

Draft

Outline for Medical Home Legislation

November 15, 2009

Standards and Criteria: qualifications for designation as a patient centered medical home define three tiers of participation similar to the Oklahoma model.

Tier 1:

- Supplies all medically necessary primary and preventive services.
- Provides all scheduled immunizations.
- Organizes clinical data in paper or electronic form using a patient-centered charting system.
- Maintains and updates members' medication list and reviews all medications during each office visit.
- Maintains a system to track diagnostic tests and provide follow-up on test results.
- Maintains a system to track referrals including self-referrals by members.
- Supplies care coordination and continuity of care through proactive contact with members and encourages family participation in care.
- Supplies education and support utilizing various materials and processes appropriate for individual patient needs.

Tier 2, includes all of Tier 1 requirements plus the following:

- Accepts electronic communication.
- Supplies voice-to-voice telephone coverage to panel members 24 hours per day, seven days per week, where patients can speak to a licensed health professional. Triage and forwards calls as appropriate.
- Written copy of the mutual agreement between medical home and patient is maintained in the patient's record.
- Maintains an office schedule of at least 30 scheduled hours per week.
- Uses scheduling process to promote continuity with clinicians, including accommodation for walk-in, routine, and urgent care visits.
- Implements and documents behavioral health/substance abuse screening procedure and makes referrals as needed.
- Uses data to identify and track panel members' health and service utilization patterns.
- Coordinates care and follow-up for panel members receiving services in inpatient and outpatient facilities.
- Implements processes to promote access to care and provider-member communication.

Tier 3, includes all of Tier 1 and Tier 2 requirements plus the following:

- Utilizes electronic medical records.
- Develops a healthcare team that provides ongoing support, oversight and guidance for all medical care received by the member and documents contact with specialist and other health care providers caring for the member.
- Supplies post-visit follow-up for panel members.
- Implements specific evidence-based clinical practice guidelines for preventive and chronic care.

- Implements a medication reconciliation procedure to avoid interactions or duplications.
- Uses personalized screening, brief intervention, and referral to treatment procedures for appropriate panel members requiring specialty treatment.
- Offers at least 4 hours of after-hours care to members.
- Uses health assessment tool to identify patient needs and risks.

Organizational structure: structure should be similar to North Carolina allowing for differences at the community level, but enough of a statewide infrastructure to promote the exchange of information and dissemination of best practices.

Community networks: medical home networks do not need to be incorporated or formally organized, but should have a community-based leadership consisting of participating providers and charged with promoting coordination among network members.

Principal provider: each network should identify a principal provider who serves as the main point of contact for AHCA and the entity responsible for convening meetings of the community network.

Statewide advisory panel: the state panel should be appointed by the Governor, the Speaker of the House, and the President of the Senate. The panel should consist of seven members representing primary care physicians, specialty physicians, hospitals, insurers/HMOs, AHCA, a consumer advocate, and medical education representative. The responsibilities of the panel include advising AHCA on the management of the program and arranging meetings of the community network representatives that are focused on best practices.

Designated areas: medical homes should be developed initially in areas where the greatest potential exists for improving patient care and achieving more cost-effective health care delivery. Data on emergency department utilization and hospitalizations of Medicaid patients with chronic diseases can be used to identify these target areas.

Payment methods: primary care medical homes should receive a care management fee and payment for services should be based on a fee schedule. The care management fee should be adjusted to reflect patient needs. Fees for services should be increased based on savings more cost effective service delivery.

Evaluation measures: specific, quantitative standards for performance should be established for primary care medical homes. Examples include emergency department utilization, hospitalization for ambulatory care sensitive diagnoses, and other disease management standards. Achieving these standards should be established as qualification for higher payment rates. These evaluation measures should be expanded and modified over time.

Collaboration with other payers: in order to enable Florida to participate in federal initiatives, private insurers should be encouraged to use medical home models. Medical homes should also be explored for applicability to the state employee health insurance plan.

Hospital participation: hospitals should be incentivized to participate through the establishment of tax credits or waivers.

HMO participation: Medicaid prepaid health plans should also be able to qualify as medical home networks.

Medical education: graduate medical education programs should be encouraged to participate in medical home networks in their service areas.

Start date: October 1, 2010