Nebraska Medicaid Patient-Centered Medical Home Pilot Standards

A goal of the Nebraska Medicaid Patient-Centered Medical Home Pilot is to develop fully recognized and operating medical homes that meet the criteria of a patient-centered medical home. To achieve this, the pilot Medical Home will receive technical assistance to help transform the practice into a recognized medical home including guidance on meeting the Tier 1 required minimum standards outlined below. The Medical Home will receive a PMPM for care coordination and administration costs as a participant of the pilot. In exchange, the Medical Home will agree to meet the Tier 1 minimum standards within six months.

Once the minimum standards have been met, the Medical Home will have the option to receive an enhanced FFS on selected Evaluation and Management codes by meeting Tier 2 standards.

Tier 1 – Required Minimum Standards

In order to be recognized as a Medical Home, these minimum standards must be met in six months.

Core Competency 1: Facilitate an ongoing patient relationship with physician in a physician-directed team.

1.1	Utilize a written plan for patient communication including accommodation for patients who have a hearing or visual impairment or for patients whose second language is English (ESL).
1.2	Utilize written materials for patients to explain the features and essential information related to the Medical Home and published in primary language(s) of the community.
1.3	Utilize patient-centered care planning (including patient's goals, values and priorities) to engage patients in their care. The Medical Home plan may include a written "After Visit Summary" outlining future care plan that is given to a patient at every visit.
1.4	Utilize reminder/notification system for health care services such as, appointments, preventive care, and preparation information for upcoming visits; follow up with patients regarding periodic tests or screening; and when planned appointments have been missed.
1.5	Provide patient education and self-management tools and support to patients, families, and caregivers.
1.6	Utilize a Medical Home team that provides team based care composed of, but not limited to, the primary care physician(s), care coordinator, and office staff with a structure that values separate but collaborative functions and responsibilities of all members from clerical staff to physician.
1.7	Create and use a written action plan for the implementation of the Medical Home including a description of work flow for team members.

Core Competency 2: Coordinate continuous patient-centered care across the health care system.

2.1	Utilize written protocol with hospital(s) outlining referral and follow-up care coordination, and admission and discharge notifications.
2.2	Provide care coordination and supports family participation in care including providing connections to community resources.
2.3	Utilize a system to maintain and review a list of patient's medications.
2.4	Track diagnostic tests and provide written and verbal follow-up on results with the patient plus follows up after referrals, specialist care and other consultations.
2.5	Utilize a patient registry.
2.6	Define and identify high-risk patients in the Medical Home who will benefit from care planning and provides a care plan to these individuals
2.7	Provide and coordinate Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) services.
2.8	Provide transitional care plan for patients transferring to another physician or medical home.
2.9	Organize clinical data in a paper or electronic format for each individual patient.
2.10	Utilize a system to organize and track and improve the care of high risk and special needs patients.

Core Competency 3: Provide for patient accessibility to the services of the Medical Home.

3.1	Provide on-call access for patients to the Medical Home team 24 hours/day, 7 days/week
3.2	Offer appointments outside traditional business hours of Monday – Friday, 9 a.m. to 5 p.m.
3.3	Utilize a system to respond promptly to prescription refill requests and other patient inquiries.
3.4	Provide day-of-call appointments.
3.5	Utilize written Medical Home standards for patient access.

Core Competency 4: Commitment to efficiency of care by reducing unnecessary healthcare spending, reducing waste, and improving cost-effective use of health care services.

4.1	Establish at least two out of three of these specific waste reduction initiatives: generic medication utilization, reducing avoidable ER visits or reducing hospital readmissions.
4.2	Implement an intervention to reduce unnecessary care or preventable utilization that increases cost without improving health.

Core Competency 5: Engage in a quality improvement process with a focus on patient experience, patient health, and cost-effectiveness of services.

5.1	Establish a quality improvement team that, at a minimum, includes one or more medical staff who deliver services within the medical home; one or more care coordinators, and if a clinic, one or more representatives from administration/management, with input for the team from a patient advisory group.
5.2	Develop a formal plan to measure effectiveness of care management.
5.3	Develop an operational quality improvement plan for the Medical Home with at least one focus area.
5.4	Utilize a patient survey on their experience of care and sets a schedule for utilization. (May be developed or provided through technical assistance.)
5.5	Identify one or more patient health outcomes to improve through a clinical quality improvement program using evidence-based guidelines.

Tier 2 – Advanced Medical Home Standards (OPTIONAL)

In order to be recognized as an advanced Medical Home, upon successful completion of the Tier 1 minimum standards, the Medical Home Has the option to meet Tier 2 Advanced Medical Home Standards.

6.1	Offer patient education and self-management tools and support to patients, families and caregivers through the Medical Home and/or coordination of community resources.
6.2	Utilize a system to monitor drug usage, drug interaction and effectiveness of a patient’s medications.
6.3	Offer end-of-life planning or counseling to patients who may benefit from these services.
6.4	Develop enhanced care plans that are coordinated with school, nursing home, home care, chronic care and/or end of life plans for identified high risk patients.
6.5	Work towards the use of or currently use electronic medical records.
6.6	Demonstrate an increase in patient compliance with preventative care, ex. immunizations, cancer screenings, diabetes checks, heart disease screenings.
6.7	Implement all three of these specific waste reduction initiatives: generic medication utilization, reducing avoidable ER visits and reducing hospital readmissions.
6.8	Monitor the effectiveness of the intervention/project selected in Tier 1 Minimum Standard 4.2.

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