

BUILDING MEDICAL HOMES IN STATE MEDICAID AND CHIP PROGRAMS

Neva Kaye and Mary Takach

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Portland, Maine Office:
 10 Free Street, 2nd Floor
 Portland, ME 04101
 Phone: [207] 874-6524

Washington, D.C. Office:
 1233 20th Street, NW, Suite 303,
 Washington, D.C. 20036
 Phone: [202] 903-0101

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EXECUTIVE SUMMARY

With 47 million uninsured Americans, double digit inflation in medical spending and health outcomes that lag far behind other nations, comprehensive health care reform that addresses access, cost and quality issues is a national priority. A primary care oriented system may have benefits for population health, equity in health and cost containment and has been shown to reduce racial and ethnic disparities,¹ and result in significantly lower health care costs and improved life expectancy diseases for those with chronic diseases.²

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. First advanced by the American Academy of Pediatrics in the 1960's for certain pediatric populations, the medical home concept has evolved to embrace all populations. In 2007, four major physician groups agreed to a common concept of the patient centered medical home (PCMH) defined by seven "Joint Principles." Supporters of the PCMH model have joined together to form the Patient Centered Primary Care Collaborative (PCPCC) that represents employers, medical specialty societies, health plans and other organizations.

Since 2006 more than 30 states have initiated projects to improve Medicaid and Children's Health Insurance Programs (CHIP) to advance medical homes. Several states also are driving state-wide transformation by using their purchasing leverage to make changes in state health benefits plans and in the private sector. This paper summarizes these activities and provides state policy makers with examples of promising practices, lessons learned and ideas they can adapt to work in their state.

This paper was informed by research that started with a brief survey of Medicaid and CHIP directors and targeted Internet research. A working meeting of eight leading states (Colorado, Idaho, Louisiana, Minnesota, New Hampshire, Oklahoma, Oregon and Washington) convened in July 2008 provided for a significant amount of NASHP's research. These eight states - in addition to North Carolina and Rhode Island which have well-developed medical home initiatives - helped us identify five major strategies for other states to consider in developing their own plans:

1. Forming partnerships with key players (including patients, providers and private sector payers) whose practices the state seeks to change,
2. Defining medical homes to help establish provider expectations and implementing processes to recognize primary care practices that meet those expectations,
3. Aligning reimbursement and purchasing to support and reward practices that meet performance expectations,
4. Supporting practices to help advance patient-centered care, and
5. Measuring results to assess whether their efforts are succeeding in containing costs, improving quality and patient experience.

FORMING KEY PARTNERSHIPS

State Medicaid agencies play a key role in advancing medical homes but they are not doing this alone. All 10 study states are partnering with other stakeholders such as other payers, primary care providers and the organizations that represent them, patients and advocacy groups to affect broad system change. These part-

nerships take many different forms including multi-payer stakeholder collaboratives —bringing commercial insurers and other purchasers such as state employees’ health benefit groups to the table to further spread transformation. Other states have formed formal stakeholder groups that participate in planning the state initiative. Finally, all study states are using means such as surveys and public meetings to get feedback on their plans from a broad range of stakeholders.

DEFINING AND RECOGNIZING A MEDICAL HOME

The foundation for building a medical home begins with a definition that describes valued principles or characteristics. The 10 study states are divided on how to define medical homes. Four have adopted the Joint Principles, others developed their own definition. Although states do not agree on a single definition, most definitions used reflect core primary care values.

States that reimburse practices that function as medical homes are putting in place measurable standards and developing a process for recognizing which practices meet those standards. Many of the states that have adopted the Joint Principles as their definition also plan to use the National Committee for Quality Assurance Physician Practice Connections - Patient Centered Medical Home (NCQA PPC-PCMH) tool—either alone or in conjunction with other state requirements. Some states, providers and other experts have raised concerns that this tool places too much weight on technology, is too costly and limits recognition to physician practices only. These states are using other tools and processes to recognize medical homes.

ALIGNING REIMBURSEMENT AND PURCHASING

Although three of the primary study states have not yet made a final decision on payment structure, all 10 are planning to add payments for high performing medical home practices. Strategies include:

1. Providing separate per member per month and/or lump sum payments (in addition to standard payments for medical services).
2. Enhancing some visit rates (e.g. well child visits) to minimize the changes providers and payers need to make to their existing billing and payment systems and to create an incentive for provider outreach to patients.
3. Leveraging the managed care purchasing process by modifying selection criteria or contracts.

SUPPORTING PRACTICES

There are a number of policies states are using to support the delivery of patient-centered care both within a medical practice and between a practice with other providers, settings, and patients, families and caregivers.

Within practices, these policies include designating medical home providers, establishing open scheduling and expanded hours and securing provider/patient agreements to ensure a point of first contact care for beneficiaries. In addition, states are providing incentives for practices to form teams, attend learning collaboratives, use practice coaches and hire care coordinators. To help facilitate coordination outside practices between other providers, settings and patients, states are establishing health information exchange networks, referral tracking systems and patient engagement activities including self-management workshops, personal health records and decision making tools.

MEASURING RESULTS

The increasing interest in improving access to high-performing medical homes is based on the evidence that doing so will improve care and contain costs. Ultimately, however, state Medicaid and CHIP officials will need to demonstrate these results in their own initiatives. By providing enhanced access to primary care, North Carolina Medicaid was able to reduce health spending by \$244 million over a two-year period while improving overall health outcomes.³ States are examining rates of hospitalizations for ambulatory care sensitive conditions and emergency department utilization using claims data and measures drawn from nationally recognized measurement sets such as Healthcare Effectiveness Data and Information Set (HEDIS). In addition, states are developing surveys to measure patient and provider satisfaction.

CONCLUSION

As many states grapple with the unsustainable growth in health costs, innovative solutions that seek to transform the health care delivery system through medical homes are being considered. State Medicaid and CHIP have strong foundational bases to develop policies that support medical homes. Expanding access to coverage cannot be sustained without attending to quality improvement and cost containment goals. The lessons learned by North Carolina Medicaid and a smaller number of other programs have shown that the provision of good, comprehensive primary care via medical homes has promise in achieving the goals of quality improvement and cost containment. Time will be required to validate these findings in other states and programs.

TABLE 1: CHARACTERISTICS OF MEDICAL HOME PROGRAMS IN 10 LEADING STATES

State	Targeted population	Focus of Care: Chronic Conditions/ all conditions	Definition	Recognition
Colorado	Medicaid, CHIP Plans to extend to all children in state.	Children: all conditions Adult Pilot: Cardiovascular Disease, Diabetes, Low Back Pain, Prevention, Depression	Children's definition found in 2007 legislation (SB 07-130) Joint Principles (adult pilot)	Developed own standards (pediatric practices) NCQA PPC-PCMH (adult pilot)
Idaho	All residents of Idaho	All conditions	Joint Principles	TBD
Louisiana	Medicaid/CHIP	All Conditions	Joint Principles (modified)	NCQA PPC PCMH plus additional criteria
Minnesota	Medicaid/CHIP Plan to extend to all insured Minnesotans by 2010	Complex conditions first	Defined in 2008 Minnesota statute	Developed own standards
New Hampshire	Medicaid adults	Chronic conditions	Joint Principles	NCQA PPC-PCMH
North Carolina	Medicaid/CHIP	All conditions	Defined in provider handbook	Developed own standards

TABLE 1: CHARACTERISTICS OF MEDICAL HOME PROGRAMS IN 10 LEADING STATES (CONTINUED)

State	Targeted population	Focus of Care: Chronic Conditions/ all conditions	Definition	Recognition
Oklahoma	Medicaid/CHIP	Children, Pregnant women and women in breast and cervical cancer prevention and treatment programs	Joint Principles	Developed own standards
Oregon	All residents of Oregon	All conditions	Defined in 2007 legislation Healthy Oregon Act	Developed own standards
Rhode Island	Medicaid adults	Adults with disabilities Multi-payer pilot: adults with coronary artery disease, depression and diabetes	Joint Principles	NCQA PPC-PCMH
Washington	Medicaid/CHIP	Children and adults with disabilities	Defined in 2007 legislation. (Senate Bill 5930 Chapter 259)	Developed own standards

INTRODUCTION

With 47 million uninsured Americans, double digit inflation in medical spending and health outcomes that lag far behind other nations, comprehensive health care reform that addresses access, cost and quality issues is a national priority. A primary care oriented system may have benefits for population health, equity in health and cost containment, as illustrated by these findings:

- The Commonwealth Fund 2006 Health Care Quality Survey showed that when adults have health insurance and access to a medical home—defined as timely, well-organized care with enhanced access to providers—racial and ethnic disparities are reduced or eliminated.⁴
- In the United States, adults with a primary care physician had 33 percent lower health care costs and were 19 percent less likely to die from a manageable chronic care condition than were those who received care from a specialist (after adjustments for demographic and health characteristics).⁵
- A Mercer analysis showed that North Carolina Community Care operations in State Fiscal Year 2004 saved \$244 million in overall healthcare costs for the state while improving overall health outcomes for select illnesses. Similar results were found in 2005 and 2006.⁶

Improving Medicaid and Children's Health Insurance Programs (CHIP) by offering participants access to high performing medical homes is one approach to transforming the delivery system. 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. States are already moving in this direction—in 2008 the National Academy for State Health Policy (NASHP) identified over 30 states that had taken some type of recent (2006 or later) action intended to advance medical homes for Medicaid and CHIP participants. NASHP, in coordination with the Patient Centered Primary Care Collaborative (PCPCC) and with the support of The Commonwealth Fund, has been studying and supporting these efforts for over a year. Over the course of this project NASHP used several different methods to gather and disseminate information about state strategies and policy options for advancing medical homes, including:

- Research to identify the policy options that states are selecting and implementing: a brief survey that included Medicaid and CHIP directors, governors' health policy advisors, selected state legislators and their staff, (among others); targeted Internet research; and a detailed survey of eight leading states.
- Case studies of leading states that were presented to a broad state audience via webcast and summarized in policy briefs.
- Peer-to-peer learning opportunities for states that also enabled them to work with NASHP and other experts to develop and refine new policy options: a two-day Summit for leading states followed by a limited amount of group technical assistance, a one-day workshop for a broad range of states at NASHP's annual conference and a listserv for those seeking to advance medical homes at the state level.

This paper summarizes this body of work. It is intended to assist state policymakers and others in their efforts to advance medical homes by providing them with information they can use to improve Medicaid and CHIP beneficiaries' access to high performing medical homes. Specifically, it provides policy makers with information about: (1) complementary activity in the private sector and at the federal level that

may make this an opportune time for states' efforts in this area (2) the amount and scope of recent state activity, and (3) five strategies states are using to advance medical homes and the options they have for implementing those strategies.

THE TIMING IS RIGHT

In recent years there has been growing interest on the part of primary care providers, the private sector and the federal government in transforming health care delivery by advancing medical homes. As a result, there are a number of complementary activities that states may be able to use to support their efforts in this area. Many of these activities are summarized here and more are examined in the appendices.

