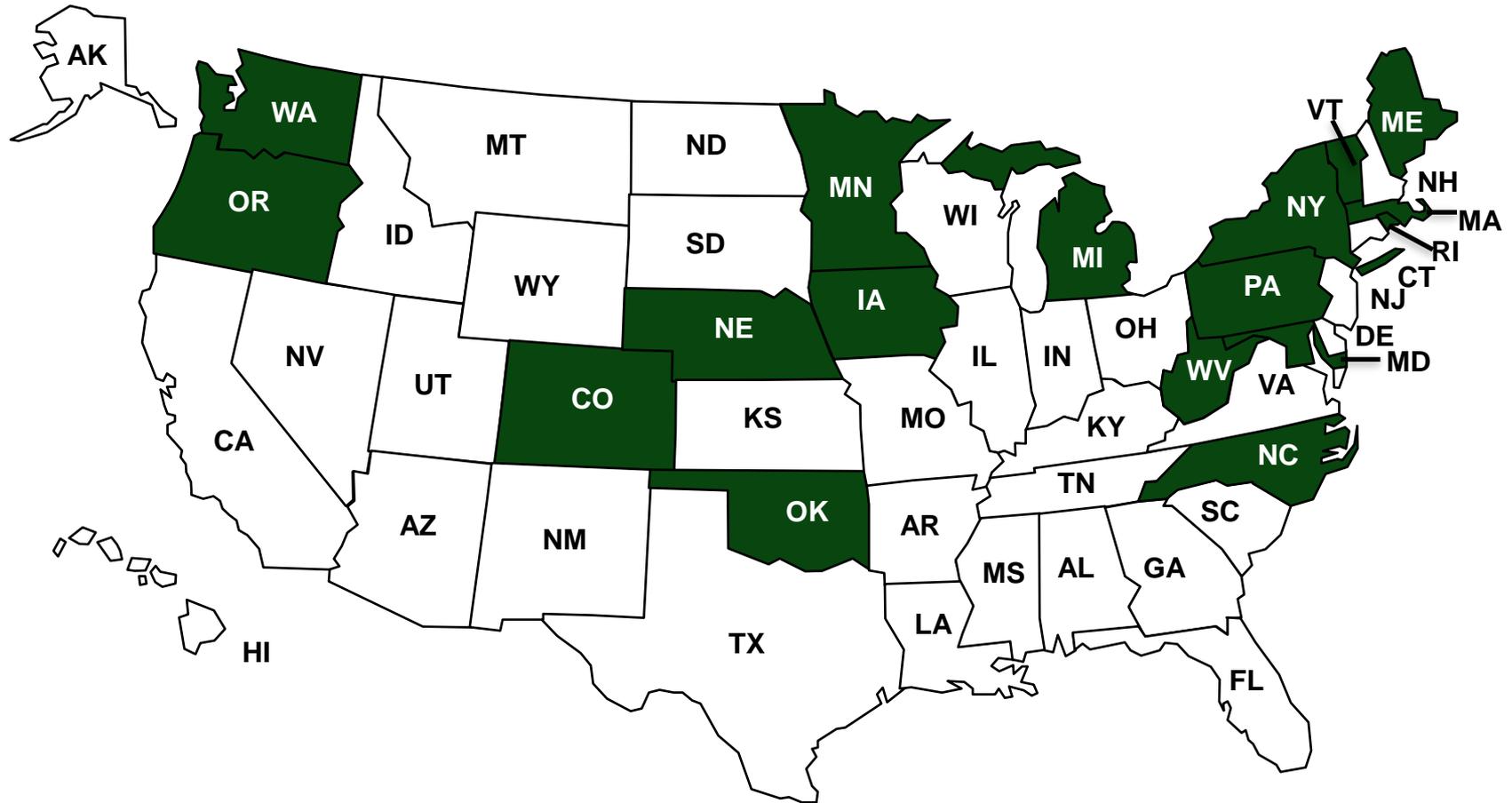
Graphic Source: Ed Wagner. Presentation entitled "The Patient-centered Medical Home: Care Coordination." Available at:  
[www.improvingchroniccare.org/downloads/care\\_coordination.ppt](http://www.improvingchroniccare.org/downloads/care_coordination.ppt)

