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Medicaid Medical Home Task Force Report

Recommendations for Designing and Implementing a Medical Home Pilot Project for Florida Medicaid

February 2010

Table of Contents

Executive Summary 1

Medical Home Task Force Overview 3

Florida Medicaid Overview 5

Florida Medicaid Delivery Systems 6

Task Force Findings and Recommendations 8

Closing Comments 16

Appendix A – September 30, 2009 Meeting

Florida Medicaid: Program Overview:
http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/medical_home_tf/medicaid_overview_093009.pdf

Medical Home Models: Concepts & Use:
http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/medical_home_tf/medical_home_models_concepts_use.pdf

Medical Homes for Children with Special Needs:
http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/medical_home_tf/medical_homes_for_children_with_special_needs.pdf

THERE'S NO PLACE LIKE (A MEDICAL) HOME (Presentation):
http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/medical_home_tf/medical_home_pp.pdf

THERE'S NO PLACE LIKE (A MEDICAL) HOME (Paper):
http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/medical_home_tf/medical_home.pdf

Medical Home Model management of diabetes mellitus in the surgical patient:
http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/medical_home_tf/dm_surgical_patient.pdf

Medical Home Management of the Diabetic Patient:
http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/medical_home_tf/medical_home_diagram.pdf

Medical Home Model Management of DM Type 1:
http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/medical_home_tf/medical_home_dm_type_1.pdf

Appendix B – October 27, 2009 Meeting

Pennsylvania's ACCESS Plus EPCCM Program:
http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/medical_home_tf/2009-10-27/access_plus_102709.pdf

Community Care of North Carolina:
http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/medical_home_tf/2009-10-27/ccnc_102709.pdf

Washington State's Medical Home Projects:
http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/medical_home_tf/2009-10-27/washington_medical_home_102709.pdf

Appendix C – November 18, 2009 Meeting

SoonerCare Oklahoma's Program:
http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/medical_home_tf/2009-11-18/soonercare_oklahoma_program_111809.pdf

Appendix D – December 16, 2009 Meeting

Considerations for a Medical Home Pilot Program:
http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/medical_home_tf/2009-12-16/considerations_medical_home_pilot_program.pdf

Key Characteristics of Pilot Program:
http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/medical_home_tf/2009-12-16/mhtf_summary_points.pdf

Executive Summary

The Medical Home Task Force was established by Senate Bill 1986, under the authority of Section 409.91207(5), Florida Statutes. The responsibility of the Task Force was to assist the Agency for Health Care Administration (Agency) in reviewing medical home models and make recommendations for a Medicaid medical home pilot project. The Agency is responsible for submitting these recommendations to the Florida Legislature and the Governor by February 1, 2010.

In July 2009, the Secretary of the Agency appointed ten Task Force members that represented Florida Medicaid health plans and networks, medical and health care professional associations, medical schools, and advocacy groups. The Task Force met five times between September 2009 and January 2010. At the initial meeting, Agency staff provided an overview of the Florida Medicaid program and delivery systems and several Task Force members gave presentations on medical home concepts and models. Subsequent meetings included presentations by Medicaid staff from four states that have implemented medical home programs – North Carolina, Oklahoma, Pennsylvania, and Washington. Based on these presentations and discussion among Task Force members, the Task Force made recommendations in the following areas:

- **Defining the medical home –** The Task Force would like to use as a model the National Committee for Quality Assurance's (NCQA's) standards for Patient-Centered Medical Homes in selecting components of the medical home pilot and would like to set up three different tiers of medical home providers and services. The Task Force strongly recommends using a "bottom-up" approach to defining the structure of the medical home pilot by soliciting feedback and proposals from community-based networks and providers on what type of medical homes they can provide to Medicaid recipients.
- **Determining medical home pilot sites –** The Task Force recommends that at least one rural area and one urban area with an academic setting/medical school be included as pilot sites. Local providers' level of interest in participating in the medical home pilot should be taken into account. Special consideration should be given to areas with high levels of uncoordinated care, as evidenced by frequency of emergency room visits and hospital admissions.
- **Medical home pilot participants –** The Task Force recommends that a Medical Home Advisory Board work with the Agency to determine which Medicaid recipients would best be served by the medical home pilot, and focus on those who appear to have uncoordinated care or a lack of access to care. Task Force members suggested that the pilot could be a mixed model that includes MediPass providers, community networks, hospitalists, specialists, and managed care organizations, but that it should allow "bottom up" designs that incorporate strong community based partnerships.
- **Medical home pilot services -** The Task Force recommends that every recipient have a primary care provider who provides and/or coordinates all health care for the recipient and is available on a 24/7 basis. This should include developmental, mental, and behavioral health care.
- **Administration of the medical home pilot –** The Task Force recommends that a Medical Home Advisory Board be appointed to work with the Agency on planning and implementing the medical home pilot, including setting core process criteria and quality measures. The Agency should administer the pilot with input and feedback from the Advisory Board. The Task Force recommends that there be a strong evaluative component to the pilot and that a single independent evaluator conduct an evaluation of the pilot and provide a final report to the Legislature.