1. Creation of the Joint Principles of the Patient Centered Medical Home and the Patient Centered Primary Care Collaborative

First advanced by the American Academy of Pediatrics (AAP) in the 1960s, AAP later defined a medical home as a “continuous, comprehensive, family-centered, compassionate and culturally effective place of health care.”⁷ In 2007 this concept was further expanded by four major primary care physician groups (AAP, American Academy of Family Physicians, American College of Physicians and American Osteopathic Association). They defined the Patient Centered Medical Home (PCMH) model as an approach that provides comprehensive primary care to children, youth and adults in “a setting that facilitates partnerships between individual patients and their personal physicians and when appropriate, the patient’s family.”⁸ The seven Joint Principles of the Patient Centered Medical Home (PCMH) translate this definition into key elements that practices need to have in place to be a PCMH. They are:

1. *Personal physician* - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
2. *Physician directed medical practice* – personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
3. *Whole person orientation* – personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals for all stages of life.
4. *Care is coordinated and/or integrated* across all elements of the complex health care system.
5. *Quality and safety are hallmarks of the PCMH.* This includes practices going through a voluntary recognition process; ongoing education; use of evidence-based medicine and clinical decision-support tools to guide decision making; as well as other necessary elements to improve quality and safety.
6. *Enhanced access to care* is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician and practice staff.
7. *Payment appropriately recognizes the added value* provided to patients who have a patient-centered medical home.⁹

These four physician groups also founded the Patient Centered Primary Care Collaborative (PCPCC) which is led by IBM. The PCPCC is a coalition of major employers, consumer groups, patient quality organizations, health plans, labor unions, hospitals, physicians and many others who discuss, advocate and share information to help transform practices, reform reimbursement, evaluate demonstrations and broadly implement the PCMH. The PCPCC has helped spawn development of several multi-stakeholder medical home demonstration projects that have included public payers.

2. Availability of New Tools to Help Payers Recognize and Pay for Medical Homes

There are several tools available to both public and private payers to help them recognize provider practices that are functioning as high performing medical homes. These recognition tools have been helpful for payers in developing a reimbursement framework to motivate and reward practice change. The Physician Practice Connections[®] - Patient Centered Medical Home (PPC-PCMHTM) is probably the most widely used in recent medical home initiatives. This tool was developed by the National Committee for Quality Assurance (NCQA) in collaboration with the four physician groups that developed the Joint Principles. Payment frameworks have been developed to support the step-wise achievement of the three NCQA levels. There are other tools being considered and used including the Primary Care Assessment Tool developed by Starfield and Cassidy, the Assessment of Chronic Illness Care developed by Wagner et. al. and the Medical Home Index developed by Cooley and McAllister.

3. Medicare is conducting a medical home demonstration project

Legislation, originally passed in 2006 and bolstered in 2008, mandates that the Centers for Medicare and Medicaid (CMS) design a medical home demonstration project for its fee-for-service high needs Medicare population. The three-year design will include no more than eight states, and will target the enrollment of 400 practices, 2,000 physicians and 400,000 Medicare beneficiaries.¹⁰ All patient enrollees must have at least one chronic disease, making approximately 86 percent of Medicare beneficiaries eligible.

4. Federal funding for health information technology

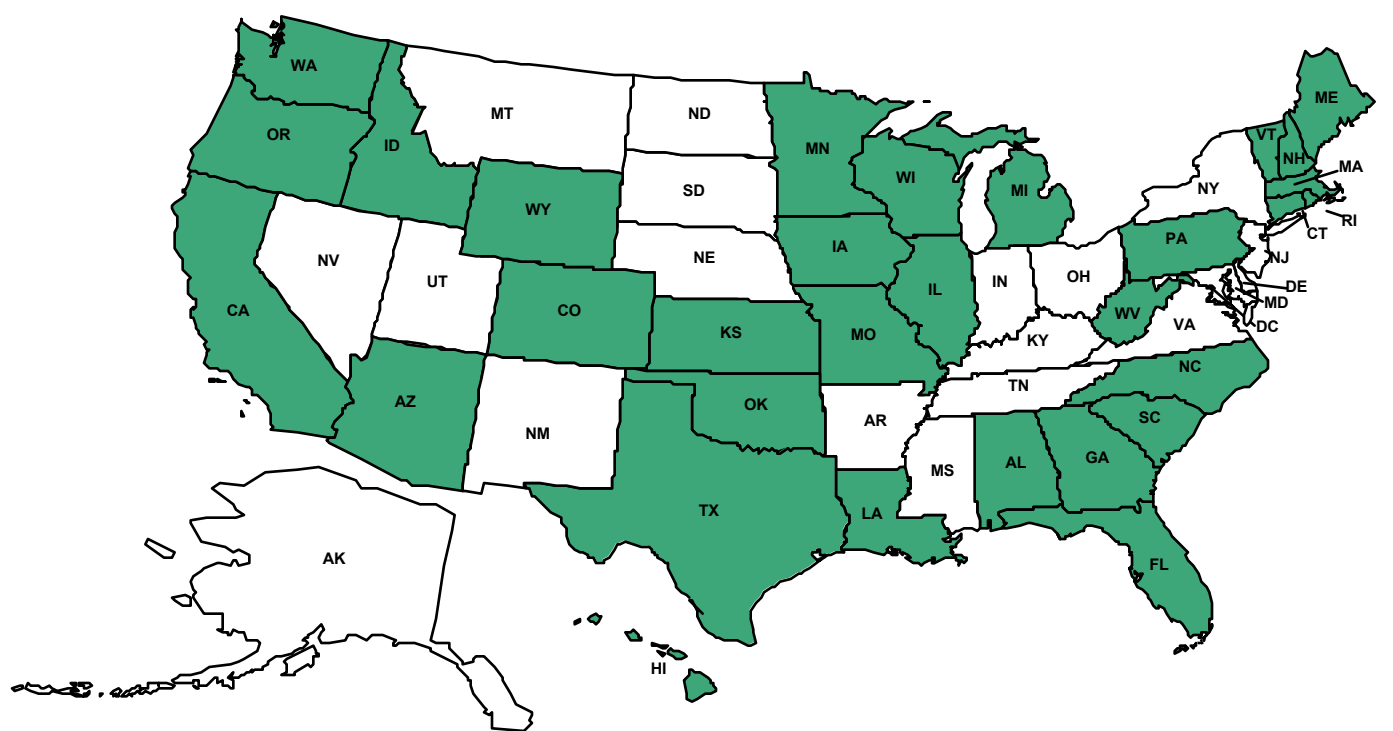
Medical homes can be supported by an enhanced infrastructure that includes health registries and health information exchange. The projects described in this paper, often driven by Medicaid agencies, offer important examples of how health information technology (HIT), as described in the Joint Principles, is enabling optimal patient care, performance measurement, patient education and enhanced communications. The recent enactment of the American Recovery and Reinvestment Act of 2009 (ARRA) has provided additional funding opportunities for states to support the medical home infrastructure through HIT and information sharing. The Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of the ARRA, authorized roughly \$36 billion in federal outlays over six years for HIT. This act requires the implementation of a policy framework to support the design, development and operation of a nationwide HIT infrastructure to allow the electronic use and exchange of health care information with the goal to avail each U.S. citizen an electronic health record by 2014. As a result, states have a critical role in both the distribution and the actual implementation of the HITECH funding and the ability to align these investments with delivery system improvements such as medical homes.

There are two other federal programs that have funded HIT infrastructure in states to support medical homes. Established by the Deficit Reduction Act of 2005 (DRA), Medicaid Transformation Grants have provided funding for innovative systems that improve Medicaid's efficiency, cost-effectiveness and quality of care. Congress approved a one-time \$150 million funding outlay that was distributed over fiscal years 2007 and 2008. Out of 42 grants awarded, eight states used Medicaid Transformation grant funds to develop the technology infrastructure for medical home programs.¹¹

In addition, the Medicaid Information Technology Architecture (MITA) initiative provides numerous state Medicaid agencies federal Medicaid matching funds to enhance Medicaid Management Information Systems (MMIS) capacity to integrate clinical and administrative data for better decision-making.¹² States are eligible to receive a 90 percent federal match for purchase/implementation and 75 percent federal match for the maintenance of an MMIS system.¹³ New Hampshire is currently using this opportunity to update its MMIS. By 2010, it is hoped that this system will be capable of creating a medical home designation, patient assignment and prospective and incentive payments.¹⁴

 AMOUNT AND SCOPE OF RECENT STATE ACTIVITY

Federal Medicaid programs and CHIP provide strong foundations on which to build medical homes. Both of these programs offer comprehensive services, including services to support beneficiaries' access to care, such as transportation, translation and case management. This is especially true for children who have access to the Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit which explicitly includes outreach to engage families in ongoing primary care, well child care, expanded coverage of treatment and care coordination. In addition, most states deliver Medicaid and CHIP services using some form of a managed care model. Primary care case management and/or managed care organizations provide a framework to address the delivery system reform needed, including reimbursement and infrastructure reform. (See appendix on Federal Medicaid and CHIP Policies that can Support Medical Homes). Despite this promise there is evidence that Medicaid and CHIP beneficiaries often do not have access to high performing medical homes--in 2003, only 31 percent of children under 100 percent of the federal poverty limit had access to a medical home.¹⁵ To address this disconnect, many states are working to advance medical homes.



Source: NASHP scan of state Medicaid-led medical homes projects, 2008

States with Medicaid-led Medical Homes projects (31)

Between January and October of 2008, NASHP staff conducted a scan of state Medicaid and CHIP efforts to advance medical homes.¹⁶ We identified a wide variety of efforts reaching back to the 1990s (see http://www.nashp.org/Files/medical_home_scan_Nov_2008.xls for complete results). The scan identified a total of 34 recent initiatives in 31 states that sought to improve the availability of medical homes for Medicaid or CHIP participants. This count includes initiatives that met the following criteria: (1) program implementation (or major expansion or improvement) in 2006 or later, (2) Medicaid or CHIP agency participation (not necessarily leadership), (3) explicitly intended to advance medical homes for Medicaid or CHIP participants and (4) evidence of commitment, such as workgroups, legislation, executive orders or dedicated staff.

Each state's journey toward medical homes has been approached from a variety of different directions and is at different stages. However, the data does show some themes in target population and delivery systems. And the willingness of these states to pass supporting legislation and dedicate resources to these efforts confirms their real interest in advancing medical homes.

TARGET POPULATION

The scan data indicate that most states (24) are targeting a subgroup of Medicaid beneficiaries, at least at the start of their efforts. Seven, however, plan to advance access to medical homes for all state citizens—either starting with the Medicaid population (Idaho, Iowa, Michigan, Minnesota, Washington and West Virginia) or including Medicaid beneficiaries as an explicit target population (Oregon) in a broader statewide effort. In addition, Arizona, Colorado and Georgia explicitly target their entire CHIP program (which serves only children)—all three are also targeting some or all Medicaid beneficiaries.

The targeted subgroups include Medicaid beneficiaries with complex needs (9), such as children with special health care needs, children in foster care, or adults with chronic illness or disability. These are the groups which offer the greatest potential for both costs savings and improved care since their members' needs and costs are higher than other beneficiaries. There are 11 states that describe their target populations as Medicaid managed care enrollees. Finally, given the utility of the EPSDT benefit as a base for medical homes, it is not surprising that three states are working to advance medical homes for all children served by Medicaid (Colorado, Hawaii and Iowa).

DELIVERY SYSTEM

States are seeking to advance medical homes through the three types of delivery systems in wide use in Medicaid and CHIP programs (Managed Care Organizations (MCO), PCCM and fee-for-service). The scan did not identify a delivery system for two states (Michigan and West Virginia). However, among the remaining 29 states, 18 were seeking to advance medical homes through MCOs, 12 through PCCMs and 11 through fee-for-service. Also, nine were seeking to implement their initiative through more than one type of delivery system.

- Minnesota, Missouri, Oregon and Wisconsin were implementing their initiatives through MCO and fee-for-service delivery systems.
- Kansas and Rhode Island were implementing their initiatives through both MCOs and their PCCM program.
- Idaho, Iowa and Washington were planning on implementing their initiative through all three types of systems.