# What does medical home really mean?

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

Slide courtesy of Minnesota Department of Health/ Minnesota Department of Human Services

# Seventeen “Leading” State Programs That Tie Payment to Objective Medical Home Criteria



Note: North Carolina data includes only those seven regions participating in the Medicare Advanced Primary Care Demonstration, not the entire state-wide Community Care of North Carolina (CCNC) Program.

# Broad Stakeholder Buy-In is Fundamental

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- ❖ State Leadership
- ❖ Taskforces, workgroups, steering committees, town meetings
- ❖ Planning with providers & consumers
- ❖ Working with QI collaboratives
- ❖ Collaborating with other state agencies
- ❖ Partnering with foundations & universities
- ❖ Joining forces with other payers/purchasers
  - State & public employees
  - Multi-payer medical home initiatives

# Raising Standards of Care

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## NCQA Medical Homes

- ❖ Iowa
- ❖ Maine\*
- ❖ Maryland\*
- ❖ Massachusetts\*
- ❖ Michigan\*\*
- ❖ New York
- ❖ North Carolina\*\*\*
- ❖ Pennsylvania\*
- ❖ Rhode Island
- ❖ Vermont
- ❖ West Virginia

## State standards

- ❖ Colorado
- ❖ Minnesota
- ❖ Nebraska
- ❖ North Carolina
- ❖ Oklahoma
- ❖ Oregon
- ❖ Washington

*\*modified NCQA*

*\*\*NCQA or BCBS*

*\*\*\*In 7-region pilot area only*

# NCQA PCMH 2011 Content and Scoring

<p><b>PCMH1: Enhance Access and Continuity</b></p> <p>A. <b>Access During Office Hours**</b>            B. After-Hours Access            C. Electronic Access            D. Continuity            E. Medical Home Responsibilities            F. Culturally and Linguistically Appropriate Services            G. Practice Team</p>	<p>Pts</p> <p>4 4 2 2 2 2 4 20</p>	<p><b>PCMH4: Provide Self-Care Support and Community Resources</b></p> <p>A. <b>Support Self-Care Process**</b>            B. Provide Referrals to Community Resources</p>	<p>Pts</p> <p>6 3 9</p>
<p><b>PCMH2: Identify and Manage Patient Populations</b></p> <p>A. Patient Information            B. Clinical Data            C. Comprehensive Health Assessment            D. <b>Use Data for Population Management**</b></p>	<p>Pts</p> <p>3 4 4 5 16</p>	<p><b>PCMH5: Track and Coordinate Care</b></p> <p>A. Test Tracking and Follow-Up            B. <b>Referral Tracking and Follow-Up**</b>            C. Coordinate with Facilities/Care Transitions</p>	<p>Pts</p> <p>6 6 6 18</p>
<p><b>PCMH3: Plan and Manage Care</b></p> <p>A. Implement Evidence-Based Guidelines            B. Identify High-Risk Patients            C. <b>Care Management**</b>            D. Manage Medications            E. Use Electronic Prescribing</p>	<p>Pts</p> <p>4 3 4 3 3 17</p>	<p><b>PCMH6: Measure and Improve Performance</b></p> <p>A. Measure Performance            B. Measure Patient/Family Experience            C. <b>Implement Continuously Quality Improvement**</b>            D. Demonstrate Continuous Quality Improvement            E. Report Performance            F. Report Data Externally</p>	<p>Pts</p> <p>4 4 4 3 3 2 20</p>

**\*\* Must Pass Elements**

# NCQA PCMH Scoring

6 standards = 100 points  
6 *Must Pass* elements

**NOTE:** *Must Pass* elements require a  $\geq 50\%$  performance level to pass

Level of Qualifying	Points	Must Pass Elements at 50% Performance Level
Level 3	85 - 100	6 of 6
Level 2	60 - 84	6 of 6
Level 1	35 - 59	6 of 6
Not Recognized	0 - 34	< 6

Practices with a numeric score of 0 to 34 points and/or achieve less than 6 “Must Pass” Elements are not Recognized.

