

Strategies States Can Use to Support the Infrastructure of a Medical Home

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Many people in the United States do not have access to high quality, point-of-entry primary care.¹ And, there is substantial evidence indicating that “sufficient access to high quality primary care results in lower overall health care costs and lower use of higher cost services, such as specialists, emergency room, [and] inpatient care.”² As a result of these factors, private and public payers are interested increasingly in developing new models of service delivery that better support the provision of effective, patient-centered primary care, including the Patient Centered Medical Home (PCMH) model. The PCMH model calls for establishing primary care teams that attend to the multifaceted needs of patients, and provide whole person, patient centered care.

The purpose of this *State Health Policy*

Briefing is to examine strategies states can use to recognize and support practices that function as a medical home. This is the second in a series of briefs produced by The National Academy for State Health Policy (NASHP) in partnership with the Patient Centered Primary Care Collaborative (PCPCC).

Recognizing High Performing Medical Homes

In order to support medical homes, payers must define what they expect practices to do and how they will know when practices are meeting those expectations. According to the PCPCC, a medical home is “a physician-directed medical practice that provides point-of-entry, enhanced primary care in a continuous fashion, across the health care spectrum, and is comprehensive, coordinated and delivered in the context of family and community.”³ The PCPCC recommends that practices go through a “voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide” PCMH services. It should be noted that most of the initiatives fostered by the PCPCC are using the National Physician Practice Connections® - Patient Centered Medical Home (PPC-PCMH™) tool developed by National Committee for Quality Assurance (NCQA).

According to Dr. Ann O’Malley of the Center for Studying Health System Change, a variety of tools are available to measure practice performance. Currently, no single tool has been identified as ideal, but there is general agreement on what the tools should measure:

First Contact Care ensures that there is a designated, personal, provider point-of-entry or “gateway” for new problems.

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Structure (capacity) measures should include: geographic access, phone access, ease in making an appointment, after-hours care, and language and cultural orientation.

Process (performance) measures look at utilization and capture information at both the population level and practice level to measure patient input and data on the first visit for a new problem at the PCMH.

Longitudinality is a principle that values ongoing patient care over time.

Structure (capacity) measures can include the use of patient list/registry and mutual recognition of the PCMH by both the physician and patient.

Process (performance) measures capture the extent to which patients' care occurs at the PCMH for all problems except for those for which a referral is indicated.

Comprehensiveness is a principle that ensures that the provider arranges for services across all of a patient's health care needs.

Structure (capacity) measures evaluate if the PCMH provides services to meet all common health needs and arranges for services that are uncommon.

Process (performance) measures use chart audits/records to gather utilization information on types of problems and diagnoses seen and the extent to which care occurs in the PCMH or gets referred out.

Coordination is a principle that values the integration of care across a person's conditions, providers, and settings.

Structure (capacity) measures look at continuity from two perspectives: visit continuity with a qualified practitioner or medical record continuity from visit to visit.

Process (performance) measures capture "problem recognition" from previous visits, including information on care received outside of the PCMH. Referrals are coordinated and tracked by PCMH.⁴

O'Malley advises states to consider several questions when selecting a measurement tool, including:

- Do the measures in the tool capture the medical home concepts properly?
- Is there evidence that the concept being measured is associated with improved processes and outcomes for patients?
- Is using the tool burdensome for practices or the state agency?
- Does the tool incorporate provider and patient input as well as some clinical data?
- Does the tool measure achievement rather than mere potential?

Strategies for Supporting Practices

During the project that the National Academy for State Health Policy (NASHP) is conducting on advancing patient centered medical homes in Medicaid and SCHIP, we are seeking to identify strategies that can be used by state Medicaid and SCHIP agencies to support medical homes. We are searching out strategies that can be used within each of the major types of systems states use to deliver primary care: capitated systems in which states contract with MCOs, Primary Care Case Management (PCCM) programs in which states contract directly with primary care providers (PCPs), and fee-for-service. While we have already identified a wide variety of strategies, they can be placed into three broad categories.

1 - States can provide primary care providers with three sets of information that helps PCPs function as a medical home

- a. *Information about their individual patients' needs and utilization.* Illinois, for example, uses Medicaid claims data to provide PCPs with information on their patients' prescription drug use, emergency room visits, inpatient care, and more. The state also uses Medicaid claims data to identify which of the PCPs patients are due for preventive care services.⁵
- b. *Information about their own performance, including comparisons to that of their peers or objective benchmarks.* Alabama, for example, gives each PCP an individual profile on their performance in critical areas, including: EPSDT periodic screening rates, immunization rates, and specialty care visit rates. This profile shows both the PCP's rates and that of the provider's peers.⁶
- c. *Information regarding best practices and continuing education.* North Carolina, for example, works

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The National Academy for State Health Policy (NASHP) is an independent academy of state health policy makers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government.