EVIDENCE OF COMMITMENT

Most states had made a formal commitment to advancing medical homes, such as passing legislation (16), dedicating resources (7) and/or dedicating a portion of their transformation grant funding (8). For example:

- In 2008, the Iowa legislature charged the Iowa Department of Public Health with creating the Medical Home Advisory Council. The Council's purpose is to develop recommendations for implementing a statewide patient-centered medical home system. The system will be phased in starting with children covered by Medicaid and eventually expand to include all state citizens. The legislation also provided the Department \$165,600 for up to four employees.
- In 2007, the Missouri legislature tasked the Medicaid agency with developing health care homes for all Medicaid enrollees to begin September 2008, to be in place by July 2011. The legislation also created the HealthNet Oversight Committee to oversee implementation of all aspects of the legislation, including those related to health care homes.

STRATEGIES TO INCREASE ACCESS TO HIGH PERFORMING MEDICAL HOMES FOR
MEDICAID AND CHIP PARTICIPANTS

Through the course of this project NASHP examined the efforts in 10 leading states in detail. (In the remainder of this paper these 10 states are referred to as the primary study states). All 10 of these states participated in the previously described state Summit as faculty and/or participants. In addition, NASHP conducted a detailed survey of these states after the Summit (Appendix B), convened them after the Summit via conference call and asked them to review a draft of this paper. Table 2 presents an overview of the medical homes initiatives in the primary study states.

TABLE 2: OVERVIEW OF MEDICAL HOME INITIATIVES IN THE 10 PRIMARY STUDY STATES

Colorado	In 2007, the state enacted legislation calling for medical homes for all children enrolled in Medicaid and CHIP programs. ¹⁷ The target date for implementation of this initiative, which is led by the Department of Health Care Policy and Financing, was July 2008. In addition, the Colorado Clinical Guidelines group has convened a formal multi-payer pilot to implement medical homes for adults with chronic conditions in the Denver area. The 2-year pilot is due to be implemented in 2009. Colorado Medicaid is participating in this effort.
Idaho	“Target for a Healthy Idaho” initiative will provide each person access to a medical home under the direction of a primary care provider. The state plans to concurrently address multiple system weaknesses including its current shortage of primary care physicians. Idaho will first implement information technology to provide the foundation for medical homes.
Louisiana	The legislature directed the state in 2007 to develop and pilot medical homes to increase access, improve quality and provide sustainability in medical care for Medicaid and uninsured populations. This effort will build on the existing Community Care program (state’s PCCM program) and features local network integrated systems of care.
Minnesota	The state enacted legislation in 2007 to begin policy planning for medical home services for Medicaid enrollees. In 2008, the state enacted legislation extending the requirement to provide (and pay for) medical homes to all payers regulated by state government. The standards for recognition are to be implemented by July 2009 and care coordination payment to recognized practices is to begin by July 2010. The state is working with provider and patient communities to develop specific criteria and recognize providers that meet those criteria to provide comprehensive care coordination and care plan development.
New Hampshire	A multi-payer medical home pilot involving all payers, including Medicaid and Medicare, providers and subject experts is being planned. Stakeholders are working together to create primary care medical homes for adults with disabilities. In 2009, the state will shift the existing disease management budget, about \$1.3 million a year, to the program and use its Comprehensive Healthcare Information System in evaluation.

TABLE 2: OVERVIEW OF MEDICAL HOME INITIATIVES IN THE 10 PRIMARY STUDY STATES (CONTINUED)

North Carolina	North Carolina implemented its initial medical home initiative in 1991 through a traditional PCCM program (Carolina Access) for Medicaid beneficiaries who qualify for coverage because they belong to low-income families. In 1998, an enhanced PCCM program (Community Care of North Carolina) began as a pilot based on the Carolina Access program. Under this program, providers were required to form networks that include primary care providers, safety net and specialty care providers in collaboration with the local health departments, departments of social services and hospital(s). Primary care providers direct the care that program participants receive. Both primary care providers and the networks receive a per member per month fee to implement population management strategies (such as disease and care management, population stratification, preventive services and coordination across delivery settings), as well as support in implementing practice improvements from Community Care of North Carolina (CCNC). Program data confirms both cost savings and quality improvement—and the state is expanding the program to people who qualify for both Medicaid and Medicare (dually-eligible).
Oklahoma	The Oklahoma Health Care Authority (OHCA), which administers the Medicaid program, has a new PCCM program— SoonerCare Choice— to guarantee the availability of a medical home with a primary care provider for all members. This will (1) enhance patient choice and participation in health decisions; (2) assure all members receive all necessary preventive and primary care; (3) reduce inappropriate emergency department visits and hospitalizations; (4) realign payment incentives to improve cost effectiveness and quality, and (5) promote the use of health information. This change was recommended by the provider community and was implemented in January 2009.
Oregon	Oregon passed legislation in 2007 that formed the Oregon Health Fund Board. This Board is partnering with consumers, providers, purchasers and payers to develop a comprehensive reform plan that will, among other things, provide every Oregonian with an integrated health home. These plans build on multiple efforts in both the public and private sectors to pilot medical home initiatives.
Rhode Island	Medicaid implemented the Connect Care Choice program in September 2007. This program builds on a PCCM program structure to provide access to advanced medical homes for adults with chronic conditions. In addition, Rhode Island's health insurance commissioner convened the Rhode Island Chronic Care Sustainability Initiative to translate medical home principles into a multi-payer pilot. The Initiative includes representatives of payers, purchasers and providers—including Medicaid and all commercial payers. The pilot began October 2008 and will run for two years in five practices serving more than 25,000 people. Much of the structure was developed based on the Connect Care Choice experience.
Washington	The Medical Home Initiative is a series of public-private efforts supported by multiple state agencies and the legislature, with leadership from the Governor's Office. Public and private stakeholders are working together to improve health outcomes by expanding access to primary care providers and medical homes. Medical homes for Medicaid beneficiaries are being developed and implemented in conjunction with existing chronic care management programs. The state plans to begin pilots for Medicaid beneficiaries, state employees and others in 2010. In 2009, the state plans to conduct a learning collaborative for providers seeking to more effectively serve as medical homes and conduct a reimbursement study.

Our work with the primary study states identified five major strategies being used to advance medical homes for Medicaid and CHIP beneficiaries. These strategies encompass a variety of the following approaches for other states to consider as they move forward with medical home plans:

1. Forming partnerships with key players (including patients, providers and private sector payers) whose practices the state seeks to change.
2. Defining medical homes to help establish provider expectations and implementing processes to recognize primary care practices that meet those expectations.
3. Aligning reimbursement and purchasing to support and reward practices that meet performance expectations.
4. Supporting practices to help advance patient-centered care, and
5. Measuring results to assess whether their efforts are succeeding not only in changing primary care practices but also containing costs and improving quality, including patient experience.

The remainder of this paper examines the primary study states and their efforts in each of these five areas.

FORMING KEY PARTNERSHIPS

State Medicaid and CHIP agencies play a key role in advancing medical homes. They are large purchasers and payers of health care providing over 60 million poor and low-income people with health coverage.¹⁸ But Medicaid and CHIP agencies are not working on medical homes alone—all 10 study states, are partnering with other stakeholders, such as other payers, primary care providers and the organizations that represent them, patients and advocacy groups. These other stakeholders are important partners in program design, implementation and operation. They bring both experience and resources and contribute greatly to designing and implementing effective medical homes. In some states, state agencies are convening the partnerships, while in others, they are joining the efforts of other stakeholders. In addition to working with stakeholders to develop their programs, seven states are partnering with other payers, mostly from the private sector.

INVOLVING PROVIDERS AND CONSUMERS IN PLANNING

All 10 primary study states had involved providers and consumers in planning (Table 3). Most included some representatives of these stakeholder groups in the ongoing design and development of their plans. They found that the real life experience of these individuals was key to developing policy improvements that would effectively serve both patients and providers. These individuals can identify the system and program policies that do not support medical homes—and can provide valuable feedback on which policy options will best address the issue. In addition, involving ‘respected peers’ in the development process and often as the messenger for change, is a very effective method of encouraging stakeholders to support the changes.

Most states also gathered input from a large number of stakeholders at defined points in their process. This broader effort achieved several purposes: (1) introduce the new program to stakeholders, (2) surface issues that the, necessarily, limited number of stakeholders directly involved in program design did not identify, and (3) build public support for the program. The processes used in Colorado and Oregon illustrate how other states are combining multiple strategies to involve providers and consumers in planning.

Colorado Medicaid’s medical home standards for children were developed by the 75-member evaluation task force made up of family leaders, mental and physical health providers, NCQA, local chapters of the AAP and AAFP, researchers and state agency staff. This group worked to develop measurable standards based on a review of relevant literature and an in-depth examination of the standards developed by NCQA and other organizations. They also conducted a statewide survey on their draft standards and received input from 80 percent of pediatricians across the state. They found that both providers and families were eager for partnerships—and that this process offered them a venue for expressing their hopes and concerns. The process also increased stakeholder understanding of and support for the changes—and helped the state identify technical assistance needs. State representatives emphasize that their work with stakeholders builds on past work in the areas of family leadership development and pediatric provider.¹⁹

The Oregon Health Fund Board is responsible for the development of a comprehensive plan to “...ensure access to health care for all Oregonians, contain health care costs and address issues of quality in health care.” The Board created committees that included more than 100 key stakeholders and consumers to develop various aspects of the plan, including a delivery system committee. A major feature of the plan developed by the committee is the variety of strategies to advance medical homes and ensure their availability to all Oregonians.²⁰ The 19-member committee that created this plan includes representatives of

medical providers, health systems, local health departments, consumers, workers and employers. In both the spring and fall of 2008, the Board sought input on their plans through Town Forums, open to all, across the state. More than 1,300 people participated in the 15 forums in the spring of 2008.²¹

TABLE 3: STATE STRATEGIES FOR PARTNERING WITH PROVIDERS AND PATIENTS

State	Formal planning body	Securing input on plans
Colorado (children)	75 member task force included provider and family leadership, staffed by Medicaid	State-wide survey of providers
Colorado (adult)	Colorado Clinical Guidelines Collaborative convened the planning group for a multi-payer pilot. The Collaborative is a non-profit coalition of health plans, physicians, hospitals, employers, government agencies, quality improvement organizations and others	
Idaho	<p>Eight-member Governor's Select Committee on Health Care created by Executive Order includes providers and is charged with follow-up on recommendations from Idaho Health Care Summit including advancing medical homes.</p> <ul style="list-style-type: none"> • Chair is Executive Director of a community health center • Medicaid Director is a member • Twelve-member Health Quality Planning Commission, established in legislation, includes provider and purchaser representatives • Oversees technology aspects of effort • Chair is state senator, staffed by Medicaid and others 	Convened series of public meetings
Louisiana	Health Care Quality Forum	
Minnesota		Medicaid convened multiple meetings with consumers, providers and their representatives
New Hampshire	<p>Reimbursement and Medical Home Workgroup includes providers and citizen representatives</p> <ul style="list-style-type: none"> • Convened by New Hampshire Citizens Health Initiative • Medicaid agency is participating in the workgroup 	The Citizens Health Initiative is convening a series of meetings
North Carolina	<p>Community Care of North Carolina is a partnership that includes providers</p> <ul style="list-style-type: none"> • Sponsored by Medicaid agency, among others • Administration provided by the Office of Rural Health and Community Care • Local health departments, departments of social services and hospitals 	Each network is run locally by an executive director, who oversees a team of case managers, as well as a medical director, who works with local physicians who provide input.