# Raising Standards of Care

## Maine—Modified NCQA

NCQA criteria plus 10 additional standards, such as:

- Behavioral health integration
- Population risk-stratification and management
- Same-day access
- Team-based care
- Inclusion of patients & families in redesign
- Focus on cost containment and waste reduction in QI activities
- Integration of health IT
- Connection to community resources

Sources: [www.mainequalitycounts.org](http://www.mainequalitycounts.org);  
[www.okhca.org/providers.aspx?id=8470&menu=74&parts=8482\\_10165](http://www.okhca.org/providers.aspx?id=8470&menu=74&parts=8482_10165)

## Oklahoma—State Developed

Tier One: 8 requirements, such as:

- Provides/coordinates all primary and preventive care
- Organizes clinical data in electronic or paper format
- Maintains a system to track referrals, tests and follow-up results

Tier Two: additional 9 requirements, such as:

- Open access scheduling
- Limited after-hours coverage

Tier Three: 5 more requirements, such as:

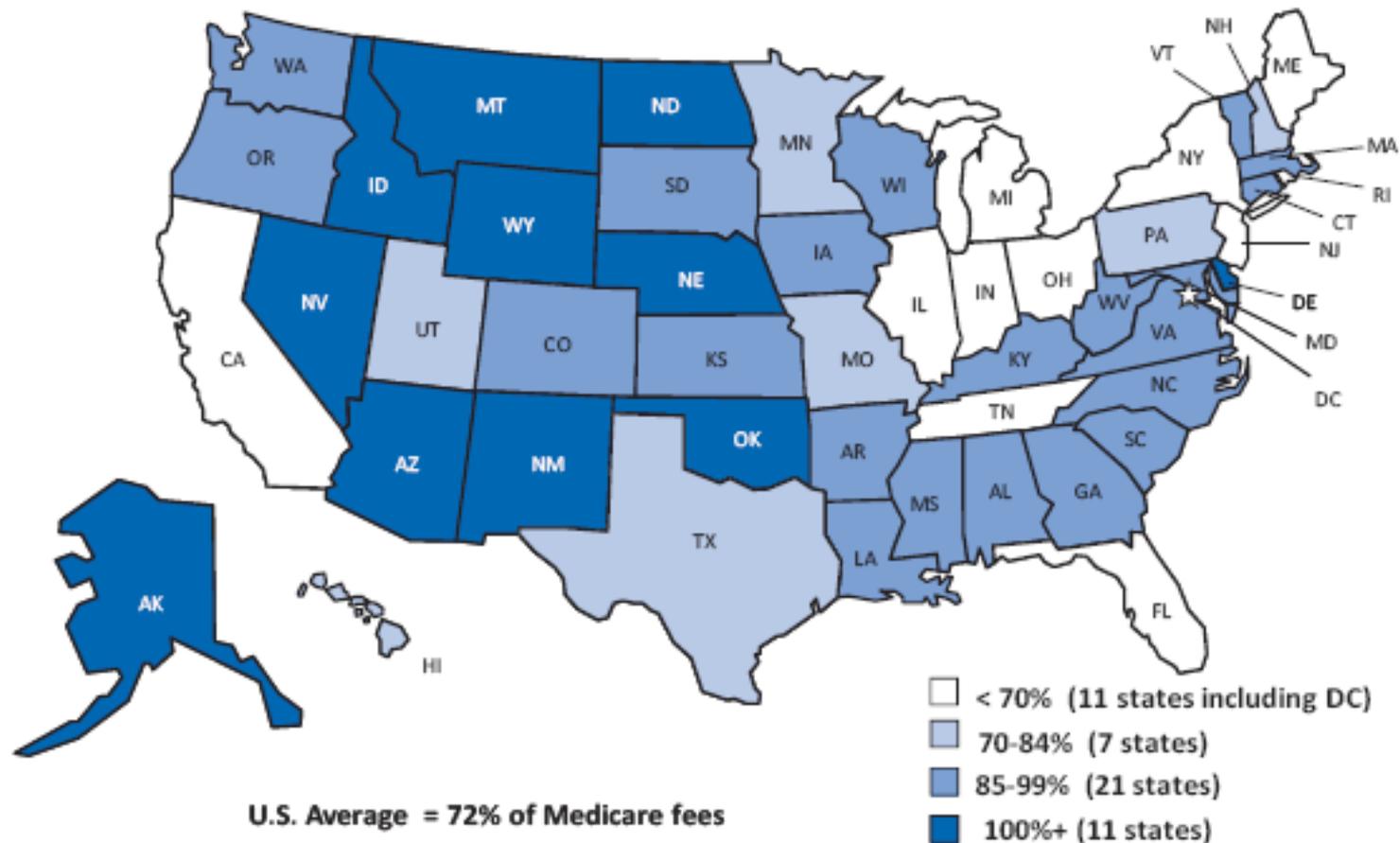
- Work in teams
- Medication reconciliation