- **Financing and reimbursement for the medical home pilot –** Based on findings from other states' Medicaid medical home programs, the Task Force finds that provider fees—both for office visits and case management—are essential ingredients for getting adequate participation in the pilot. Strong consideration should be given to reimbursement models that include enhanced fees for services, case management fees, and pay for performance/incentive payments. Provider payments will need to cover increased Health Information Technology (HIT) costs as well, although the Task Force recommends that some of these costs may be defrayed by investments the state is already making in HIT. While the pilot may require significant investment of staff time and dollars up-front, the Task Force believes that Florida will achieve savings through a medical home model, as other states have reported. While it is not possible to estimate the exact amount of savings, it is anticipated that more coordination of care in those areas lacking such principles will result in lower costs and will reduce the potential for fraud and abuse to occur. Additionally, the Task Force strongly recommends that any program design should investigate payment methodologies to ensure a return on investment.

Medical Home Task Force Overview

The Medical Home Task Force was established by Senate Bill 1986, under the authority of Section 409.91207(5), Florida Statutes. The responsibility of the Task Force was to assist the Agency for Health Care Administration (Agency) in reviewing medical home models and make recommendations for a Medicaid medical home pilot project. The Agency is responsible for submitting these recommendations to the Florida Legislature and the Governor by February 1, 2010. Based on the Task Force's discussions and recommendations, the Agency for Health Care Administration (Agency) developed this report, which was reviewed by the Task Force members.

This Task Force consisted of ten members appointed by the Secretary of the Agency, based on the statute listed above. Agency staff served as facilitator and resources for, but not members of, the Task Force.

Members of the Task Force were:

Andy Behrman, President and Chief Executive Officer
Florida Association of Community Health Centers

Coy Irvin, M.D., Board of Directors
Florida Academy of Family Physicians

John Kaelin, Senior Vice President
United Health Care

Stephen Klasko, M.D., Dean
University of South Florida School of Medicine

Jack McRay, Advocacy Manager
AARP

Rich Morrison, Regional Vice President for Government Affairs
Florida Hospital Association

Chris Paterson, President
Sunshine State Health Plan

Rocky Slonaker, M.D., Medical Director/Corporate Compliance Officer
Pediatric Associates

Phyllis Sloyer, R.N., Ph.D., FAHM, FAAP, Division Director
Children's Medical Services/Florida Department of Health

Anne Swerlick, Deputy Director
Florida Legal Services

The Task Force met five times between September 2009 and January 2010. At the first meeting, Agency staff provided an overview of the Florida Medicaid program and several Task Force members presented information on medical home concepts and models, including two models currently operating in Florida (Children's Medical Services Network and Federally Qualified Health Centers [FQHCs]). The second and third meetings included presentations by

Medicaid staff from North Carolina, Oklahoma, Pennsylvania, and Washington on their respective Medicaid medical home programs. The third meeting also included a presentation by Agency staff on national health care reform legislation, including proposed medical home-related provisions. At the fourth Task Force meeting, members shared their ideas regarding medical homes and developed recommendations for a Florida Medicaid medical home pilot project. The fifth meeting gave Task Force members an opportunity to review and finalize this report. Each of the Task Force meetings were public meetings and had time allotted at the end for public comment.

Florida Medicaid Overview

The Medicaid program is a state-administered program that is jointly financed by state and federal funds to provide health care to aged, blind, and disabled individuals as well as to pregnant women, families, and children in families below specified federal poverty level limits. Each state administers its program under a federally approved state plan. There are federal requirements regarding populations and services that must be provided as well as optional services and eligibility groups that may be covered. Medicaid programs vary from state to state and within states over time due to differences in optional service coverage, limits on mandatory and optional services, optional eligibility groups, income and asset limits for eligibility, and provider reimbursement methodology and levels. In State Fiscal Year 2009-10, Florida Medicaid was appropriated $17.5 billion in funds. The federal share of funding is 67.64%, while the state share is 32.36%.[1]

It is estimated that there will be 2.7 million eligible recipients of Florida Medicaid and that Florida will spend approximately $6,625 per eligible in 2009-10. In fiscal year 2010-11, it is projected that there will be 2.9 million eligible recipients and that Florida will spend approximately $6,584 per eligible. Forty-five percent of all Medicaid expenditures cover hospitals, nursing homes, Intermediate Care Facilities for the Developmentally Disabled, Low Income Pool and Disproportionate Share Payments. About seven percent of expenditures are for prescribed medications.