State	Formal planning body	Securing input on plans
Oklahoma	<ul style="list-style-type: none"> • 16 member Medical Home Task Force established in legislation to study implementation of PCMH in private and public coverage, staffed by Insurance Department • 11 member, Medical Advisory Task Force created to advise Oklahoma Health Care Authority is composed of provider organization representatives, staffed by Medicaid 	Town hall meetings convened across state in Fall 2008
Oregon	<ul style="list-style-type: none"> • 7-member Oregon Health Fund Board established in legislation includes providers and consumer representatives • 19-member service delivery system committee, includes consumers and providers <ul style="list-style-type: none"> • Chaired by provider representative • Staffed by Oregon Health Policy and Research 	Town forums for all stakeholders, convened across state at two points in plan development
Rhode Island	Chronic Care Sustainability Initiative membership includes providers, convened by State Health Insurance Commissioner	
Washington		Medicaid, Health Care Authority convened multiple meetings with consumers, providers and their representatives

PARTNERING WITH OTHER PAYERS

Seven of the Medicaid or CHIP agencies in the primary study states were working with other payers to advance medical homes.

Four of the primary study states (Colorado, Minnesota, New Hampshire and Rhode Island) are all partnering with private sector payers and others in formal multi-payer initiatives seeking to implement common definitions and standards for medical homes, reimbursement structures and outcomes. This common approach ensures that participating providers are receiving a consistent message about how payers wish them to deliver care and which improvements to prioritize. In turn this allows the practices to focus more of their resources on the common issues—and to combine payment (and other resources offered by payers) to develop an infrastructure that serves all patients. Patients also receive a consistent message about how they should access care. For similar reasons:

- Washington Medicaid and the Washington Health Care Authority are partnering with the primary care community to develop reimbursement models and promote practice change.
- Health plans in Idaho and Oregon are working with state agencies to advance medical homes, but have not entered into a formal multi-payer initiative.

Among the 10 study states, Rhode Island was the first to implement a multi-payer medical home pilot. In July 2006, the state's Health Insurance Commissioner convened the Chronic Care Sustainability Initiative to translate medical home principles into a multi-payer pilot program. Initial membership included a broad range of payers, purchasers and providers. Together these organizations paid for and

delivered care to most state residents—both those with private coverage and those with public coverage. This group is supported by the technical expertise of the Department of Health and the state's Quality Improvement Organization. In October 2008, these partners began a two-year pilot at five practices serving more than 25,000 patients. The pilot includes all adults diagnosed with diabetes, depression and coronary artery disease served by the participating practices except those covered by Medicare fee-for-service.

According to Rhode Island Health Insurance Commissioner Christopher Koller, his agency was an effective convener. As the state's health insurance regulator, the agency both commands the attention of purchasers and payers and can allay fears that anti-trust issues will be raised by a common effort.

Rhode Island's multi-payer pilot encountered many barriers. For example, all participants wanted a return on their investment and it was difficult to bring the group to consensus on common outcomes. Other barriers were specific to different groups of participants. For example, some large national payers (e.g., health plans) were reluctant to allow their state-licensed affiliates to adopt policies and practices that differed from those of the national payer. Since they usually compete for business, payers are not accustomed to collaborating with other plans and feared that doing so would reduce their competitive advantage.

According to Koller, overcoming those barriers required trust among participants and maintaining a focus on the common goals of reducing the overall cost of care, improving quality and access and strengthening primary care. He also advised others seeking to convene multi-payer pilots to engage major purchasers as advocates, involve consumers, develop physician leadership and collaboration, educate all stakeholders about the need for system reform and participate in national PCMH efforts.

DEFINING AND RECOGNIZING A MEDICAL HOME

The foundation for building a medical home often begins with a definition that describes the concept in terms of valued principles or characteristics. From this definition, states often develop measurable standards and a process for recognizing which practices meet those standards. Without such standards and processes, states will not know which practices to reimburse, or end up spending their limited funding on practices that are not high-functioning medical homes. Defining and recognizing a medical home is also important because it establishes concrete expectations that can motivate medical practices to change how they deliver care.

DEFINING MEDICAL HOMES

Although all states do not agree on a single definition of a medical home, most definitions used by states reflect these core primary care values:

1. Having a personal physician or provider who provides first contact care or a point of entry for new problems,
2. Ongoing care over time,
3. Comprehensiveness of care, and
4. Coordination of care across a person's conditions, providers and settings.²²

The 10 primary study states are divided on the sources for the definition of medical homes—one state is divided on the definition depending on the population described: Colorado has one definition for its adult population and another one for its child population. Six of the states (Colorado (adult), Idaho, Louisiana, Oklahoma, New Hampshire and Rhode Island) are using the Joint Principles as their definition. The Joint Principles emphasize a “physician-directed practice.”

However, Louisiana and Oklahoma have modified the Joint Principles' emphasis on physician-directed practices. Specifically, Louisiana reports, “While much language of the Joint Principles focuses on the physician, the Louisiana Medical Home Committee believes that any design of a patient-centered medical home must be responsive to the locale of the individuals accessing care and the available resources and does not require that the patient-centered medical home be physician-directed. The definition of the model does not require a particular degree or license; however, it does require that functions and outcomes are delivered in a measurable manner by licensed providers.”²³

Five of the study states (Colorado (child), Minnesota, Oregon, North Carolina and Washington) developed their own definition of a medical home. Four codified it in legislation (see Table 4). These four states, as well as others identified in the state scan, differ from the Joint Principles definition of “physician-directed practice” by allowing other certified Medicaid providers—such as nurse practitioners and physician assistants—to be a medical home. In their legislation, Colorado (child), Oregon and Minnesota also refer to a medical home as a health or health care home. The definitions in these four states have been developed based on state experience and stakeholder input. Examples from Minnesota and North Carolina illustrate the process used to develop these definitions.

- Minnesota's approach to defining medical homes has evolved over a decade. It began in the late 1990s with Title V Children with Special Health Care Needs program and was formally shaped in 2008 with health care reform legislation that requires “health care homes” for all Medicaid and CHIP beneficiaries, state employees and privately insured in Minnesota.²⁴ This legislation was

informed by prior Medical Home Learning Collaborative participants, Department of Human Service’s workgroup, legislature and community. The legislation calls for standards to be developed that meet 10 criteria that embrace the characteristics of a patient-centered medical home. (see table 4)

- North Carolina Medicaid’s PCCM program began in the 1990s and has evolved to include many of the Joint Principles through policy decisions made by the state, with considerable input from stakeholders along the way. Nurse practitioners and physician assistants are two of the many provider types who can serve as medical homes. Characteristics of the medical home are detailed in the provider and/or beneficiary handbook — an approach also taken by eight other states identified in our state scan.²⁵

TABLE 4: DEFINITIONS AMONG THE STUDY STATES THAT DID NOT ADOPT THE JOINT PRINCIPLES

State	Definition
Colorado (child)	<p>“Medical Home” means an appropriately qualified medical specialty, developmental, therapeutic, or mental health care practice that verifiably ensures continuous, accessible and comprehensive access to and coordination of community-based medical care, mental health care, oral health care and related services for a child. A medical home may also be referred to as a health care home. If a child’s medical home is not a primary medical care provider, the child must have a primary medical care provider to ensure that a child’s primary medical care needs are appropriately addressed. All medical homes shall ensure, at a minimum, the following:</p> <ul style="list-style-type: none"> (a) health maintenance and preventative care; (b) anticipatory guidance and health education; (c) acute and chronic illness care; (d) coordination of medications, specialists and therapies; (e) provider participation in hospital care; and (f) twenty-four hour telephone care. <p><i>Source: State legislation</i></p>
Minnesota	<p>The standards developed by the commissioners must meet the following criteria:</p> <ul style="list-style-type: none"> (1) emphasize, enhance and encourage the use of primary care and include the use of primary care physicians, advanced practice nurses and physician assistants as personal clinicians; (2) focus on delivering high-quality, efficient and effective health care services; (3) encourage patient-centered care, including active participation by the patient and family or a legal guardian, or a health care agent as defined in chapter 145C, as appropriate in decision making and care plan development and providing care that is appropriate to the patient’s race, ethnicity and language; (4) provide patients with a consistent, ongoing contact with a personal clinician or team of clinical professionals to ensure continuous and appropriate care for the patient’s condition; (5) ensure that health care homes develop and maintain appropriate comprehensive care plans for their patients with complex or chronic conditions, including an assessment of health risks and chronic conditions; (6) enable and encourage utilization of a range of qualified health care professionals, including dedicated care coordinators, in a manner that enables providers to practice to the fullest extent of their license; (7) focus initially on patients who have or are at risk of developing chronic health conditions; (8) incorporate measures of quality, resource use, cost of care and patient experience; (9) ensure the use of health information technology and systematic follow-up, including the use of patient registries; and (10) encourage the use of scientifically based health care, patient decision-making aids that provide patients with information about treatment options and their associated benefits, risks, costs and comparative outcomes and other clinical decision support tools. <p><i>Source: 2008 Minnesota statute</i></p>

State	Definition
North Carolina	<p>Carolina ACCESS is North Carolina's Medicaid managed care program. It provides you with a medical home and a primary care provider (PCP) who will coordinate your medical care. What is a medical home? A medical home:</p> <ul style="list-style-type: none"> • offers the very best of care for you. The staff will know you and your medical history. They will coordinate your health care with other doctors who may need to treat you. • can be a doctor's office, a community clinic, or a local health department. • provides a PCP you can call for help when you need to. You no longer have to go to the emergency department when your problem does not threaten your life or risk your health without immediate treatment. • provides treatment and/or medical advice 24 hours a day, 7 days a week. <p><i>Source: Carolina ACCESS member handbook</i></p>
Oregon	<p>Primary care medical home can generally be characterized as a primary care practice which provides the following to its patients: a continuous relationship with a physician; a multidisciplinary team that is collectively responsible for providing for a patient's longitudinal health needs and making appropriate referrals to other providers; coordination and integration with other providers, as well as public health and other community services, supported by health information technology; an expanded focus on quality and safety; and enhanced access through extended hours, open scheduling and/or email or phone visits.</p> <p><i>Source: The Medical Home Model of Primary Care: Implications for the Healthy Oregon Act</i></p>
Washington	<p>An approach to providing health care services in a high-quality, comprehensive and cost-effective manner. The Washington State Department of Health describes core elements of a medical home as:</p> <ul style="list-style-type: none"> • Compassionate and Culturally Effective • Coordinated and Comprehensive • Family-centered • Accessible and continuous <p>Programs must be evidence-based, facilitate the use of information technology to improve quality of care, acknowledge the role of primary care providers and include financial and other supports to enable these providers to effectively carry out their role in chronic care management and improve coordination of primary, acute and long-term care for those clients with multiple chronic conditions.</p> <p><i>Source: Senate Bill 5930 Chapter 259</i></p>

RECOGNIZING PRACTICES AS MEDICAL HOMES

There are a variety of tools available for states to use to identify practices that meet medical home standards. Currently, no single tool has been identified as ideal, but there is general agreement that the tool or process used should recognize and measure the four pillars of primary care. (See text box next page.) Experts emphasize that payers choose qualification or recognition tools that are evidence-based and reflect these primary care pillars and caution against choosing non-evidence-based tools that are costly and timely for practices and present barriers to those practices seeking to become medical homes.²⁶

NCQA Recognition Tool

The Joint Principles call for practices to undergo a “voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide” patient-centered medical home services. The four physician groups that developed the Joint Principles worked with National Committee for Quality Assurance to develop the Physician Practice Connections - Patient Centered Medical Home (PPC-PCMH) tool. This tool takes a systems approach to recognition by assessing practice performance on nine standards: access and communication; patient tracking and registry functions; care management; patient self-management support; electronic prescribing; test tracking; referral tracking; performance reporting and improvement; and advanced

Measurements to Recognize Practices that Serve as Medical Homes

First Contact Care ensures that there is a designated, personal, provider point-of-entry or “gateway” for new problems.