# Increasing payments to support primary care delivery

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- ❖ Payments for ongoing medical home costs
  - Raising base primary care fee for service rates
  - Monthly care management payments
  - Lump sum infrastructure payments
  - Enhanced Fee For Service payments for certain visits
  - Payments for new visit codes (i.e. behavioral health and after hour visit codes)
  - Payments to community networks/teams
- ❖ Payment incentives for performance
- ❖ Managed care contracts

# Medicaid-to-Medicare Provider Fee Ratios for All Services, 2008



**Note:** Tennessee does not have a Fee-For-Service Component in its Medicaid Program

**Source:** Kaiser Family Foundation. *Medicaid: A Primer*. June 2010.

Report #7334-04. Available at: [http://kff.org/medicaid/upload/7334-](http://kff.org/medicaid/upload/7334-04.pdf)

[04.pdf](http://kff.org/medicaid/upload/7334-04.pdf)

# Select Care Coordination Payments in Medical Home Initiatives

State Initiative	Per member per month range	Adjusted for Patient Complexity or Demographic	Adjusted for Medical Home Level	Lump Sum Payment	Financial Incentive Based on Quality
Iowa	\$1.50 - \$3.00		▲		▲
Maine	\$3.00 - \$7.00				
Maryland	\$4.68 - \$8.66	▲	▲		▲
Massachusetts	\$2.10 - \$7.50	▲		▲	▲
Michigan	\$3.00-\$4.50	▲			▲
Minnesota	\$10.14 - \$79.05	▲			
Oklahoma	\$2.93 - \$8.41	▲	▲	▲	▲
Pennsylvania	\$3.00 - \$8.50	▲	▲	▲	▲
Rhode Island	\$3.00			▲	
Vermont	\$1.20 - \$2.39		▲		
Washington	\$2.00 - \$2.50				▲

# Additional Support for Practice Transformation

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- ❖ 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, RI
  - Community-based: MN, NC, OK, VT
  - State-based: CO, OK

# Does it Work?

## Summary of Key Cost and Quality Findings

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### ❖ Colorado Medical Home Initiative for Children

- Median annual costs \$215 less for children in medical home practices due to reductions in emergency department visits and hospitalizations
- Median annual costs \$1,129 less for children with chronic diseases in a medical home practice than those without such care

### ❖ Oklahoma SoonerCare

- Per-capita member costs declined \$29 per-patient/per-year from 2008-2010 with increases in evidence-based primary care including breast and cervical cancer screening.
- Positive feedback from both providers and patients

### ❖ Vermont Blueprint for Health

- In one Blueprint community, in-patient use and related per month costs decreased by 21 and 22 percent, respectively
- Emergency department use and related per person per month costs decreased by 31 and 36 percent, respectively
- Mixed results for another Blueprint community.

