

Enhanced Medical Home Strategies

Key Themes:

- Growing momentum to move beyond FFS to more coordinated approaches (e.g., EPCCM, medical home).
- Increasing interest in alternative financing methods (e.g., shared risk/savings, P4P, etc.).
- Emerging efforts to develop and test more appropriate performance measurement and monitoring strategies.

Components of EMH

- Predictive Modeling
- Health Risk Assessments
- Physical-Behavioral Health Integration
- Role of Medical Homes
- Engagement Strategies (Patients and Providers)
- Accountability

Elements of EMH

- A participant is linked with a physician, medical practitioner, clinic, or other safety net provider who will serve as their medical home.
- The medical home acts as a team to:
 1. Assess the participant's health care needs;
 2. Coordinate and plan the participant's care;
 3. Provide quality primary care services and preventive screenings;
 4. Authorize referrals to specialists; and
 5. Provide linkages to other care and equipment providers.
- The medical home integrates IT to support quality and safety.

Member Benefits/Provider Supports

- Beneficiaries are offered:
 - ▶ Toll-free health advice, 24/7;
 - ▶ In person health education and counseling;
 - ▶ Linkages to community-based services (housing, behavioral health, etc.);
 - ▶ Integrated care management for those identified as having complex medical and social needs.
- Providers are offered:
 - ▶ Practice support as needed;
 - ▶ Training and education on Patient-Centered Medical Home;
 - ▶ Technical assistance on quality improvement, evidence-based medicine, IT resources.

Model Option 1: State-operated

- Oklahoma's Sooner Care Choice:
 - ▶ Builds on, supports, and strengthens the existing primary care provider network
 - ▶ Provides supports to beneficiaries and providers (nurse advice; education)
 - ▶ Provides care coordination to high risk beneficiaries
 - ▶ P4P model rewards providers
 - ▶ Difference for CA: OK pays Medicare rates to providers; fully capitated managed care was not viable

Model Option 2: Single Private Vendor

- State of Illinois:
 - ▶ Single contractor provides all operations
 - ▶ Vendor forms and operates provider network
 - ▶ Vendor provides supports for beneficiaries and providers
 - ▶ Care coordination through subcontracted arrangement for high risk population
 - ▶ Is relatively quick to implement & can be contracted at risk
 - ▶ Difference for CA: local involvement not a priority

Model Option 3: Local Public/Private Partnership

- Community Care of North Carolina:
 - ▶ Gradually developed local public/private entities in 14 geographic locations
 - ▶ Local entities responsible for network, provider and beneficiary supports
 - ▶ Local determination of QI efforts
 - ▶ State funds are split between providers and regional partnerships
 - ▶ Difference for CA: NC had many years to develop model before cost neutrality was required

Model Option 4: Blended Model

- Washington's King County Care Partners:
 - ▶ Local entities given preference if willing and able to contract for enhanced medical home
 - ▶ Statewide contract awarded to cover remaining geographical regions
 - ▶ Statewide vendor's role diminished over time, shifting responsibility to local and state staff as they developed capacity
 - ▶ Difference for CA: grew out of totally unmanaged care for ABD population; cost neutrality a goal but not required