Florida's Medicaid State Plan is a large, comprehensive written statement describing the scope and nature of the Medicaid program. In order to receive federal funds under Title XIX of the Social Security Act, the Agency submits its State Plan to the Centers for Medicare and Medicaid Services (CMS) for approval. The State Plan outlines current Medicaid eligibility standards, policies, and reimbursement methodologies and indicates the state's agreement to administer the Medicaid program in accordance with the requirements of Titles XI and XIX of the Social Security Act. In general, medical services defined within the State Plan cannot be limited by geographic area or vary in amount, duration, or scope by population. Furthermore, fee structures must be efficient and economical.

In order for states to implement Medicaid programs which deviate from their State Plan (that vary by geographic areas or by amount, duration, and scope of services), a state must request a waiver from the Centers for Medicare and Medicaid Services (CMS). A waiver program is one that is requested by a state and approved by CMS that waives certain requirements of the Social Security Act. The type of waiver requested indicates which provisions of the Social Security Act are waived. The waiver types are: 1915(b), 1915(c), and 1115. Florida Medicaid has several waivers:

- 1915(b) waiver for non-emergency transportation and for Medicaid managed care programs
- 1915(c) waiver for 15 specialized home and community based services programs
- 1115 waiver for Family Planning, Meds-AD, and Medicaid Reform programs

[1] The State is receiving an enhanced federal medical assistance percentage rate from October 1, 2008 through December 31, 2010 as authorized in the American Recovery and Reinvestment Act of 2009. On January 1, 2011, the federal share of funding will return to the pre-stimulus amount which is approximately 54%.

Florida Medicaid Delivery Systems

Florida Medicaid offers health care to eligible recipients through two main types of delivery systems: fee-for-service and managed care. The fee-for-service system serves those Medicaid recipients who are not eligible for or enrolled in MediPass (a Primary Care Case Management [PCCM] program) or other managed care programs. Fee-for-service recipients may receive services from any enrolled Medicaid provider, but no generalized case management is available in the fee-for-service system. The managed care delivery system offers a variety of coordinated systems of care which are defined by federal regulations, including:

- Primary Care Case Management Program (Florida's MediPass and Children's Medical Services Network)
- Managed Care Organizations (HMOs and Provider Service Networks [PSNs])
- Prepaid Ambulatory Health Plan (Prepaid Dental Health, Minority Physician Networks, Disease Management Programs, and Hospitalist Program)

Federal regulations specify which Medicaid recipients may enroll in or be assigned to these managed care delivery systems. Most recipients in the Aged and Disabled (SSI), Temporary Aid to Needy Families (TANF), and MediKids eligibility groups are required to enroll in or be assigned to managed care if the recipient does not make a choice. Children in foster care, Native Americans, and those who are dually eligible for Medicaid and Medicare may voluntarily enroll in managed care but cannot be mandatorily assigned without a waiver. Those in the Medically Needy, Family Planning, and SOBRA pregnant women eligibility groups are currently excluded from managed care enrollment.

MediPass, the Florida PCCM program, is designed to build a relationship between recipients and their personal (primary care) physicians by creating a medical home, assuring access to care, decreasing inappropriate utilization, and reducing costs. Enrollees choose or are assigned to primary care physicians (PCPs), who are responsible for providing primary care and authorizing the specialty care provided to their enrollees. MediPass providers (physicians and ARNPs) are paid a $2.00 monthly case management fee for each of their enrollees, while the services they provide to MediPass members (e.g., office visits, immunizations) are paid for on a fee-for-service basis. For the $2.00 case management fee, providers are responsible for coordinating all care for their enrollees (including child health check-ups, immunizations, preventive screenings, referrals and authorizations, and outreach), adhering to MediPass quality and access to care standards, and must be available 24 hours, 7 days per week. As of January 2010, over 550,000 Medicaid recipients were enrolled in MediPass statewide.