# Does it Work? Summary of Key Access & Satisfaction Findings

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## ❖ Colorado Medical Home Initiative for Children

- Prior to 2006, 20 percent of private physicians accepted Medicaid or CHIP. In 2010, 96 percent accept these insurances.
- Well child visits increased from 54 percent to 73 percent

## ❖ Oklahoma SoonerCare

- Since 2009, more than 244 new physicians have enrolled as Medicaid providers
- Patient 'same-day/next day appointment availability' inquiries dropped from 1,670 to 13 in 1 year
- Increases in evidence-based care screenings

# 2014 is tomorrow

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# If you build it (medical home system),

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## 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

# ... they will come.

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## **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

# Health Home (2703) provider infrastructure

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Three distinct types of providers from which a beneficiary may receive services:

1. Designated providers (physician, community health center, community mental health center, etc.)
2. A team of health care professionals linked to a designated provider (virtual, based at practice, or other sites)
3. Health team (section 3502 of ACA)

# Health Home (2703) provider standards

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- ❖ Culturally effective, patient centered care
- ❖ Evidence-based clinical guidelines
- ❖ Preventive & health promotion services
- ❖ Mental health & substance abuse services
- ❖ Care management, care coordination, & transitional care
- ❖ Chronic disease management, including self-management
- ❖ Individual and family supports
- ❖ Long-term care supports & services
- ❖ Person-centered care plan
- ❖ HIT to link services, facilitate communication, provide practice feedback
- ❖ Continuous quality improvement program

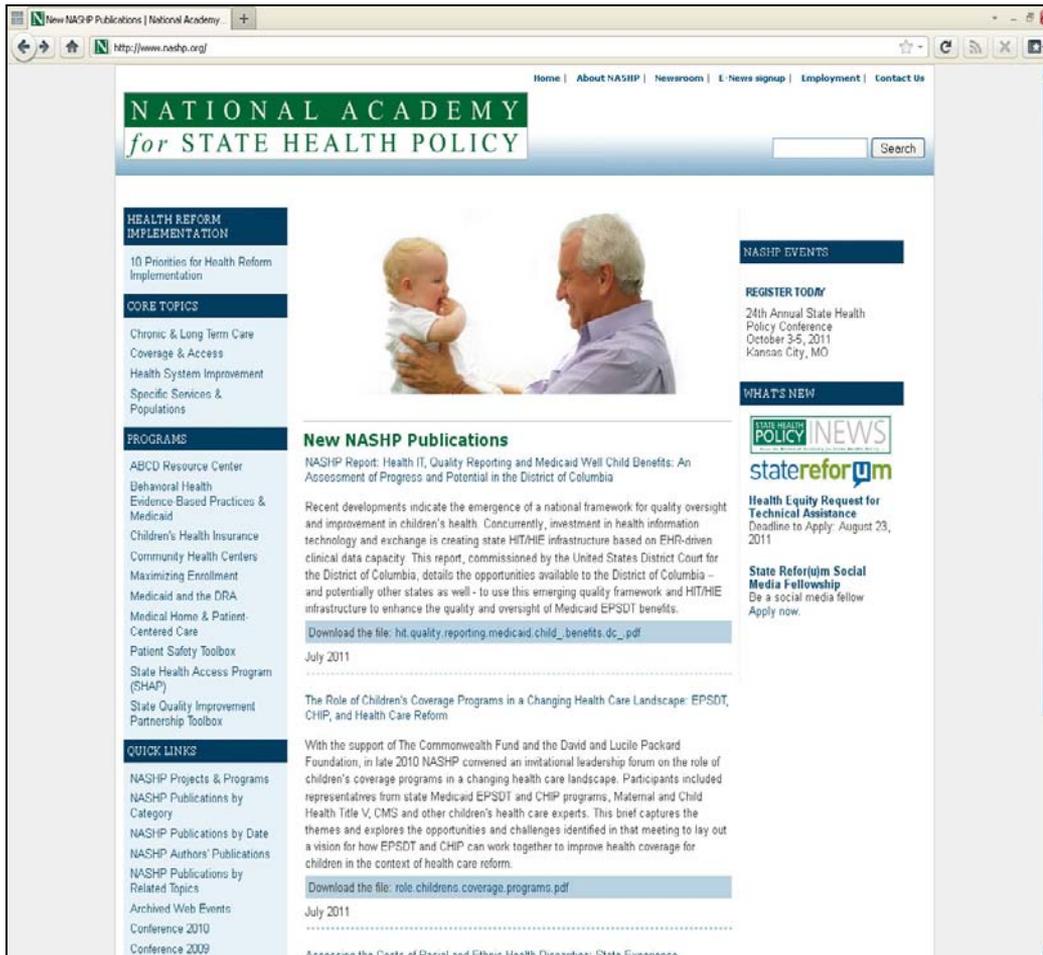
# Other sources of funding to build your “dream home”

