



## Building the Medical Home: Under Construction in the States

## FORUM SESSION ANNOUNCEMENT

A DISCUSSION FEATURING:

**Mary Takach**

*Policy Specialist*

National Academy for State Health Policy

**Joan Henneberry**

*Executive Director*

Department of Health Care Policy and Financing

**Christopher G. Atchison**

*Associate Dean, College of Public Health*

University of Iowa

**Anthony Rodgers**

*Director*

Arizona Health Care Cost Containment System

**Jeffrey Schiff, MD**

*Medical Director*

Minnesota Health Care Programs

FRIDAY, JUNE 5, 2009

11:45AM–12:15PM—Lunch

12:15PM–2:00PM—Discussion

### LOCATION

Reserve Officers Association  
One Constitution Avenue, NE  
Congressional Hall of Honor  
Fifth Floor

*(Across from the Dirksen  
Senate Office Building)*

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**SESSION**

Promoting adoption of the medical home model remains a central theme in health reform discussions. The concept is wielded to serve a number of policy aims, from shoring up primary care practice to coordinating care for patients with multiple complex chronic conditions to encouraging more widespread use of health information technology (HIT) as a vehicle for delivery system transformation. The Patient-Centered Primary Care Collaborative, a broad-based coalition formed to develop and advance the patient-centered medical home (PCMH), reports on 23 multi-stakeholder demonstrations underway around the country and notes that there has been legislation or other PCMH activity in 44 states.<sup>1</sup>

Whether a single model can successfully serve such disparate goals as encouraging more medical students to choose careers in primary care and helping patients and caregivers manage multiple complex chronic conditions is still an open question. One place to explore that question is in state Medicaid programs, which serve both children (who most often need preventive and primary care, though a subset also have chronic and/or disabling conditions) and an aged/blind/disabled population often in need of complex and continuous care.

Medicaid programs offer other advantages as a PCMH testing ground. They have experience serving a low-income population that frequently needs social services (such as transportation and child care) as well as clinical services. States already have amassed considerable experience with case management, disease management, and other monitoring and coordination approaches for their Medicaid beneficiaries. They work with providers in a variety of structures, including individual medical practices, community health centers, and managed care networks. They have experimented with reimbursement approaches, such as per-member per-month payments for primary care case management, designed to promote participation and quality improvement among providers. Some have even developed an infrastructure of community-based resources to supply non-clinical support services to beneficiaries and their primary care providers.

Some observers hope that state (and eventual federal) efforts will be evolutionary in nature, helping to transform the way care is delivered as they gradually bring in more complex populations and test new ways to influence provider behavior. Several states are already planning to extend the medical home model beyond the public programs. For example, Pennsylvania is piloting a multipayer chronic

care initiative, involving commercial insurance carriers as well as Medicaid managed care plans, in the southeast part of the state.

This Forum session, the third in a series examining PCMH programs,<sup>2</sup> brings together representatives from four states who are engaged in implementing such programs. Colorado, building on a successful pediatric medical home pilot, is paying enhanced rates to providers to deliver EPSDT (early and periodic screening, detection, and treatment) services to children in Medicaid and CHIP (Children's Health Insurance Program, formerly known as SCHIP) programs. Separately, the state is expanding a pilot program for disabled adults. Iowa's PCMH initiative, managed by the Department of Public Health, aims to manage services from prevention to end-of-life care, reducing costs and care disparities in the process. The Arizona Health Care Cost Containment System (or AHCCCS, as the Medicaid and CHIP programs are collectively known), operates entirely via managed care contractors, and has put those contractors on notice to develop their medical home capability. Arizona is also using a Medicaid Transformation Grant from the Centers for Medicare & Medicaid Services to develop HIT tools to support medical home functions. Performance measurement and quality reporting are well-established in Minnesota; the PCMH program there has a strong emphasis on quality improvement as well as patient engagement.

## KEY QUESTIONS

- How broadly does a state define "medical home"? How do states attempt to meet the varying needs of different sub-populations, with respect to factors such as age, level and kind of services required, and cultural appropriateness?
- What support is offered to help practices change their organization or the way they function: connection to community services? coaching services? technical assistance with HIT?
- Does the PCMH model seem better suited to one practice structure or size? Will community health centers and integrated delivery systems be eligible for support under PCMH?
- What financial incentives are offered to encourage participation, quality improvement, and/or documenting performance?
- How do states view the role of HIT in supporting a medical home? Is there an expected role for existing health information exchanges?

- How will a state determine whether a PCMH program is worth the extra resources committed to it? Is there a way to measure patient-centeredness as well as access and cost savings?
- To what extent is medical home development part of a broader health reform plan in the state? Is it seen as a step toward system transformation and a population health orientation?
- What advice would states offer federal policymakers, particularly with respect to dovetailing state and federal PCMH proposals?

### SPEAKERS

**Mary Takach**, policy specialist with the National Academy for State Health Policy, will summarize findings of a recent study of 10 states' PCMH programs, including elements associated with successful development. State representatives who will engage in facilitated discussion are **Joan Henneberry**, executive director of Colorado's Department of Health Policy and Financing (which oversees public health insurance programs including Medicaid and CHIP) and advisor to the governor on health policy; **Christopher Atchison**, associate dean of the College of Public Health at the University of Iowa and a former director of the state's Department of Public Health; **Anthony Rodgers**, director of the AHCCCS, which incorporates Medicaid and CHIP; and **Jeffrey Schiff, MD**, medical director of Minnesota Health Care Programs, a division director in the Department of Human Services, and a practicing pediatrician.

### ENDNOTES

1. For general information on the Patient-Centered Primary Care Collaborative, see the PowerPoint presentation available for download at [www.pcpcc.net/content/general-presentation-materials](http://www.pcpcc.net/content/general-presentation-materials).
2. For details on the two previous sessions in this series, see the Web entries for the June 27, 2008 ([www.nhpf.org/library/details.cfm/2632](http://www.nhpf.org/library/details.cfm/2632)) and October 28, 2008 ([www.nhpf.org/library/details.cfm/2681](http://www.nhpf.org/library/details.cfm/2681)) meetings.