

Medicaid Medical Home Task Force Report

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

February 2010



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 to 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

Dr. Coy Irvin, Board of Directors Member
Florida Academy of Family Physicians

John Kaelin, Senior Vice President
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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. 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 discuss and finalize this report.

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 the federal poverty level. Each state administers its program under a federally approved state plan. There are federal requirements that must be met 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 on eligibility, and provider reimbursement 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%. 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. 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 (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 Plan to the Centers for Medicare and Medicaid Services (CMS). The 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 and fee structures defined within the state plan cannot be limited by geographic area, amount, duration, or scope. That is, State Plan services and fee structures must apply to all recipients and providers equally.

In order for states to implement 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 waivers
- 1115 waiver for family planning, Meds-AD, and Medicaid Reform programs

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 Organization (HMOs and Provider Service Networks [PSNs])
- Prepaid Ambulatory Health Plan (overlay services such as Prepaid Mental Health and Prepaid Dental Health)

Federal regulations specify which Medicaid recipients may enroll in or be assigned to these managed care delivery systems. Those in the Aged and Disabled, Temporary Aid to Needy Families (TANF), and MediKids eligibility groups may be required to enroll in or be assigned to managed care. 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. Those in the Medically Needy, Retroactive Eligibility, and Family Planning and SOBRA pregnant women eligibility groups are 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, ARNPs, and physician assistants) are paid a \$2.00 monthly case management fee for each of their enrollees, while the services they provide to MediPass members are paid for on a fee-for-service basis.

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.

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 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 offer services like 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 their enrollees.

Task Force Findings and Recommendations

The Medical Home Task Force met five times between September 2009 and January 2010. During the meetings, Task Force members shared and discussed their ideas of what elements a Medicaid medical home pilot should include. 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?

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. 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 who collectively take 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, allow for 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 about how other state Medicaid programs are implementing some if not all of these principles in their medical home programs. North Carolina's medical home program, Community Care of North Carolina (CCNC), includes 14 community networks, over 3500 physicians, and serves over 950,000 enrollees. 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.

Oklahoma's program, SoonerCare Choice, 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 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. 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.

Washington's Medicaid medical home program is in partnership with King County Care Partners (KCCP). Approximately 8000 Medicaid recipients are eligible for the program each month and must be in the SSI/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.
- The Task Force suggested using the NCQA Patient-Centered Medical Home standards as a starting point for developing the components of 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 a Task Force or 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.

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

- Medicaid spending
- Recipients
- Size of overall population
- Ability of a single evaluator to conduct a research study of the pilot area
- At least one rural area
- An urban area with an academic setting/medical school
- Level of uncoordinated care

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.

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 pilot serve those recipients that are currently eligible for Medicaid managed care and that the Task Force/Advisory Board work with the Agency to determine other recipient eligibility categories to include. The Task Force/Advisory Board and the Agency should work together to determine provider qualifications and required services for the Medicaid medical home pilot. 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, and managed care organizations, but that it should allow "bottom up" designs that incorporate strong community based partnerships.

What services will be provided through the medical home pilot?

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 did not make specific recommendations about the types of services that medical home providers should offer, other than its recommendation that every recipient should have a primary care provider who is available on a 24/7 basis. The Task Force also recommends that this provider should 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 and coordinated for recipients by their medical home provider. As the Task Force/Advisory Board and Agency develop the criteria for the three tiers of medical home providers, the specific services associated with each tier will be defined.

How will the pilot program be administered?

North Carolina uses Community Networks as the administrative entities for their 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 provide 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:

The Task Force recommends that a Medical Home Task Force or Advisory Board be created to work with the Agency on setting core process criteria for the pilot. The Advisory Board should include consumers as well as health care providers and clinicians. 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 a single 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. 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. 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. 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.

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

The Task Force recommends that payment for primary care services may be a PMPM amount or on a FFS basis. The fee schedule for the medical home pilot should include an increased case management PMPM payment to participating providers or should include new codes for medical home functions that will be reimbursed. Payment needs to cover care coordination and increased health information technology costs (HIT), 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. 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).

Closing Comments

The Task Force strongly recommends that a Task Force or Advisory Board be created to work with the Agency on the above 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

- Legislation passes establishing a medical home pilot.
- A Medical Home Advisory Board appointed.
- The Agency will seek federal waiver approval for the medical home pilot (may take up to nine months). Implementation of the pilot including any waivers that are authorized is contingent upon review and approval by the legislature.
- 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

The Agency will continue implementation work with the Advisory Board. The Medical Home Task Force recommendations described above suggest that planning and implementation for the medical home pilot include the following steps:

- Education of potential participants including providers, consumers, and other stakeholders;
- Solicit input about 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; and
- Monitor and assess the pilot and provide a final report to the legislature.