Provider Service Networks (PSNs) are defined in Section 409.912(4)(d), Florida Statutes, as an integrated health care delivery system owned and operated by a health care provider (or group of affiliated health care providers) which provides a substantial proportion of the health care items and services under a contract directly through the provider or group of affiliated providers. PSNs are required by contract to ensure that their enrollees have access to all Medicaid State Plan services, with a few exceptions, and a complete network of providers. Payment to PSNs may be on a fee-for-service or prepaid basis. As of January 2010, PSNs operated in seven counties. Over 98,000 Medicaid recipients were enrolled in fee-for service PSNs while over 40,000 were enrolled in capitated PSNs in January 2010.

Health Maintenance Organizations (HMOs) are entities licensed under Chapter 641, Florida Statutes. They provide comprehensive Medicaid services to a defined population of Medicaid recipients. HMOs are required by contract to ensure that their enrollees have access to all Medicaid State Plan services for which they are responsible and a complete network of providers. HMO networks are not limited to Medicaid providers, and some plans have

expanded their benefits beyond those required to be covered under the State Plan (for example, adult dental). The Agency contracts with HMOs on a prepaid fixed monthly rate per member (e.g., capitation rate), for which the HMO assumes all risk for providing covered services to its enrollees. As of January 2010, over one million Medicaid recipients were enrolled in HMOs, which are available in 37 counties.

Task Force Findings and Recommendations

During the five meetings of the Medical Home Task Force, Task Force members shared and discussed their ideas of what elements a Medicaid medical home pilot should include. Task Force members presented information on existing variations on medical home models in Florida through the Children's Medical Services Network and through Federally Qualified Health Centers (FQHCs). Presentations on existing Medicaid medical home programs were made by staff from North Carolina, Oklahoma, Pennsylvania, and Washington. These presentations gave the Task Force a variety of options to consider regarding the structure and implementation of a medical home program for Florida Medicaid. The Task Force's discussion of what a medical home pilot program should look like in Florida centered on the following issues:

- What is it? How should "medical home" be defined and what qualifications/criteria should be met for a provider to earn a medical home designation?
- Where is it? In what areas of the state should the pilot be implemented?
- Who will participate? What eligibility groups of recipients should be included? What types of providers? Should payors other than Medicaid be included?
- What services will be provided through the medical home program? What disease management or chronic care management services should be required? What information systems and technology utilization should be required? What medication management services should be required?
- How will the pilot program be administered? What federal authority is needed? Who will be the organizing authority and the administrative entity of the pilot? What evaluation methods will be used to assess the effectiveness of the pilot?
- What financial and other resources will be needed and available for the pilot? What reimbursement model should be used? Key issues include physician fees and incentive fees.

Defining a Medical Home

Task Force members acknowledged that there are multiple ways to define a medical home. Most states that have implemented a medical home program have adopted the elements, or at least a variation of the elements, presented in the "Joint Principles of the Patient Centered Medical Home" that were released in February 2007 by four major physician groups (American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and the American Osteopathic Association)(available online at http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home). In January 2008, the National Committee for Quality Assurance (NCQA) released standards for patient-centered medical homes based on the physician groups' joint principles (NCQA standards may be ordered for free online at http://www.ncqa.org/tabid/629/Default.aspx#pcmh). These joint principles include the following as characteristics of a medical home:

- A personal physician for each patient to serve as first contact and to provide continuous and comprehensive care.
- Physician-directed medical practice, in that the personal physician leads a team that collectively takes responsibility for patients' ongoing care.
- Whole person orientation – the personal physician is responsible for providing or ensuring access to care with other providers as needed, for all types of care and at all stages of life.
- Care is coordinated and/or integrated across all elements of the health care system and the community.

- Quality and safety are high priorities, with an emphasis on evidence-based medicine, patient involvement in developing care plans and decision making, and reporting on performance measures.
- Enhanced access to care through open scheduling and new methods through which patients, personal physicians, and practice staff may communicate.
- Payment methodologies that recognize care management and coordination work that happen outside face-to-face visits, support adoption and use of health information technology, establish separate FFS payments for face-to-face visits, allow physicians to share in savings resulting from the medical home model, recognize case-mix differences between practices, and allow incentive/bonus payments for achieving measurable performance standards and quality improvements.

Agency staff and the Task Force asked several states to present information on their Medicaid medical home programs, in order to learn how other state Medicaid programs are implementing some if not all of these principles in their medical home programs. Hearing about programs from four other states made it clear to the Task Force that each state had a unique starting point from which their medical home programs grew. Brief descriptions are included in this report. For more information, please refer to the state presentations in Appendices B and C of this report and a report by the Center for Health Care Strategies titled "Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States", which describes the programs in North Carolina, Oklahoma, and Pennsylvania, among others (available online at http://www.chcs.org/publications3960/publications_show.htm?doc_id=1013920).