- *Structure (capacity) measures* should include: geographic access, phone access, ease in making an appointment, after-hours care and language and cultural orientation.
- *Process (performance) measures* look at utilization and capture information at both the population level and practice level to measure patient input and data on the first visit for a new problem at the PCMH.

Longitudinality is a principle that values ongoing patient care over time.

- *Structure (capacity) measures* can include the use of patient list/registry and mutual recognition of the PCMH by both the physician and patient.
- *Process (performance) measures* capture the extent to which patients’ care occurs at the PCMH for all problems except for those for which a referral is indicated.

Comprehensiveness is a principle that ensures that the provider arranges for provision of services across all of a patient’s health care needs.

- *Structure (capacity) measures* evaluate if the PCMH provides services to meet all common health needs and arranges for provision of services that are uncommon.
- *Process (performance) measures* use chart audits/records to gather utilization information on types of problems and diagnoses seen by providers and the extent to which care occurs in the PCMH or gets referred out.

Coordination is a principle that values the integration of care across a person’s conditions, providers and settings.

- *Structure (capacity) measures* look at continuity from two perspectives: visit continuity with a qualified practitioner or medical record continuity from visit to visit.
- *Process (performance) measures* capture “problem recognition” from previous visits, including information on care received outside of the PCMH. Referrals are coordinated and tracked by PCMH.

Source: Ann O’Malley, “How do we know a practice is a PC-MH?” Presentation at Medical Home Summit, July 24, 2008. Retrieved March 23, 2009. http://www.nashp.org/Files/Omalley_MedicalHomeSummit.pdf

electronic communications. (See www.ncqa.org for more information)

Within each standard there are between two and five structural elements, all with point values, that indicate the kinds of documentation that is required to pass or achieve points. There are some elements that practices must pass before receiving certain recognition levels. NCQA administers the recognition process and practices that choose to undergo the process undergo a self-audit and may be awarded one of three levels of recognition:

- To achieve basic level 1 recognition, practice scores must be within 25-49—and include 5 out of 10 “must pass” elements;
- To achieve intermediate level 2 recognition, practice scores must be within 50-74—and include all 10 “must pass” elements; and

- To achieve advanced level 3, practice scores must be within 75-100 and include all 10 “must pass” elements and include a fully functional electronic medical record.

Four of the study states are using the NCQA tool. (These states also adopted the Joint Principles):

- Colorado (adult), New Hampshire and Rhode Island are solely using the PPC-PCMH.
- Louisiana is using the PPC-PCMH and additional state-developed criteria, such as local projects aimed at building capacity and facilitating implementation.

State-developed recognition tools

Some states, providers and other experts have raised concerns that the PPC-PCMH tool is too costly and places too much weight on technology-dependent standards, such as electronic medical records, compared to standards that emphasize access, communication, comprehensiveness and care coordination.²⁷ Critics express concern that a practice could score well by focusing on the technological aspects of care without providing patient-centered care or better clinical outcomes.²⁸ Another barrier identified is that NCQA will only recognize physician-led practices.

Several states worked to avoid these barriers by developing their own criteria and recognition process. (see Table 5 for state-developed recognition tools) Some have used elements of the PPC-PCMH. Colorado’s program for children offers an illustration of this approach. The criteria and recognition process were developed to better meet the needs of small pediatric practices that may not have extensive resources or health information sharing capability. These criteria were developed using survey input from 500 provider practices, parents and other stakeholders. Colorado also took many elements of the PPC-PCMH tool and did a “crosswalk” with some existing tools using stakeholder feedback. These tools included some currently used by practices, such as the Medical Home Index and the EPSDT 416 report. Practices seeking to participate as medical homes for children may choose whether they will use the NCQA recognition process or that developed by the state.

TABLE 5: MEDICAL HOME RECOGNITION PROCESSES USED AMONG PRIMARY STUDY STATES THAT DID NOT ADOPT THE NCQA PPC-PCMH RECOGNITION TOOL

State	Status of recognition process development
Colorado (child)	<p>Reached agreement on 11 standards covering 8 domains.</p> <ol style="list-style-type: none"> 1. 24/7 access to a provider or trained triage service. 2. Child/family has a personal provider or team familiar with their child’s health history. 3. Appointments are based on condition (acute, chronic, well or diagnostic) and provider can accommodate same day scheduling as needed. 4. A system is in place for families to obtain information and referrals about insurance, community resources, non medical services, education and transition to adult providers. 5. Provider and office staff communicates in a way that is family centered and encourages the family to be a partner in health care decision making. 6. Provider and office staff demonstrate cultural competency 7. The Medical Home takes the primary responsibility for care coordination. 8. Age appropriate preventive care and screening are provided or coordinated by the provider on a timely basis. 9. The designated Medical Home adopts and implements evidence-based diagnosis and treatment guidelines. 10. The child’s medical records are up to date and comprehensive and upon the family’s authorization, records may be shared with other providers or agencies. 11. A Medical Home has a continuous quality improvement plan that references Medical Home standards and elements²⁹

TABLE 5: MEDICAL HOME RECOGNITION PROCESSES USED AMONG PRIMARY STUDY STATES THAT DID NOT ADOPT THE NCQA PPC-PCMH RECOGNITION TOOL, CONTINUED

State	Status of recognition process development
Minnesota	<ul style="list-style-type: none"> • State authorized funds to hire dedicated staff and convene a workgroup to create the criteria for participation in the care coordination program. • Minnesota Department of Health and Department of Human Services are working with provider and patient communities to develop proposed criteria for certifying providers. Criteria proposed include <ul style="list-style-type: none"> • participating in a learning collaborative, • using an internal registry for patient population management, • keeping updated care plans and • including parent/patient representatives on care teams
North Carolina	<p>A candidate for participation in Community Care of North Carolina (CCNC) must meet the criteria below:</p> <ul style="list-style-type: none"> • Perform primary care that include certain preventative services; • Ability to create and maintain a patient/doctor relationship to provide continuity of care; • Establish hours of operation for treating patients at least 30 hours per week; • Provide access to medical advice/services 24/7; • Maintain hospital admitting privileges or have a formal agreement with another doctor based on ages of the members accepted; • Refer or authorize services to other providers when the service cannot be provided by the PCP; • Use reports provided by Medicaid as guides in maintaining the level of care that meets the goals of CCNC and patient needs.³⁰ • Implement evidence-based best practices for core quality and disease initiatives; <p>Since 2008 with the implementation of the chronic care initiative:</p> <ul style="list-style-type: none"> • Develop a transitional support program across delivery systems • Provide team based care on those highest risk members; • Work in concert with network pharmacist on poly-pharmacy, poly-prescriber and medication adherence and reconciliation; • Integrate self-management programs.
Oklahoma	<p>Oklahoma Health Care Authority (OCHA) has developed a tiered reimbursement system with requirements stratified to reflect the advancement of the practice as a medical home.³¹</p> <p>Tier One - Entry Level Medical Home</p> <p>PROVIDER shall:</p> <ol style="list-style-type: none"> 1.1 Provide or coordinate all medically necessary primary and preventive services; 1.2 Participate in the Vaccines for Children (VFC) program if serving children and meet all Oklahoma State Immunization Information System (OSIIS) reporting requirements; 1.3 Organize clinical data in a paper or electronic format as a patient-specific charting system for individual patients; 1.4 Review and maintain a list of all patient medications; 1.5 Maintain a system to track tests and provide follow-up on test results, use a tickler system to remind and notify patients as necessary; 1.6 Maintain a system to track referrals including referral plan and patient report on self referrals, use a tickler system to remind and notify patients as necessary; 1.7 Provide care coordination and support family participation in coordinating care, including but not limited to securing referrals for specialty care and prior authorizations; 1.8 Provide patient education and support. <p>PROVIDER may choose to:</p> <ol style="list-style-type: none"> 1.9 Accept electronic communication from OHCA in lieu of written notification; 1.10 Provide 24 hours a day/7 days a week voice to voice telephone coverage with immediate availability of an on-call medical professional.

TABLE 5: MEDICAL HOME RECOGNITION PROCESSES USED AMONG PRIMARY STUDY STATES THAT DID NOT ADOPT THE NCQA PPC-PCMH RECOGNITION TOOL, CONTINUED

State	Status of recognition process development
Oklahoma Continued	<p>Tier Two – Advanced Medical Home PROVIDER shall meet all Tier One requirements shown above as 1.1 through 1.10 and shall also: 2.1 Obtain signed mutual agreement on the role of the medical home between provider and patient; 2.2 Maintain a full-time practice which is as defined as having established appointment times available to patients during a minimum of 30 hours each week; 2.3 Use scheduling processes including open scheduling; 2.4 Use mental health and substance abuse screening and referral procedures; 2.5 Use data received from OHCA to identify and track medical home patients both inside and outside of the PCP practice; 2.6 Coordinate care and follow-up for patients who receive care in inpatient and outpatient facilities, as well as when the patient receives care outside of the PCP’s office; 2.7 Implement processes to promote access and communication. PROVIDER shall also meet at least three of the following requirements: 2.8 Develop a PCP led practice health care team to provide ongoing support, oversight and guidance; 2.9 Provide after-visit follow up for the medical home patient; 2.10 Adopt specific evidence-based clinical practice guidelines on preventive and chronic care; 2.11 Use medication reconciliation to avoid interactions or duplications; 2.12 Accept on his/her panel children in state custody who are voluntarily enrolled in SoonerCare 2.14 Accept and engage a practice facilitator through the SoonerCare Health Management Program, use health assessment to characterize panel members’ needs and risks and/or document patient self-management plans for panel members with chronic disease. 2.15 Make after hours care available to patients by offering panel members appointments during at least four (4) hours each week outside of the hours of 8am to 5pm, Monday through Friday.</p> <p>Tier Three – Optimal Medical Home PROVIDER shall meet all Tier One and Tier Two requirements shown as 1.1 through 2.15 and shall also: 3.1 Organize and train staff in roles for care management, create and maintain a prepared and proactive care team, provide timely call back to patients, adhere to evidence-based clinical practice guidelines on preventive and chronic care; 3.2 Use health assessment to characterize panel members’ needs and risks; 3.3 Document patient self-management plans for panel members with chronic disease; 3.4 Develop a PCP-led practice health care team to provide ongoing support, oversight and guidance; 3.5 Provide after-visit follow up for the medical home patient; 3.6 Adopt specific evidence-based clinical practice guidelines on preventive and chronic care; 3.7 Use medication reconciliation to avoid interactions or duplications; 3.8 Accept on his/her panel children in state custody who are voluntarily enrolled in SoonerCare Choice as their medical home provider; 3.9 Use personalized screening, brief intervention and referral to treatment (SBIRT) procedures designed to assess an individual’s behavioral health status. PROVIDER may also: 3.10 Use integrated care plans to plan and guide patient care; 3.11 Use secure systems that provide for patient access for personal health information; 3.12 Report to OHCA on PCP performance;</p>
Washington	<ul style="list-style-type: none"> • Performance measures will be developed following a decision on reimbursement mechanism which may include performance based reimbursement. • Considering using Puget Sound Health Alliance’s evidence-based guidelines and quality of care measures. • Performance measures will also be defined as part of the 2009 Medical Home Collaborative.

ALIGNING PURCHASING AND REIMBURSEMENT

Reimbursement is an important means of supporting and rewarding behavior, or, as the common saying goes, “You get what you pay for.” All of the primary study states, as well as many other states identified in the NASHP scan have (or are developing) reimbursement policies to support the administrative costs of operating as a high performing medical home, including care coordination. These states’ approaches can be grouped into three broad categories:

1. Providing separate per member per month and/or lump sum payments (in addition to standard payments for medical services)
2. Enhancing payment rates for certain visits (e.g., well child visits)
3. Leveraging the managed care purchasing process by modifying selection criteria or contracts can encourage health plans and the broad range of providers that form health care systems to make the changes needed to better support medical homes. However, plans and systems need flexibility to manage care which may prove a barrier to a state agencies desire to standardize how medical home practices are qualified, reimbursed and supported.