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with PCPs to help them understand and incorporate best practices in treating conditions such as asthma and diabetes. The state also provides educational material that PCPs can distribute to patients.

2 - States can use two strategies to help PCPs coordinate their patients' care

- a. *Provide resources (usually funding) to the practices that they can use to pay for care coordination.* Rhode Island Medicaid, for example, pays providers participating in its PCCM program who have a nurse case manager more than those who do not have a nurse case manager.
- b. *Pay for care coordination through a separate system (or contract) that is designed to support the PCPs and is linked to their practice.* Oklahoma, for example, has dedicated state staff who accept referrals from PCPs (and others) and are tasked with assisting providers and program participants in accessing and coordinating care.⁸

3 – States can advance and support Health Information Technology

Health information technology (HIT) that supports health information exchange holds the promise of connecting all the dots – from patients to providers to purchasers – with the goal of transforming health care by providing timely, relevant information. Many states are utilizing Medicaid Transformation grants and Medicaid Information Technology Architecture (MITA) to do this. Eight states (Alabama, Arizona, Hawaii, Minnesota, Oregon, Rhode Island, West Virginia, and Wisconsin) are using Medicaid Transformation grants to support medical home practices. Many others are promoting access to electronic registries to support physician practices. For instance, Louisiana Medicaid provides access to the state immunization database and rewards providers who access the information and who achieve specified immunization performance.

SYNERGY WITH THE PRIVATE SECTOR

The private sector is also engaged in efforts to support practices in functioning as effective medical homes. This situation creates opportunities for synergy – both private and public payers may accomplish more if they work together. In Rhode Island, there are initiatives working to bring these payers together to support medical homes.⁹ In addition:

- Several national health plans, including Aetna, MVP Health Care, and UnitedHealthcare are planning a demonstration project in the Mid-Hudson region of

New York. The project will include approximately one million covered lives and 500 providers. Participating practices will employ electronic health records, ePrescribing, online provider portals, and adopted standards for continuity of care and care coordination per PPC-PCMH™ guidelines. The practices will continue to receive their regular reimbursement for the services they provide to patients. They will also receive additional reimbursement based on their performance and the outcomes they produce. The project is funded by the New York Department of Health and the health plans.¹⁰

- In early 2008, UnitedHealthcare will launch pilots in Colorado, Rhode Island, and Florida. These pilots will use a randomized design, assigning 24,000-30,000 patients to intervention and control practices, focusing on adult practices, and lasting 24 months. Intervention practices will receive education, tools to meet key qualifications, access to health information technology tools such as the physician dashboard, an assigned mentor to provide consultation based on need, and opportunities for peer group learning and ongoing assistance.¹¹

Putting the Pieces Together: How Illinois, Pennsylvania, and Arizona are Combining Strategies to Support Medical Homes

The remainder of this *Briefing* examines how Arizona, Illinois, and Pennsylvania are supporting practices that serve as medical homes for Medicaid and SCHIP beneficiaries. These three states were selected because of the diversity of their approaches: less intense support for beneficiaries with a broad range of needs through a PCCM program (Illinois); intense support for children with special health care needs established through an MCO delivery system (Pennsylvania); and the development of health information technology infrastructure to support plans and practices (Arizona).

ILLINOIS: SUPPORTING MEDICAL HOMES THAT SERVE A BROAD SPECTRUM OF MEDICAID AND SCHIP BENEFICIARIES THROUGH A PCCM PROGRAM

Illinois' Primary Care Case Management Medical Home Initiative began in fall 2006 with the goals of assuring medical homes and improving primary and preventive care. According to Dr. Stephen Saunders of Illinois Medicaid, there are 1.6 million beneficiaries enrolled and 5,300 medical homes (physicians and clinics) established with a capacity to serve more than 5 million members.

Along with fee-for-service reimbursement for the services they provide, PCPs are paid a per member per month (PMPM) fee for every person whose care they are responsible to manage even if the enrollee does not receive services that month (\$2/per child, \$3/per adult, \$4/per disabled or elderly enrollee). In order to receive this added reimbursement, PCPs must adhere to certain requirements that include maintaining hospital admitting and/or delivery privileges and providing enhanced access to appointment scheduling.

Illinois Health and Family Services' (HFS) main approach to helping PCPs fulfill their roles as medical homes is to provide access to valuable information built around Medicaid data claims, along with outreach and support efforts. PCPs receive monthly patient rosters through the mail or electronically, and which provide reminders about when needed preventive services such as well-child visits, pap smears, or mammograms are due. PCPs will also receive provider profiles that use HEDIS and HEDIS-like metrics to track performance and to compare against other Medicaid providers across the system. In addition to feedback on preventive services, these profiles will also list beneficiaries with chronic diseases and measure how the provider has done in meeting the clinical standard of care for beneficiaries with certain chronic diseases. PCPs will also have the opportunity to receive a bonus payment for meeting certain HEDIS benchmarks.

