

The Taskforce for Implementation of the Patient-centered Medical Home Model in State Medicaid and SCHIP Programs

Presented by:

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About NASHP

- 20 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
- NASHP staff
 - Develops, identifies, and disseminates promising practices
 - Work informed and guided by members
 - Funded mostly by foundations through project work
- Working together across states, branches and agencies to advance, accelerate and implement workable policy solutions that address major health issues

About The Taskforce

- Funded by The Commonwealth Fund
- Partnership of PCPCC & NASHP
 - Supports a goal of the Center for Public Payer Implementation
 - Responds to interest of NASHP members in medical homes
 - Focus on developing/disseminating state policy options, not individual technical assistance or federal policy
- Taskforce Goals
 - Help policymakers better understand the PCMH Model and strategies for implementing patient-centered primary care
 - Identify/develop policy options for implementing PCMH principles
 - Support and track state efforts to implement the PCMH model

Task Force Products (1)

- Three webcasts and briefs to inform policymakers
 - State strategies for reimbursement (completed)
 - State strategies to support practices (completed)
 - Topic TBD (9/08)
- Web and e-mail scan to identify existing models, strategies, and policy options
 - initial scan completed, analysis underway
- Develop dedicated webpage on NASHP site
 - Post products developed under Taskforce guidance
 - Post tools developed by states
 - Links to relevant research and private sector efforts

Task Force Products (2)

- 1.5 day working meeting of teams from states working to implement medical home model (7/08)
- Policy report, policy brief and final webcast to convey Summit results to state program managers and policymakers (9-10/08)
- Convene two conference calls to enable states working to implement PCMH to exchange ideas and experience (10/08)
- Convene session at NASHP annual conference to disseminate project findings (10/08)

Why Focus on Improving Medical Homes in Medicaid/SCHIP now?

- Medicaid agencies have a long-standing interest in providing medical homes to program participants
- Circumstances are right for making major advances in Medicaid's implementation of medical homes
 - New opportunities
 - There are existing structures on which to build
 - State agencies already developing new models/approaches/strategies