In addition, some states are sharing savings or using pay-for-performance to reward effective medical homes. Finally, states and other purchasers in three states (Pennsylvania, Rhode Island and Vermont) have aligned their reimbursement structures in state-facilitated ‘multi-payer collaboratives’ that also use these reimbursement structures.³²

SEPARATE PAYMENT FOR ADMINISTRATIVE COSTS

Many states have elected to pay practices for ongoing administrative costs through a separate payment made in addition to the standard payment for the medical services the practice delivers to enrolled patients. Separate payments may be paid either as a per member per month or a lump sum payment. Separate payments ensure that medical home providers clearly see that they are being reimbursed for the extra costs they may incur for meeting the state’s definition of a medical home. However, providers and payers need to develop a process for accepting and tracking these payments.

State Medicaid agencies paying a per member per month payment often do so under the federal authority that allows them to operate a Primary Care Case Management (PCCM) program. Medicaid agencies first began implementing PCCM programs in the 1990s and, as of 2006, about 14 percent of percent of all Medicaid beneficiaries were enrolled in these programs.³³ Since the 1990’s primary care providers participating in PCCM programs have received the standard fee-for-service for all services they deliver directly, plus an additional per person per month fee to cover the cost of managing their patients’ care (usually \$2-5). This payment structure aligns well with that espoused by the PCPCC (see text box 4). Five of the primary study states are taking this approach (Idaho, New Hampshire, North Carolina, Oklahoma and Rhode Island). The reimbursement models now being considered by these states differ in three important ways from those used in many existing PCCM programs.

1. The per-person per-month fee paid for an individual patient may differ based the needs of the enrollee or the structure of the medical home. Rhode Island Medicaid, for example, pays a higher fee to practices that qualify as an advanced medical home and use an EMR. North Carolina, however, pays \$3 per person per month for an enrolled patient who qualifies for Medicaid as a poor child or parent and \$5 for those that qualify as a member of the “aged, blind, or disabled” eligibility group.³⁴

2. The per-person per-month fee in the new programs may be higher than those paid previously. This reflects the change in target populations. Many existing programs were aimed at children and parents of children who qualify for Medicaid or CHIP. Many of the new programs are targeted to adults with disabilities or the elderly—groups with more complex needs. Rhode Island practices that care for moderate to high risk Connect Care Choice members (primary care case management program) and have a nurse care manager integrated into their practice receive an additional \$30 per person per month.
3. North Carolina pays two per member per month fees for each enrolled individual—one to the primary care provider and one to the network to which the provider belongs. The networks use this payment to pay for medical home supports that a single practice might not be able to afford. For example, networks have hired: part-time or full-time medical directors to oversee quality, meet with practices and serve on State Clinical Directors Committee; a PharmD for medication management; clinical coordinator/director to oversee network operations; and care managers to assist practices.)

Two examples illustrate how states are using these approaches.

1. Oklahoma Medicaid pays medical home providers a tiered per member per month payment for administrative costs through their PCCM program that ranges from \$3.03 to \$8.69.³⁵ In addition, this state paid providers a one-time payment to support their transition from the previous program to this new arrangement.
2. All public and private payers in Vermont are participating in “Integrated Blueprint” pilots. In the pilots providers are paid a per member per month fee that varies based on the number of points the practice scored on the NCQA-PPC-PCMH (not the level reached). The fee for practices that score 25 points is \$1.20 and can reach \$2.39 for practices that score 100 points. Payers also share the cost of local Community Care Teams that engage the entire community in health maintenance, prevention and care for chronic disease.³⁶ Some payers are providing lump sum payments to cover these costs while others are paying an additional per person per month payment.

ENHANCED VISIT RATE

Both Colorado (children’s program) and Minnesota are paying an enhanced visit rate for some visits (e.g., well child visits). This approach minimizes the changes providers and payers need to make to their existing fee-for-service billing and payment systems. It also creates an incentive for provider outreach to

Hybrid Model, espoused by the PCPCC

According to the PCPCC, the most effective way to re-align payment incentives to support the PCMH would be a three-part payment model that includes:

1. A monthly care coordination payment for the physician work that falls outside of a face-to-face visit and for the health information technologies needed to achieve better outcomes. Bundling of services into a monthly fee removes volume-based incentives and promotes efficiency. The prospective nature of the payment recognizes the up-front costs to maintain the required level of care. Care coordination payments should be risk-adjusted to ensure that there are no incentives to avoid the treatment of the more complex, costly patients.
2. A visit-based fee-for-service component that recognizes visit-based services that are currently paid under the present fee-for-service payment system and maintains an incentive for the physician to see the patient in an office visit when appropriate.
3. A performance-based component that recognizes achievement of quality and efficiency goals.

Extracted from: Patient Centered Primary Care Collaborative, “Proposed Hybrid Blended Reimbursement Model”, May 2007, PCPCC, retrieved March 23, 2009. <http://www.pcpcc.net/content/proposed-hybrid-blended-reimbursement-model>

patients. However, over time, providers may come to think of the enhanced payment as the standard payment and not recognize that they are being reimbursed for providing ‘enhanced’ care. Medicaid agencies that use this payment model use the federal authority that enables them to define covered services and establish payment rates for those services. Although both states are using the same structure the amount paid by each varies considerably, primarily due to the populations each serves.

- Colorado plans to pay primary care providers who meet medical home standards an enhanced fee for all EPSDT visits provided to program participants. The enhancement is calculated to be about the equivalent of \$3 per member per month for a year (\$36). The Medicaid and CHIP agencies believe that this approach will provide an incentive for practices to provide EPSDT visits to program participants—and the state considers that service to be the cornerstone of a child’s medical home.
- Medical home providers in Minnesota will receive a higher fee for evaluation and management visits than other providers when the visit includes specified tasks and is provided to their patients who have five or more chronic diagnoses. The enhanced fee ranges from \$73.64 to \$458.52 based on the number of chronic diagnoses and the type of primary care provider. Certified medical home providers may receive no more than one enhanced fee per qualified patient every six months.³⁷

MANAGED CARE PURCHASING LEVERAGE

As of 2006, 42 percent of Medicaid beneficiaries received their primary care services through MCOs that also cover a comprehensive set of services including hospital and specialty care.³⁸ In these arrangements, the state usually pays a set per-person per-month (capitation) rate intended to cover both the costs of the services and administration. Many states value these arrangements because they offer a means for managing a broad range of services.

States with MCO programs can implement medical homes through the purchasing process. They are leveraging the managed care purchasing process by modifying selection criteria or contracts. This encourages (or requires) health plans and the broad range of providers that form health care systems to make the changes needed to better support medical homes. However, plans and systems need flexibility to manage care which may prove a barrier to a state agencies desire to standardize how medical home practices are qualified, reimbursed and supported.

Among the primary study states, Oregon has made the most progress toward using this process to support medical homes for Medicaid and CHIP participants—but has not yet developed any specific purchasing mechanisms. However, the agency that purchases coverage for Oregon’s state employees has already established medical home as one of the domains they examine during the purchasing process—and some contracted plans have already made moves to better support medical homes.

Through NASHP’s medical home scan we also identified an effort by Arizona’s Medicaid program. In their last procurement, this agency required all MCOs seeking to participate in their acute care program to describe how they would promote a medical home system. The Medicaid agency has since selected one of their contractors to develop their proposed model and is providing the MCO additional funding to do so.

PAY-FOR-PERFORMANCE AND SHARED SAVINGS

Many of the states seeking to advance medical homes are adding a ‘pay for performance’ or ‘shared savings’ component to their basic payment structure. For example,

- Oklahoma is requiring providers to achieve quality and efficiency goals.
- Idaho pays medical home providers for identifying their diabetic patients on a registry.
- Alabama is sharing the savings produced by the program with providers. The portion of savings each receives is based on performance on specified measures and the size of the patient panel.

SUPPORTING PRACTICES

All of the study states have developed strategies with other stakeholders to plan, develop and implement policies that support practice change and provide practices with access to skilled professionals to help them function as high performing medical homes.

SUPPORTING IMPROVEMENT *WITHIN* PRIMARY CARE PRACTICES

To help practices better support the delivery of patient-centered care, states have developed policies promoting first contact care, team-based care and information to practices.

First contact care

As stated earlier, a medical home requires every patient to have a regular, first point of contact for each new problem or health need. State policies that establish expectations for both patients and providers around this central medical home tenet include:

- **Encouraging the medical home relationship.** Patients need to know who their medical home is, what they can expect from their medical home and what their medical home expects of them. Without establishing this relationship up front, patients will continue to use care outside of the medical home without informing their medical home provider—leading to fragmented patient care.³⁹
 - In Oklahoma, to qualify as a tier two medical home, the provider must obtain a signed mutual agreement that describes the role of the medical home between provider and patient.
 - The Louisiana Quality Forum is working with patients to help them understand what they should expect from a medical home.
- **Establishing access to regular primary care providers.** North Carolina and Oklahoma require providers to have appointment times available to patients at least 30 hours each week. Oklahoma also requires providers (tier two) to maintain open scheduling processes. States that are using the NCQA recognition tool (Colorado (adult), Louisiana, New Hampshire, Rhode Island) require practices to meet continuity of care requirements that include patient access to their personal provider and same-day scheduling.
- **Providing after hours care.** Oklahoma providers (tier two) must offer expanded hours to their patients offering appointments at least four hours each week outside of the hours of 8-5, M-F. Most states require practices to offer patients 24/7 voice contact access to a health professional.

Team-based care

Many providers are simply not aware of how to work within a team to accomplish the numerous tasks required in a medical home.⁴⁰ States are developing policies that provide incentives for practices to develop teams to shift some of the responsibilities off the primary care providers' shoulders and on to other team members. Some of these policies include:

- **Paying a monthly care coordination fee.** Most states are paying or planning to pay a monthly care coordination fee intended to help practices hire or designate someone on site – usually a nurse or medical assistant – to perform this function. Both Rhode Island (Connect Care Choice) and Minnesota adjust the monthly care coordination fee to account for the time needed to care for complex patients.
- **Providing additional payments to hire care coordinators.** Rhode Island's multi-payer medical home pilot requires payers to pay practices a per member per month care coordination fee *and* share in the salary and benefits costs of an on-site nurse care manager.

- **Using recognition criteria to promote practice teams.** The NCQA recognition tool, used by many states, has criteria that require the use of non-physician staff to help manage patient care. States that have developed their own recognition tools have also included similar criteria:
 - Minnesota’s medical home criteria calls for each practice to designate an on-site practice care coordinator with protected time and space.
 - Oklahoma providers (tier three) must organize and train staff in roles for care management and create and maintain a practice team.
- **Supporting team-based care learning experiences.** Learning collaboratives help foster team-based care while learning about best practices. (See *Information to Practices* section for more information.)