Illinois supports practices by providing the PCPs with secure access to two years of Medicaid claims data that provide information on pharmacy, immunizations (7 years of data), office visits, hospitalizations, diagnosis, and procedures. This access gives providers important information to better understand the patient's history and plan patient care. PCPs and their staff receive support from provider services representatives in the field. The provider service representatives provide outreach and education to support providers and their staff on site, through training sessions and monthly webinars, on topics such as quality assurance and EPSDT support. PCPs have access to additional support

through a secure web portal that contains PCP support and education materials.

PENNSYLVANIA: SUPPORTING MEDICAL HOMES THAT SERVE CHILDREN WITH SPECIAL HEALTH CARE NEEDS THROUGH AN HMO DELIVERY SYSTEM

Pennsylvania's Children's Health Insurance Program (CHIP) is one of the nation's oldest children's health insurance programs and a model for the federal State Children's Health Insurance Program (SCHIP). The state's program serves approximately 170,000 children up to age 18 through eight MCOs.

According to Lowware Holliman of the Pennsylvania CHIP and adultBasic programs, Highmark (an MCO) brought a problem to the state's attention. The company was finding that some children in the CHIP program had special health care needs, but did not qualify for Medicaid. Before that time CHIP had not focused on developing strategies to serve these children but rather on referring them to Medicaid. Through a Pennsylvania Insurance Department RFP, Highmark Caring Foundation's Care Coordination Program for Children with Special Health Care Needs pilot project was approved in January of 2005. According to Dr. Carey Vinson of Highmark, this project assists families with children with special health care needs with navigating the health care system to obtain services that are available but not readily or easily accessible through the SCHIP program.

Highmark supports providers by informing them of the children enrolled in the Caring Program, sharing care plans with physician practices, providing appropriate (non-medical) referral information, coordinating care and communication among multiple practitioners and facilities, and providing family-centered education to the family to support adherence to the physician medical care plan.

The state hopes, through its next MCO procurement, to encourage other MCOs to adopt care coordination practices, especially with regard to chronic needs, and to assist practices to become medical homes.

ARIZONA: USING HEALTH INFORMATION TECHNOLOGY (HIT) TO SUPPORT MEDICAL HOMES

Arizona, according to Anthony Rodgers of Arizona Medicaid, is using health information exchange (HIE) supported by HIT to achieve five objectives that support providers and incorporate many principles of a patient centered medical home:¹²

1. integrate health care delivery,
2. increase transparency of health care cost and quality,
3. promote productive interchange between provider and

patient,

4. enable consumers and patients to make informed decisions and actively participate in their own care, and
5. enable health care providers to provide cost effective care management and use clinical decision support tools to reduce cost and improve quality.

Arizona is working toward statewide adoption of interoperable electronic health records, and envisions using these records to both support and assess plan and practice performance, including performance related to serving as a medical home. The state also plans to use this system to offer consumers health care cost and quality information that is relevant to their individual needs. Arming consumers with timely, relevant information will enable them to better assess their health care choices and improve their interactions with providers. This, in turn, will enhance a patient's ability to communicate directly with his or her providers. Improved communication with coordinated care is the hallmark of the patient-centered medical home and a medical home is a hallmark of high quality, high performing, and cost-effective health care system.

NASHP's Patient Centered Medical Homes Project

The National Academy for State Health Policy (NASHP) and The Patient Centered Primary Care Collaborative (PCPCC) are partnering on a one-year project to *Advance Patient Centered Medical Homes in State Medicaid and SCHIP Programs*. Funded by The Commonwealth Fund, this project includes a series of four web seminars and accompanying *State Health Policy Briefings* that discuss strategies for states to consider for supporting practices in fulfilling their role as a medical home.

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Notes

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- 8 Oklahoma Health Care Authority. Care Management. http://www.okhca.org/providers.aspx?id=2044&parts=7499_7501. Retrieved 2 May 2008.
- 9 The Rhode Island Chronic Care Sustainability Initiative is underway in 2008 and is an all-payer demonstration project that is using a fee for service model with enhanced per member per month for all members to pay for implementing agreed upon “key services” with options for performance payments. For more information, please see our first webcast brief, *Supporting the Patient Centered Medical Home in Medicaid and SCHIP: Savings and Reimbursement*. http://www.nashp.org/files/shpbriefing_pcmhsavings.pdf.
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