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**Eight State Teams Selected to Form New NASHP Consortium to Advance Medical Homes**

**WASHINGTON, DC, September 1, 2009** – The National Academy of State Health Policy (NASHP) announced today that eight state teams were selected through a competitive process to form NASHP’s new Consortium to Advance Medical Homes for Medicaid and Children’s Health Insurance Program (CHIP) Participants. Selected states have committed to work together, with the support of NASHP through a grant from The Commonwealth Fund, to develop and implement policies that increase Medicaid and CHIP program participants’ access to high performing medical homes. A medical home is an enhanced model of primary care in which care teams attend to the multi-faceted needs of patients and provide whole person comprehensive and coordinated patient-centered care.

Each state will receive a one-year program of technical assistance to support their efforts. The technical assistance program will provide opportunities for consortium members to exchange insights and experience with national experts and their peers, as well as both in-person and distance learning and both group and individual assistance. The Medical Home Consortium will be administered by NASHP.

The Consortium will launch with an invitation-only Medical Home Learning Session in October. The kick-off meeting will bring together the newly selected state teams to share information regarding medical home initiatives and policy developments with other teams in a collaborative setting. Experts, including mentors from leading states, will help consortium members understand their policy options and develop/refine their plans for achieving five key policy goals: develop key partnerships, define and recognize medical homes, improve purchasing and reimbursement policies, support practice change, and measure progress.

Eight state teams were selected— Alabama, Iowa, Kansas, Maryland, Montana, Nebraska, Texas, and Virginia. Selection was based on specific criteria:

- The state’s documented commitment to improving the quality and availability of medical homes to Medicaid and/or SCHIP participants;
- The comprehensiveness of the state’s plans;
- The strength of the project team;
- The likelihood that the state’s experience, challenges, and goals for medical home advancement will offer lessons and guidance for other states; and
- The extent to which a state’s work to date offers it potential to realize maximum benefit from Consortium resources.

NASHP’s project will be informed by previous, Commonwealth Fund-supported work. The original Consortium to Advance Medical Homes completed its work earlier this year. Eight states – Colorado, Minnesota, New Hampshire, Oklahoma, Washington, Idaho, Louisiana and Oregon – made significant progress in advancing medical homes within their borders and will be involved as expert faculty mentors in the new Consortium state project. NASHP disseminated their work to a national audience through webcasts, reports, and briefs available on the medical homes section of NASHP’s web site, <http://www.nashp.org>.

The following highlights some of the ways new Consortium members are hoping to use the technical assistance provided to help advance medical homes in their state Medicaid and CHIP programs.

**Alabama** has a well established Medicaid & CHIP primary care case management program in place that includes many critical elements of Patient Centered Medical Homes (PCMH) such as designated primary care providers (PCP), some electronic medical records with information sharing (enabled with Medicaid Transformation Grant funds), payment incentives including per member/per month and incentive payments, and some quality monitoring. Alabama is looking to strengthen its core team, conduct a gap analysis of practices, expand its medical home definition into practical adoption steps, better support and incent practice change and develop a strategy to link PCPs with measures linked to quality outcomes.

**Iowa** has legislative support for establishing and spreading the PCMH model as a standard of care for all citizens as a major component of its health care reform. Plan will begin with Medicaid children. Workgroups and partnerships have been established, and recommendations have been made to implement a multi-payer reimbursement model and expand infrastructure that will better support PCMH model including educating providers, fostering health information technology, and addressing prevention and chronic care management. Consensus on the Joint Principles has been reached and further work is required to develop recognition criteria, reimbursement models, infrastructure support, and effective measurement criteria.

In 2007 the **Kansas** legislature codified a medical home definition, established a stakeholder process, and emphasized intent to phase in medical homes for all Medicaid and CHIP enrollees with an initial focus on children enrolled in managed care and primary care case management. Funding for program enhancements has been denied due to budget constraints, but future requests will be made. Purchasing and reimbursement policies need development, resources and support needed to implement practice change have been identified, but strategies and policies will need to be developed, and there are no identified programs measures.

In **Maryland** an Executive Order focused on improving healthcare quality identified the creation of an all-payer medical home pilot as a priority for 2009-2010. The stakeholder process includes several working groups that have adopted a definition of PCMH, and agreed upon National Committee for Quality Assurance recognition standards. Legislative and funding support has been established for an information technology/sharing infrastructure. Work is still required to develop purchasing/reimbursement policies, practice coaching, and set benchmarks for measuring progress.

**Montana** has a primary care case management program for most of its Medicaid enrollees with a lock-in primary care case management program for high cost/risk Medicaid patients. They are developing a Health Improvement Plan that will contract with local community health centers to offer care coordination and management for high cost/risk beneficiaries using predictive modeling software. The community health centers will hire health coaches and licensed nurses who will work as part of the care team with PCPs. The state has begun forming partnerships and developing a medical home definition. Work is required on purchasing and reimbursement policies, and supporting practice change. Plans are underway to measure provider and client satisfaction using surveys and to use claims query software to perform certain measurements.

**Nebraska's** 2009 Legislature passed legislation to establish a medical home pilot to be designed and implemented by 2012, including appointing a seven member Governor's Medical Home Advisory Council by October 2009. Possibly using a fee for service system with a primary care case management model, Medicaid/CHIP clients of all ages in one or two rural geographic areas have been targeted. A Department of Health and Human Services Core planning team is in place that will work with the Governor's Council. Until the council is in place, decisions on defining, recognizing, purchasing, supporting practice change, and measuring progress will not be made, but considerable research and planning is underway to develop the backbone for decision-making.

**Texas** has dedicated \$25 million to test eight to ten Health Home models to determine the best model to launch statewide. Pilots are expected to be implemented by March 2010. The state has hired a consultant to work with state officials to establish all the core components of the pilots, including forming an expert panel to advise the pilots. Work has yet to begin on most of the core decisions needed for the pilots. In addition, at the request of the state's legislature, Texas Medicaid will be developing a Health Information Exchange infrastructure to provide PCPs access to electronic health records, electronic prescribing, and other features that will serve to support many of the pilot principles.

**Virginia** is looking to transition a Medicaid primary care case management program in southwestern Virginia to a medical home pilot consisting of primary care, behavioral health, disease and case management, and other services. Targeted population includes vulnerable citizens, including aged, blind, and disabled populations, and low income families with children. Partnerships have been established with Community Care Network of Virginia, and the former head of the Virginia chapter of the American Academy of Pediatrics supports the initiative. Other core components of medical homes, including defining, recognizing, purchasing, supporting practice change, and measuring progress, have been researched (with some concept papers drafted), but no decisions have been made regarding core aspects of the pilot.

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