Information to practices

Primary care practices need information to improve patient care. There are a number of approaches that states are using, working with stakeholders, to assist providers incorporate best practices and new resources into office procedures, apply evidence-base guidelines to clinical care and provide information about needs and utilization of the patients served by the practice—and how well the practice is meeting some of those needs. Information to practices can take the form of learning collaboratives, practice coaches and data support and include the following policies:

- **Partnering to provide learning collaboratives.** Learning collaboratives provide ongoing peer-to-peer learning opportunities that teach medical home principles and create a network to support practice improvements using face-to-face learning sessions, monthly conference calls and progress reports.⁴¹ Louisiana, Minnesota, Rhode Island and Washington are partnering with stakeholders, often the state quality improvement organization (QIO), to provide learning collaboratives to support practice change.
 - CareOregon, one of Oregon’s Medicaid managed care plans, conducts learning collaboratives. The state hopes to expand this model.
 - Rhode Island Department of Health and a federally qualified health center (FQHC) partnered in 1997 to develop a collaborative on diabetes. From this early partnership, a state-wide collaborative developed, adding 10 more FQHCs and a hospital-based practice.⁴² In 2003, the Department of Health and state QIO received a grant to train more practice teams. And more recently, the multi-payer pilot offers participating practices collaboratives on diabetes, coronary artery disease and depression.
 - Minnesota requires practice participation in learning collaboratives for recognition as a medical home.
- **Supporting on-site practice coaches.** Some states are making arrangements for practice facilitators or coaches to work on-site with practices to make improvements in areas such as addressing access, clinical information, community resources, workplace flow and NCQA requirements. Examples of this include:
 - Oklahoma has made practice facilitators available to providers who care for certain SoonerCare members who have chronic diseases as part of the Health Management Program. Practice facilitators generally work on-site for 4 to 6 weeks with the primary care practice to implement system changes to improve: (1) quality of care, (2) preventive disease management and (3) office efficiencies.

- New Hampshire's Center for Medical Home Improvement is developing a gap analysis package to assist primary care practices participating in the medical home pilot to prepare themselves to meet NCQA recognition. New Hampshire is also developing a technical assistance program to help address access, clinical information, chronic condition management, community resources and health system development — areas all linked to NCQA standards.
- **Providing data to practices regarding their patients and performance.** States can give primary care providers data that describes their patients' needs, utilization patterns including prescription drug and hospital admission history, as well as diagnoses and visits to other providers. States are providing this kind of data at regular intervals to practices via paper or electronic means as well as adding performance information to describe how well the practice is meeting expectations. Examples include:
 - New Hampshire Medicaid plans to make beneficiary data about pharmacy services as well as paid claims directly available to providers from Medicaid program vendors. Providers already have access to a patient's pharmacy history through e-prescribing. In 2010, New Hampshire's new MMIS will have provider web portals that will be able to report data about providers' performance.
 - Oklahoma generates four kinds of profiles to selected providers biannually that give information about their patient's utilization and health care needs. Oklahoma is developing a pay-for-performance program and will involve providing feedback on meeting certain targets regarding such as Child Health Exams (EPSDT) and Breast and Cervical Cancer screenings.

SUPPORTING CARE *OUTSIDE* PRIMARY CARE PRACTICES

States are developing policies that support the integration of patient care outside the primary care practice between other providers, settings and with the patient, family or caregiver, particularly for those patients with complex illnesses who see multiple providers. As discussed in the previous section, on-site care coordinators can help with care integration, but in addition, states are developing policies that support off-site care coordinators, health information exchange and patient engagement.

Off-site care coordinators

Off-site care coordinators work directly with practice teams to improve patient care and are supported through the following state policies:

- **Paying monthly network care coordination fees.** North Carolina has organized their PCCM program into 14 non-profit community networks' and formed Community Care of North Carolina (CCNC) to support the networks' efforts to improve care.
- **Hiring extra state staff.** Some states are building off of existing programs to support providers with patient care.
 - Colorado is hiring extra EPSDT workers to provide outreach and case management to support families and providers and to help providers comply with the new medical home requirements.
 - Oklahoma's Medicaid Care Management Department has added nurses to assist in facilitating medical services for Medicaid clients with complex medical conditions.

Health information exchange

Some states, such as Idaho, are building on a complementary state initiative to establish a health information exchange that provides information to providers about private and public patients. Others are providing web

portals or registries maintained by state agencies to provide information. For example:

- Colorado recently expanded its registry— the Colorado Immunization Information System (CIIS) — to add voluntary newborn screenings and adult vaccination information to the existing children’s vaccination data. Accessing this registry helps pediatricians more easily obtain timely results and provide better patient care. Family practice providers will be able to use one electronic system to track vaccines for children, adolescents and adults.⁴³
- Louisiana Medicaid provides access to the state immunization database and rewards providers who access the information and achieve specified immunization performance.

Patient engagement

Although states believe it is important to engage patients, many efforts to advance the medical home center on providers, rather than patients. States can provide patients access to information and data to better manage their health and strengthen their links to their providers. Some policies include:

- **Increasing patient education.** There are a variety of educational options being used by states:
 - The Louisiana Quality Forum plans to increase health literacy to help patients choose a medical home, know their options of care and understand how to navigate the health care system. Louisiana also plans to reward patients for healthy behaviors with dollars for health care goods and services not currently covered by Medicaid.⁴⁴
 - Rhode Island’s Connect Care Choice (PCCM program for Medicaid adults who are elderly or disabled) helps link patients to the Stanford Chronic Disease Self-Management Program patient workshops. (See Text Box 5) and
 - Washington’s Rethinking Care initiatives involve patient activation, coaching and educational materials to patients enrolled in this programs. The Health Care Authority is working on a health information technology initiative to help patients maintain their own personal health record.
- **Measuring patient engagement.** Minnesota is required by the legislature to measure patient engagement and is currently exploring approaches to involve patients in medical home team quality improvement.

Stanford Chronic Disease Self-Management Program (CDSMP)

The Chronic Disease Self-Management Program is a 2 1/2-hour workshop given once a week, for six weeks, in community settings such as senior centers, churches, libraries and hospitals. People with different chronic health problems attend together. Workshops are facilitated by two trained leaders, one or both of whom are non-health professionals with a chronic disease themselves.

Subjects covered include: 1) techniques to deal with problems such as frustration, fatigue, pain and isolation, 2) appropriate exercise for maintaining and improving strength, flexibility and endurance, 3) appropriate use of medications, 4) communicating effectively with family, friends and health professionals, 5) nutrition and 6) how to evaluate new treatments.

Classes are highly participative, where mutual support and success build the participants’ confidence in their ability to manage their health and maintain active and fulfilling lives.

In a randomized controlled study, CDSMP patients made significant improvements in exercise, cognitive symptom management, communication with physicians, self-reported general health, health distress, fatigue, disability and social/role activities limitations. They also spent fewer days in the hospital and had fewer outpatient visits and hospitalizations yielding to a cost/savings ratio of approximately 1:10 with benefits.

Source: Stanford School of Medicine, “Chronic Disease Self-Management Program,” 2009, Stanford School of Medicine. Retrieved March 23, 2009. <http://patienteducation.stanford.edu/programs/cdsmp.tml>

MEASURING RESULTS

The increasing interest in advancing medical homes is based on the evidence that doing so will result in improved care for Medicaid and CHIP beneficiaries and contain costs. Ultimately, however, state Medicaid and CHIP officials will need to demonstrate these results in their own initiatives. They expect to affect, not just primary care, but other parts of the system, such as hospitals.

Among the primary study states, North Carolina has already demonstrated both improvements in patient outcomes and cost. North Carolina's asthma improvement initiative resulted in a 40 percent decrease in hospital admission rates, 16 percent lower emergency department use rate and 93 percent of patients receiving appropriate maintenance medications. They also found their programs saved \$231 million in fiscal years 2005 and 2006.⁴⁵

Rhode Island has planned an evaluation of Chronic Care Sustainability Initiative (multi-payer pilot) conducted by the Harvard School of Public Health, with funding from The Commonwealth Fund. Evaluators will collect qualitative information on the practices' experience of adopting the PCMH and look for evidence that adoption of the PCMH components has an impact on patients, including changes in care processes, outcomes and experiences of care and that the intervention produces changes in cost.

Among the other states, Louisiana, New Hampshire and Washington have identified potential measures, but not yet finalized their measurement plans. To date, these states have focused on measures that indicate improved quality of primary care, are likely to result in cost savings and will change fairly quickly in response to system improvements. For example:

- Louisiana, New Hampshire and Washington both expect reductions in rates of hospitalizations for ambulatory care sensitive conditions (i.e., hospitalizations that can be reduced by effective primary care, such as asthma admissions).
- New Hampshire and Washington expect a reduction in unnecessary emergency room usage.
- New Hampshire and Washington both plan to use structure and process measures to identify whether practices are changing how they deliver care. Washington expects to see increases in the number and rate of clinics that implement and maintain 24/7 access and adhere to clinical practice guidelines.

All three states plan to rely, at least in part, on measures drawn from nationally recognized measurement sets such as Healthcare Effectiveness Data and Information Set (HEDIS) and those included in Medicare's Physician Quality Reporting Initiative (PQRI) program.

- HEDIS is a measurement set that is used by most health plans, including many Medicaid-contracted MCOs. It consists of 71 measures across 8 domains of care. Each measure was developed by NCQA through a formal process that "involves identifying the clinical area to evaluate; conducting an extensive literature review; developing the measure with the appropriate Measurement Advisory Panel (MAP) and other panels; vetting it with various stakeholders; and performing a field-test that looks at feasibility, reliability and validity."⁴⁶
- The PQRI is a physician quality reporting system that was established by CMS in 2006. The 2009 version of the PQRI includes 153 quality measures, which were developed by 12 different organizations, including NCQA and the American Medical Association.⁴⁷

Finally, Washington plans to measure parent perception of quality of care and Minnesota requires certified medical home clinics to survey patients and/or families to measure their satisfaction with care delivery and level of engagement in patient care.

CONCLUSION

As many states grapple with the unsustainable growth in health costs, innovative solutions that seek to transform the health care delivery system, such as through the medical home model are being considered. Medicaid and CHIP have strong foundational bases to develop policies that support medical homes. In particular, Medicaid's responsibility in caring for special populations that have a high degree of chronic illnesses that constitute a bulk of Medicaid spending, gives strong reason for policy makers to consider a new approach to care.

Through research, NASHP has identified 31 states that are currently working to advance medical homes in their Medicaid and CHIP programs. Most of these efforts target a subgroup of their beneficiaries, particularly those with complex needs and offer the greatest potential for both costs savings and improved care. Many states plan to expand to wider populations if the model proves successful.

From these 31 states, we focused on 10 primary study states that are leading plans for medical homes in Medicaid and CHIP. These primary study states have found that the support of the legislature and/or executive branches clearly provide state Medicaid agencies with the authority to convene stakeholder groups and form partnerships that are fundamental to any medical home initiative. Through legislation, executive order or statute, Medicaid and CHIP agencies are often held to a timetable for program development and implementation and are often able to gain other stakeholders', such as commercial payers, commitment to participate.

Partnerships are crucial to the success of medical home initiatives and all of the leading states' Medicaid and CHIP agencies have stakeholder input that include consumers, providers and often their representative associations. Particularly, gaining the buy-in of physicians (who are often reluctant participants in Medicaid and CHIP programs) is crucial to achieving practice spread. Successful strategies to engage physicians have included town meetings, provider surveys, dedicated webpages and involvement of provider association groups. In addition, a number of states are involved in leading or participating in multi-payer medical home pilots to gain further provider buy-in. Providers are much more likely to participate if they can treat all patients the same, regardless of the payer and report on common measures. Payers are more inclined to participate if they have the state as a convener, avoiding anti-trust concerns and if they are able to spread the risks of added investments in provider payments and practice infrastructure.

All of the leading states have been guided by a definition that often shapes the recognition process. Defining and recognizing a medical home is important because it establishes expectations that can motivate medical practices to change how they deliver care. It also helps in developing the framework needed for added reimbursement and the ability to certify that practices qualify for added reimbursements. The 10 primary study states are divided on the sources for the definition of medical homes and also on the recognition process. Many of the states that have chosen the Joint Principles as their definition have also chosen the NCQA PPC-PCMH tool which was developed to complement the Joint Principles. Other states have found the Joint Principles too limiting in their definition of who can lead a medical home (physicians) and the NCQA PPC-PCMH too limiting (only physician practices can be certified) and burdensome (expensive and too technology focused) and have chosen or developed other definitions and recognition tools.