North Carolina's medical home program, Community Care of North Carolina (CCNC), started in 1998 as a small pilot aimed at lowering emergency room use for recipients with asthma. The CCNC program now includes 14 community networks, over 3500 physicians, and serves over 950,000 enrollees (more than two-thirds of the state's Medicaid recipients). Primary care practices receive a $1.00 per-member-per-month (PMPM) fee for providing a medical home with 24/7 access and coordination of specialty care for enrollees. These practices receive an additional $1.50 PMPM for joining a community network, which supports individual practices with medical directors, case managers, pharmacists, quality improvement specialists and tools, a statewide case management information system, and training and technical support. After implementing several interventions aimed at improving health outcomes, North Carolina increased the fee to primary care practices for aged, blind, and disabled recipients to $5.00 per-member-per-month.

Oklahoma's program, SoonerCare Choice, has evolved from a series of managed care transitions. In 1993, the Oklahoma Legislature created the Oklahoma Health Care Authority (OHCA) by statute and tasked it with reforming Oklahoma's Medicaid program by implementing a statewide managed care model. The OHCA implemented fully capitated services in urban areas of the state in 1995 and implemented a partially capitated PCCM program in rural areas in 1996. In 2003, the OHCA determined that it could operate the PCCM program in the urban areas with fewer administrative and staff costs than contracting with the fully capitated managed care organizations. The OHCA voted to move all recipients into the partially capitated PCCM program in 2004. SoonerCare Choice, the PCCM program, is a managed care model in which each member is linked to a primary care provider who serves as a "medical home" and manages basic health care needs, including after hours care and specialty referrals. A member's primary care provider may be a physician, an ARNP, or a physician's assistant. Primary care case management/care coordination fees are paid based on type of practice (children only, adults and children, adults only, and FQHCs/RHCs) and what level of medical home a practice is. SoonerCare Choice has three tiers of medical homes: Tier 1 is an entry level medical home; Tier 2 is an advanced medical home; and Tier 3 is an optimal medical home. The self-evaluation form that primary care practices use to apply for becoming a medical

home and the way in which the three tiers are designated were developed by Oklahoma staff particularly for their program. Medical home practices receive provider support and care management from Oklahoma Medicaid staff, including nurses and social service coordinators who provide telephonic support and utilize a web-based clinical case management system. Over 770 medical home providers participate in SoonerCare Choice and more than 400,000 Medicaid eligibles (over sixty percent of eligibles) are enrolled.

Pennsylvania's program, ACCESS Plus, is an enhanced primary care case management (ePCCM) program that focuses on making incentive payments to participating providers for utilization and quality outcomes. The program began in 2005 and now operates in 42 rural counties in Pennsylvania. In 27 rural counties, recipients have the option of joining a capitated health plan or the ACCESS Plus program. In the other 15 rural counties, ACCESS Plus is the only form of managed care. Over 1600 providers participate in the pay for performance program, which includes 317,000 Medicaid recipients. Pennsylvania's Medicaid Agency, the Pennsylvania Office of Medical Assistance Programs, contracts with a vendor to administer the program and provide network support, enrollment assistance, care coordination, disease management, and case management. The state agency also provides complex case management support in-house.

The Washington Legislature mandated a disease management program for Medicaid in 2001. After focusing on disease management for several years, Washington Medicaid decided to move towards a chronic care management/medical home model instead. Washington's Medicaid medical home program is in partnership with King County Care Partners (KCCP). Approximately 8,000 Medicaid recipients are eligible for the program each month and must be in the SSI/Categorically Needy Program (CNP) or aged, blind, and disabled eligibility groups. Predictive modeling is used to identify the highest risk recipients who may benefit from intensive care management. KCCP receives a PMPM fee of $8.70, $2.50 of which goes directly to provider clinics/practices. KCCP connects recipients with clinics which conduct assessments of and provide health care to the recipients. KCCP also coordinates the clinic and other services for recipients, including mental health and chemical dependency treatment, housing, transportation, and other social services.