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- ❖ Federal ARRA funding
  - Meaningful use & PCMH standards
- ❖ Public/private partnerships:
  - Multi-payer initiatives: Medicare Multi-payer Advanced Primary Care (APC) demo.
  - Stay tuned for ACO, multi-payer demos
  - Foundation grants
  - Pharma, commercial plans, provider associations
- ❖ Federal FQHC APC demo

- ❖ Staterforum.org is a space for:
  - Peer-to-peer learning and discussion
  - Exchanging reform ideas
  - Posting, organizing, and sharing useful state documents
  - Announcing off-line events and activities
  - Spotlighting the keys to successful implementation
  - Mapping states' progress in implementing health reform

# For More Information on Medical Homes....



The screenshot shows the website for the National Academy for State Health Policy. The header includes the organization's name and a search bar. The main content area is divided into several sections:

- HEALTH REFORM IMPLEMENTATION:** 10 Priorities for Health Reform Implementation
- CORE TOPICS:** Chronic & Long Term Care Coverage & Access, Health System Improvement, Specific Services & Populations
- PROGRAMS:** ABCD Resource Center, Behavioral Health, Evidence-Based Practices & Medicaid, Children's Health Insurance, Community Health Centers, Maximizing Enrollment, Medicaid and the DRA, Medical Home & Patient-Centered Care, Patient Safety Toolbox, State Health Access Program (SHAP), State Quality Improvement Partnership Toolbox
- QUICK LINKS:** NASHP Projects & Programs, NASHP Publications by Category, NASHP Publications by Date, NASHP Authors' Publications, NASHP Publications by Related Topics, Archived Web Events, Conference 2010, Conference 2009
- NEW NASHP PUBLICATIONS:** NASHP Report: Health IT, Quality Reporting and Medicaid Well Child Benefits: An Assessment of Progress and Potential in the District of Columbia. Recent developments indicate the emergence of a national framework for quality oversight and improvement in children's health. Concurrently, investment in health information technology and exchange is creating state HIT/HIE infrastructure based on EHR-driven clinical data capacity. This report, commissioned by the United States District Court for the District of Columbia, details the opportunities available to the District of Columbia – and potentially other states as well – to use this emerging quality framework and HIT/HIE infrastructure to enhance the quality and oversight of Medicaid EPSDT benefits. Download the file: [hit.quality.reporting.medicaid.child\\_benefits.dc\\_.pdf](#) July 2011
- NASHP EVENTS:** REGISTER TODAY! 24th Annual State Health Policy Conference, October 3-5, 2011, Kansas City, MO
- WHAT'S NEW:** STATE HEALTH POLICY NEWS, statereform.com, Health Equity Request for Technical Assistance, Deadline to Apply: August 23, 2011, State Reform Social Media Fellowship, Be a social media fellow. Apply now.

❖ Please visit:

[www.nashp.org](http://www.nashp.org)

[www.pcpcc.net](http://www.pcpcc.net)

❖ Contact:

[mtakach@nashp.org](mailto:mtakach@nashp.org)