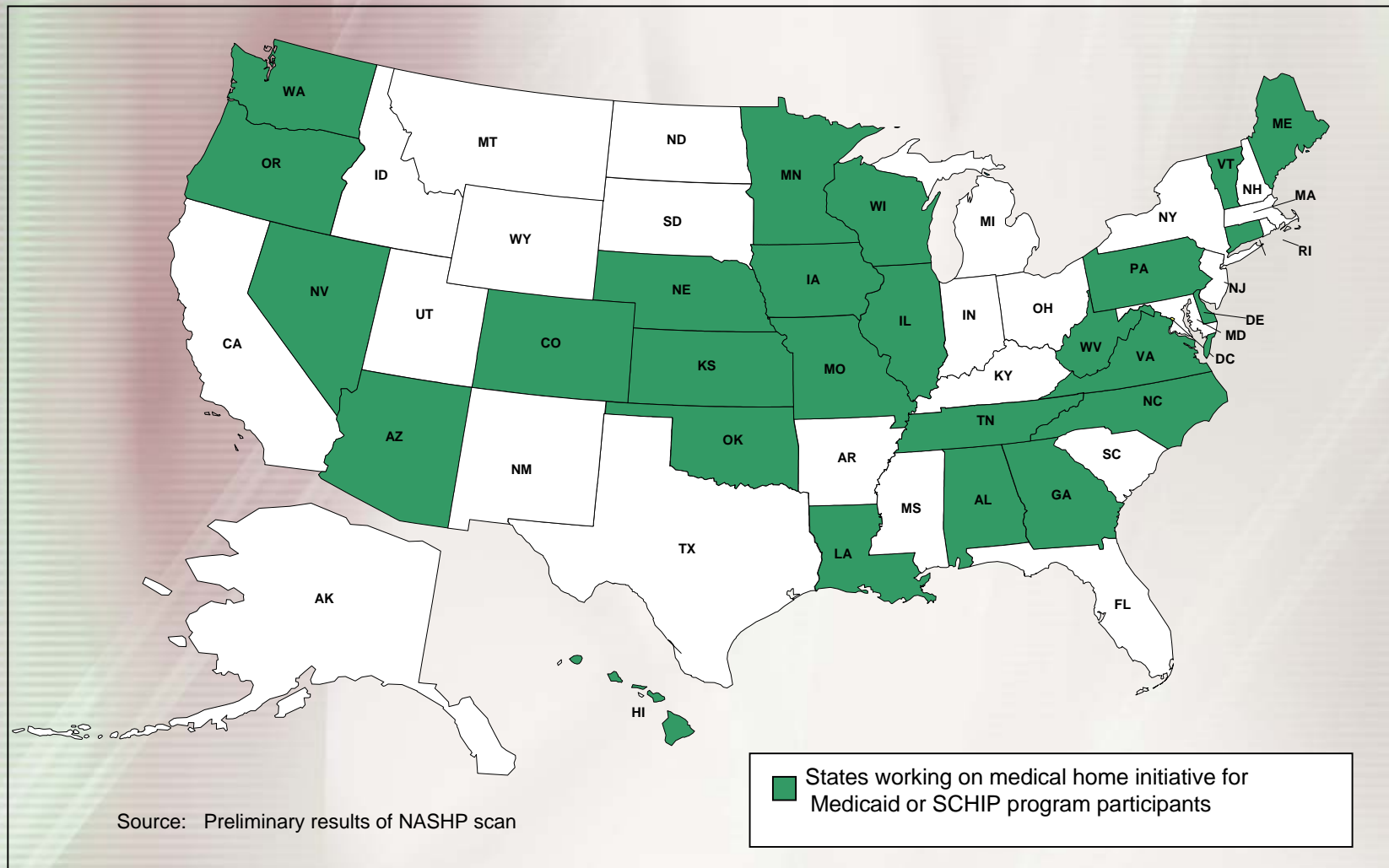
New Opportunities

- Creation of Patient-Centered Medical Home (PCMH) model and Patient Centered Primary Care Collaborative (PCPCC)
- NCQA: process and standards for assessing if practice functions as medical home
- Increase in use and usefulness of Health Information Technology—and Medicaid funding for HIT development

Past efforts that can support new efforts

- Managed Care
 - PCCM and HMO offers reimbursement structure and supports for practices
 - QI structure in place and some states have experience in using to support practice change
- Disease Management
 - States already moving toward population-based and primary care centered
- Targeted Case Management and Care Coordination
 - Offers potential funding and structures to assist practices in coordinating care
 - Needs to become more primary care-centered

Medicaid/SCHIP Programs Already Working to Implement/improve Medical Home



Identified efforts vary widely

- Most starting w/children or subgroups of people w/complex needs
- Six have legislative authority/mandates for effort (CO, LA, MO, RI, WA, WV)
- Eight developing HIT to support practices (AL, AZ, HI, MN, OR, RI, WV, WI)
- Four working in conjunction with HMO model (AZ, TN, RI, WI)
- Two developing multi-payer initiative that includes Medicaid and Medicaid-contracted HMOs (RI, CO)

Strategies to support performance

- Information Technology for PCPs
- Local care coordinators outside practice (AL, HI, RI)
- Providing PCCM fee to practice for performing functions (NC)
- Pay higher PCCM fee for enrollees w/more complex needs (IL, RI)

Strategies to incent performance

- Vary case management fee by PCP qualifications (AL, LA, MN, PA, RI)
 - Use of electronic medical records
 - Completion of CME
 - Past performance on providing immunizations
 - Enhanced access
- Share savings with PCCM providers (AL)
- Providing profiles of PCP performance compared to cohort (AL, IL)
- RI offers performance incentives to HMOs for performance relevant to effective medical home

For More Information

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