Task Force recommendations regarding defining a medical home:

Based on what the Task Force learned from other state's programs and from the members sharing their own ideas and experiences, the Task Force recommends that the medical home pilot program have the following elements:

- Every Medicaid recipient should have a primary care provider (physician, ARNP, or physician's assistant) who is available on a 24/7 basis.
- Patient care should be coordinated – the PCP must ensure that services to which recipients are referred have been received and that appropriate follow-up is done. PCPs should address both physical and behavioral health care needs of recipients and develop strong referral relationships with local mental health providers.
- The Task Force suggested using the NCQA Patient-Centered Medical Home standards as a starting point for developing the requirements to qualify as a medical home.
- The Task Force is interested in pursuing a 3-tiered approach to levels of medical homes, similar to Oklahoma.
- The Task Force recommends that an Advisory Board be appointed to assist the Agency during the planning and implementation of the Florida Medicaid medical home pilot project.

- New payment methodologies and primary care practice operations will need to be instituted for the medical home pilot. In general, based on the models from the other states that presented to the Task Force as well as the studies provided to the Task Force, adequate physician participation in the pilot is dependent upon the reimbursement rates for physician fees as well as any case management fee and/or incentive payments. Agency staff reported to the Task Force that in general, Florida Medicaid FFS rates for physician services are approximately 58% of Medicare rates, so increasing physician fees may be necessary to attract providers to participate in the medical home project. While increasing physician fees may be necessary, the Task Force strongly recommends that any program design should investigate payment methodologies to ensure a return on investment.

Where should the medical home pilot be implemented?

The Medical Home Task Force was asked to recommend two pilot areas for the medical home program. From the presentations on other states' Medicaid medical home programs, the Task Force learned that Community Care of North Carolina focuses on regional networks of providers that combine urban and rural areas to better serve Medicaid recipients. Oklahoma instituted its SoonerCare Choice program statewide. Pennsylvania's ACCESS Plus program covers 42 rural counties. Washington's medical home program took advantage of existing community partnerships by establishing the program with King County Care Partners, which serves the city of Seattle.

Task Force recommendations regarding pilot sites:
The Task Force recommends that the Advisory Board and the Agency develop criteria that would define the pilot sites based on data, including:

- Medicaid spending
- Recipients – consideration of areas that have a good case mix
- Size of overall population
- Ability of a single independent evaluator to conduct a research study of the pilot area
- At least one rural area
- At least one urban area with an academic setting/medical school
- Strong consideration of the extent of uncoordinated care as evidenced by pharmaceutical use, emergency room visits, and hospital admissions for ambulatory care sensitive conditions
- Level of interest in participating in a medical home program among local providers and community physicians

In addition to the Advisory Board and Agency developing pilot site criteria, the Task Force strongly recommends that the identification of potential pilot sites be based on community network interest and capacity for providing medical home functions. The Task Force is interested in having communities provide their ideas for medical homes that will make use of community resources and networks that are already in place. The pilot should begin small, in a couple of areas rather than statewide, although the Task Force recognizes that any savings generated through the pilot will be relative to the number of recipients and providers included in the pilot.

Who will participate in the medical home pilot project?

Most states with medical home programs have targeted a subgroup of Medicaid beneficiaries, usually with complex needs, such as children or adults with special health care needs or chronic conditions. More recently this has broadened to include all eligible populations. North Carolina's program includes all recipients but has focused interventions including chronic care and disease management, hospital transitions, and mental health integration. Oklahoma's program covers TANF and SSI/aged, blind, and disabled recipients with case management/care coordination fees based on whether practices service children only, adults and children, adults only, or are FQHCs or RHCs. Pennsylvania's program excludes dual eligibles but includes aged, blind, and disabled, over 50,000 of whom have chronic diseases covered by their disease management program. Washington's medical home program focuses on those in the SSI/CNP and aged, blind, and disabled eligibility categories who have one or more claims from the clinics participating with King County Care Partners. Although many states' medical home programs have focused on Medicaid providers and recipients, some states are beginning to work on multi-payor initiatives as well. In terms of what providers are included in a medical home program,

the states that shared their experience with the Task Force reported using a "bottom-up" approach for networks. For example, North Carolina's program has regional networks that span urban and rural areas, some of which are hospital-based and some of which have formed non-profit entities. Washington's program built on a local entity in Seattle with a network of community health centers as the locus of its medical home program.

Task Force recommendations regarding who will participate in the pilot:

The Task Force recommends that the Advisory Board and the Agency work together to identify those Florida Medicaid recipient populations that would most benefit from a medical home pilot program regardless of whether they are currently in PCCM (MediPass) or managed care organization (HMOs or PSNs) models. To the extent possible, the choice of sites and populations should be informed by assessment of data on uncoordinated care and/or lack of access to care, as demonstrated by pharmaceutical use, emergency room visits, and hospital admissions. The Advisory Board and the Agency should work together to determine provider qualifications and required services for the Medicaid medical home pilot, although the Task Force recommends soliciting community providers/ networks to propose what medical home models the providers/networks could provide rather than the Advisory Board and Agency dictating particular structures. The Task Force recommends that a three-tier service model similar to Oklahoma's be used to designate which providers are eligible to participate in the pilot program. Task Force members suggested that the pilot could be a mixed model that includes MediPass providers, community networks, hospitalists, specialists, and managed care organizations, but that it should allow "bottom up" designs that incorporate strong community based partnerships.

<u>What services will be provided through the medical home pilot?</u>

Many medical home programs have focused on disease management and chronic care management or complex care management. Depending on the size of practice, however, some practices may not have the capacity to implement their own care management programs. In North Carolina, the CCNC networks provide care management services for their participating providers, while in Oklahoma, the state Medicaid Agency provides care management support. Pennsylvania has contracted with a vendor to provide disease management and to administer its pay for performance program, while state Medicaid staff provide complex care management to enrollees. Washington contracts with KCCP to provide chronic care management and coordination with other social service and health care resources. Pharmacy/medication management can be another component of medical home programs. While it may not be feasible for all provider practices to have their own pharmacists onsite, in North Carolina, the networks provide pharmacists to support primary care practices.

Task Force recommendations regarding what services to provide in the pilot:

The Task Force recommended the Advisory Board and Agency develop the criteria for three tiers of medical home providers and define the specific services associated with each tier. The Advisory Board and Agency will consider the services and models proposed by local community providers/networks when setting the criteria for the three tiers. The Task Force also recommends that medical home providers should be available on a 24/7 basis and coordinate and ensure that follow-up is done on any services for which the recipient is referred to another provider or specialist. That is, all state plan services should be provided or arranged and coordinated for recipients by their medical home provider. The Task Force suggested that it is important for developmental, behavioral, and mental health care to be integrated with primary care.

How will the pilot program be administered?

States that have implemented Medicaid medical home programs have made significant investments in infrastructure for their programs. North Carolina uses Community Networks as the administrative entities for its program. These networks are non-profit organized healthcare arrangements with safety-net providers including PCPs, hospitals, and health departments, among others. Pennsylvania uses an enhanced PCCM model with a contracted vendor for disease management and the pay for performance project. Pennsylvania's state Medicaid staff provides support to providers through complex case management functions. Oklahoma also has a PCCM model that is administered internally by state Medicaid staff, including provider support, care management, and oversight. Oklahoma's medical home program was developed by the Oklahoma Health Care Authority and a Medical Advisory Task Force, which includes representatives delegated by provider associations in Oklahoma. Washington has used a managed care organization as an administrative entity as well as a network comprised of community health centers. For their medical home pilot programs, states have applied for and received approval for 1115 waivers and 1915(b) waivers.

Task Force recommendations regarding how the pilot should be administered:

Recognizing that improving access to and quality of care for Medicaid recipients is of critical concern to the State, while being aware of the budget pressures facing the State, the Task Force urges moving forward with the medical home pilot as quickly as is feasible, with adequate structure and funding to allow for a well planned and well run medical home pilot program. The Task Force recommends that a Medical Home Advisory Board be created to work with the Agency on setting core process criteria and a core set of quality measures for the pilot. The Advisory Board should include consumers as well as health care providers, clinicians, advocates, and managed care representatives. The medical home pilot should be administered by the Agency with input and feedback from the Advisory Board. The Agency will be responsible for submitting waiver requests for the pilot to CMS. The Task Force recommends that there be a strong evaluative component to the pilot and that a single independent evaluator conduct an evaluation of the medical home pilot and provide a final report to the Legislature. The Agency, in collaboration with the Advisory Board, will provide an annual report to the Legislature.

What financial and other resources are needed and available for the pilot? How should providers be reimbursed?

The state presentations to the Task Force indicate that it takes significant time and staffing to implement a medical home program. It is important to invest in processes such as educating providers, developing programs to improve the health literacy of recipients, training of care managers and providers, and providing support and guidance to providers in the use of health information technology. Helping providers to become medical home providers requires establishing new relationships between administrators and providers. Pennsylvania Medicaid staff reported providing education and assistance to their primary care providers to build better medical homes, and Washington found that it took time and effort to build relationships and trust with its medical home providers.

Medical home programs often require a restructuring of payments to providers as well. Some states have paid a case/care management fee PMPM to primary care providers in addition to paying for office visits on a fee-for-service basis. States have also increased their FFS reimbursement to providers, so that they are at or near 100 percent of the Medicare rate. North Carolina pays medical home providers a PMPM case management fee and increases that amount if the provider joins one of the Community Care networks. The networks themselves

receive a PMPM fee as well. North Carolina also increased their Medicaid FFS reimbursement to 95 percent of the Medicare rate. Washington pays a PMPM fee to the King County Care Partners, who administers the medical home program. More than a quarter of this fee goes directly to the clinics that serve as the medical homes. Pennsylvania's program set up different payments for different phases of the ACCESS Plus program, beginning by paying physicians for participation and encouraging recipient participation, moving to paying physicians for developing care plans with the vendor's care managers, and finally paying physicians for quality of care process improvement. Pennsylvania's Medicaid FFS reimbursement is 73 percent of the Medicare rate. Oklahoma initially used capitated bundled payments to its providers that included a PMPM fee for care coordination, but it recently unbundled these payments by moving to a fee-for-service payment system that allows billing for additional codes related to medical home functions. Oklahoma's Medicaid FFS reimbursement is 100 percent of the Medicare rate.

Task Force recommendations regarding financing and reimbursement for the medical home pilot:

The Task Force recognizes that successful medical home projects in other states have been predicated on a higher general reimbursement rate to physicians and other providers of health care services. To be successful in Florida, the Task Force finds that a medical home pilot project must address core funding issues for those who agree to provide health care services through this program. Strong consideration should be given to reimbursement models that include, but are not limited to: enhanced fees for services rendered, care management fees, and pay for performance/incentive payments.

Provider payment needs to cover care coordination and increased health information technology (HIT) costs, although the Task Force recommends that the Agency take advantage of investments the State is already making in HIT and leverage American Recovery and Reinvestment Act (ARRA) dollars for incentives to physicians that adopt differing levels of HIT in their practices. The Task Force also recommends that performance incentives be included in the reimbursement design. Performance-based incentive payments should be based on an ongoing assessment of costs saved or avoided by the medical home model and participating providers. A portion of any savings that are achieved through the pilot in subsequent years should be used for enhanced case management fees or performance incentive payments. The Task Force recommends that the Agency should pursue any funding opportunities that may be available under federal health care reform legislation (e.g., enhanced administrative match and pilot grants for medical home or health home pilots and services).

Although other states have increased their provider reimbursement rates while implementing Medicaid medical home programs, several states have achieved and reported cost savings under the medical home model. The Task Force acknowledges that it is difficult to predict the amount of savings that Florida may achieve through the medical home pilot, but asserts that better coordination of care should result in cost efficiencies and savings. Better coordination of care through the medical home pilot should also reduce the potential for Medicaid fraud and abuse, which will contribute to overall savings. The Task Force strongly recommends that any program design should investigate payment methodologies to ensure a return on investment.

Closing Comments

The Task Force strongly recommends that an Advisory Board be created to work with the Agency on the following steps, and that this pilot is one that is urgently needed. Although it is too early to set specific dates for when these steps will take place, the following is a general timeline of necessary steps:

Year 1 – 2010-11

- Legislation passes, establishing a medical home pilot. Implementation of the pilot including any waivers that are authorized is contingent upon review and approval by the Legislature.
- A Medical Home Advisory Board appointed.
- The Agency will seek federal waiver approval for the medical home pilot (may take up to nine months).
- The Agency will work with the Advisory Board on an implementation plan.
- Outreach to communities and providers regarding the medical home pilot.

Year 2 – 2011-12

The Agency will continue implementation work with the Advisory Board, including the following steps:

- Continued outreach to communities and providers regarding the medical home pilot;
- Education of potential participants including providers, consumers, and other stakeholders;
- Solicit input and "bottom-up" proposals regarding program design from interested parties such as potential participants, consumers, and stakeholders;
- Perform gap analysis of current environment, including Medicaid spending, size of population, and areas with uncoordinated care;
- Design the program by specifying:
    - Geographic pilot areas
    - Delivery system and standards
    - Reimbursement strategies
    - Recipient eligibility
    - Provider network standards, certification tier criteria and monitoring processes
    - Health information technology expectations;
- Identification and contracting with providers and managed care organizations;
- Provide technical assistance for model implementation;
- Perform readiness reviews;
- Enrollment of recipients into the medical home pilot;
- Selection of an evaluator and evaluation design for the pilot; and
- Monitor and assess the pilot and provide a final report to the legislature.