All of the leading states are working to develop and implement reimbursement reforms that support and reward practices that function as high performing medical homes mostly through fee-for-service, enhanced per member per month case management fees and pay for performance. Per member per month fees sometimes vary, adjusted for risk or with the level of practice transformation achieved. By providing incremental increases in per member per month fees based on achievement of standards, states have been able to provide incentive for practices to transform into high functioning medical homes. Some states have tied added performance

payments to practices that are providing preventive services or screenings such as EPSDT well-child visits.

Payment reform is a powerful tool to spur practice transformation, but all leading states are supporting practices as they plan and implement changes, including: assistance incorporating the best practices and new resources into office procedures via learning collaboratives, health information technology and practice coaches, providing resources to support care coordination via payments to hire staff, linkages to state care coordinators and community networks; and supporting patients' efforts to better manage their own care via informed decision making tools and self-management classes. Our experience indicates care coordination is critical to promoting practice transformation. Many states are requiring practices employ care coordination strategies in order to qualify as medical homes and receive additional payments.

Evaluating the results of medical home policy changes will be crucial for states to continue programs and justify further expansions. Some states have sophisticated evaluations underway, particularly those states that are leading multi-payer pilots. Other states are looking at use measures such as emergency department use and hospitalizations for ambulatory sensitive conditions such as asthma. Policy makers in states may need to exercise patience in evaluating the results of medical home efforts—changes in patient outcomes and health expenditures may take several years to come to realization.

Delivery system reform is a key aspect of health care reform. Expanding access to coverage cannot be sustained without attending to quality improvement and cost containment goals. The lessons learned by North Carolina Medicaid and a smaller number of other programs has shown that the provision of good, comprehensive primary care via medical homes has promise in achieving the goals of quality improvement and cost containment. Time will be required to validate these findings in other states and programs.

APPENDICES

APPENDIX A:
FEDERAL MEDICAID AND CHIP POLICIES THAT CAN SUPPORT MEDICAL HOMES

Both Medicaid and CHIP are administered by states within federal guidelines. State and federal governments share both the costs of services and program administration. Each state makes its own decisions about who the programs will cover, what services they will cover, how services will be delivered and under what circumstances they will pay for services provided to an individual. The two programs differ in the populations they serve.

- Medicaid serves poor and low-income families, people with disabilities and the elderly,
- CHIP serves children from low-income families who do not qualify for Medicaid.⁴⁸

Also, each of these programs is governed by a separate set of federal regulations. Those governing CHIP offer states more flexibility than those governing Medicaid. However, both programs must cover a comprehensive package of services. This comprehensive coverage offers a good base on which to build a medical home since the same program will pay for primary care as well as a broad array of services needed to diagnose and treat conditions.

KEY FEDERAL MEDICAID POLICIES

Several aspects of federal Medicaid requirements are particularly useful for supporting medical homes. First, Medicaid covers a comprehensive set of services, including outreach and case management. In addition, some aspects of Medicaid managed care can support reimbursement reform as well as practice change—and there is potential for using Medicaid funding to support health information technology and health information exchange initiatives that can help practices more effectively serve as medical homes. However, there is evidence that this promise is not being fulfilled—for example although federal regulations require states to achieve an EPSDT screening (well child visit) rate of 80 percent only 28 states achieved that goal in 2007. This disconnect is one of the factors driving the current interest in advancing Medical homes for this population. All stakeholders wishing to achieve that goal should be familiar with the following federal policies which provide regulatory guidance for any such effort.

MEDICAID COVERS COMPREHENSIVE SERVICES

Medicaid offers comprehensive coverage. It pays for many of the services that patients need. Under federal law Medicaid must cover: inpatient and outpatient hospital services, prenatal care, vaccines for children, physician services, nursing facility services for persons aged 21 or older, family planning services and supplies, rural health clinic services, home health care for persons eligible for skilled-nursing services, laboratory and x-ray services, pediatric and family nurse practitioner services, nurse-midwife services, federally qualified health-center (FQHC) services and early and periodic screening, diagnostic and treatment (EPSDT) services for children under age 21. Medicaid programs may also cover other services, including diagnostic services, clinic services, pharmaceutical services, eyeglasses and optometrist services, transportation services, rehabilitation and physical therapy services and targeted case management (TCM) and disease management.⁴⁹ Among these services EPSDT, TCM and disease management may be especially useful in crafting policies and strategies that support medical homes.

EARLY PERIODIC, SCREENING, DIAGNOSIS AND TREATMENT

Under federal Medicaid law, states must provide EPSDT to all children under age 21. EPSDT includes outreach and patient education, periodic well-child visits and support for accessing diagnostic and treatment services.

EPSDT law also ensures that children are able to access an even more comprehensive package of benefits than adults. States must cover all services that are required under federal Medicaid law, even if not covered for adults. For example, a state may choose not to cover dental services for adults, but EPSDT requires states to cover these services for children. In addition, federal law specifies that children must receive not only the services needed to improve or cure a condition, but also those needed to ameliorate a condition or prevent deterioration. This requirement essentially establishes a medical necessity definition for children served by Medicaid that includes prevention and early intervention—and is broader than that used in most commercial coverage.

States can use this benefit as a basis for policies and strategies to support practices serving as a child's primary care provider and to enable the practice to provide the comprehensive, coordinated care as envisioned in the Joint Principles. The major drawback to basing policies that support high-functioning medical homes on this benefit is that there is no similar benefit for adults.

TARGETED CASE MANAGEMENT

States may provide Targeted Case Management (TCM) to defined groups of beneficiaries. Examples of groups served by TCM include: pregnant women, all newborns, severely and persistently mentally ill (SPMI) adults and those who live in a homeless shelter. TCM includes assessment, care plan development, referral to services and monitoring/follow-up activities. States that qualify establish TCM coverage through their state plans. Within those plans, each state specifies the groups that qualifies for TCM. For each group, the agency also provides more details about the service, including the qualifications providers must meet to deliver the service.

TCM, as most states currently define it, is not strongly connected (much less driven) by primary care providers. But the flexibility states have to define the target groups, providers and benefit level itself offer possibilities to help practices fulfill the care coordination functions of a medical home.

MOVING FROM DISEASE MANAGEMENT TO THE CHRONIC CARE MODEL

In the 1990s, Medicaid agencies began to implement disease management programs. By 2004, 22 agencies had disease management programs. Most of these were targeted to specific diseases (such as diabetes), contracted to private companies that were not located near the beneficiary or provider and provided services that were not connected or integrated with primary care.

As the states gained experience with these programs, many began to modify them by adding elements similar to

The Chronic Care Model is defined by six essential elements that encourage high quality chronic disease care.

Health System: Create a culture, organization and mechanisms that promote safe, high quality care

Delivery System Design: Assure the delivery of effective, efficient clinical care and self-management support

Decision Support: Promote clinical care that is consistent with scientific evidence and patient preferences

Clinical Information Systems: Organize patient and population data to facilitate efficient and effective care

Self-Management Support: Empower and prepare patients to manage their health and health care

The Community: Mobilize community resources to meet needs of patients

Information adapted from: Improving Chronic Illness Care Program, "Improving Chronic Illness Care," 2009, Robert Wood Johnson Foundation, Retrieved March 23, 2009, www.improvingchroniccare.org. The Improving Chronic Illness Care program is supported by The Robert Wood Johnson Foundation, with direction and technical assistance provided by Group Health's MacColl Institute for Healthcare Innovation.

many of those envisioned in the Joint Principles of the PCPCC, such as strengthening the connection between the primary care provider and the care coordination activities of the disease management program. But two states, New Hampshire and Vermont, are planning to shift funds from their third-party disease management programs to direct support of practices that function as high performing medical homes. Several states, such as Florida and Pennsylvania, are engaged in efforts to implement the Chronic Care Model developed by Ed Wagner, MD, MPH, of the MacColl Institute for Healthcare Innovation into some or all primary care practices.⁵⁰ (See text box, previous page) If more states continue to evolve their disease management programs in these directions, they may come to serve as a support for high performing medical homes.

MEDICAID MANAGED CARE

Since the 1980s, Medicaid agencies have used two types of managed care to provide services. Managed care offers a delivery system, reimbursement and quality improvement infrastructure that states can modify to better support medical homes.

- *Primary Care Case Management (PCCM)*: In a PCCM delivery system, the Medicaid agency contracts directly with physicians or practices that agree to either provide or coordinate most care their patients (enrolled beneficiaries) need. Most states pay PCCM providers fee-for-service plus a small per enrollee per month fee to recognize the cost of coordinating care (PCCM fee). Payment variations that some states incorporate include pay for performance (e.g., Alabama), increased visit rates for primary care visits provided by the PCCM provider (e.g., Massachusetts), or paying two PCCM fees—one to the physician and one to a network of providers (e.g., North Carolina). As of June 2006, CMS reported that 28 states operated PCCM programs serving 6.5 million beneficiaries (or about 14 percent of the 45.6 million total beneficiaries).⁵¹
- *Managed Care Organization (MCO)*: In an MCO delivery system, the Medicaid agency contracts with an organization that agrees to deliver a defined set of services to a defined group of Medicaid beneficiaries for a fixed per member per month price. The contractor is at financial risk—making a profit if it spends less than the amount paid and incurring a loss if it spends more than the amount paid. Most states include a comprehensive set of benefits (at least primary, specialty and hospital care) in the scope of work. As of June 2006, CMS reported that 37 states, Puerto Rico and the District of Columbia operated MCO programs serving 19.3 million Medicaid beneficiaries (about 42 percent of total).⁵²

PCCM programs are well-suited for supporting medical homes. The payment structure is very similar to that supported by the PCPCC and the structure of the program supports a direct relationship between the primary care provider and the patient by establishing a panel of patients for which the practice is responsible and provides an organizing structure for defining relationships and referral practices between primary care and other specialists.

MCO programs also offer opportunities for supporting improvement. Under federal law, states that require beneficiaries to enroll into MCOs also must conduct an external review, hire an external quality review organization (EQRO) to conduct certain activities and require the MCOs to conduct Performance Improve Projects (PIPs). A PIP includes performance measurement, implementation of activities or interventions to improve performance and demonstrated improvement based on follow-up measurement. States have flexibility to choose topics for PIPs and to specify many of the activities that an EQRO will conduct. Previous NASHP work on the topic of developmental services found that states use this infrastructure to support practice change. This structure (and funding) is used to measure relevant performance and deliver training to practices, including conducting learning collaboratives for providers.⁵³

The purchasing process, including reimbursement strategies, also provides states with leverage to direct MCOs to support medical homes. For example, Arizona Medicaid included requirements related to medical homes in their last Request for Proposals (RFP) for acute care services. They required all applicants to describe their system and they plan to award a contract (and additional funding) to one MCO to assist in developing a medical home program for the Medicaid population.⁵⁴

KEY FEDERAL CHIP POLICIES

As previously discussed, CHIP is designed to provide coverage to children from low-income families who do not qualify for Medicaid. Every state and the District of Columbia now have a program. As of July 2005, 43 of these programs covered children from families with incomes up to or above 200 percent of the Federal Poverty Level.⁵⁵ Federal funding for CHIP is capped (unlike federal Medicaid funding). States have two options for implementing their CHIP programs—they may implement them as expansions of their Medicaid program and/or as a separate program. As of May 2007, 11 states operated a Medicaid expansion program, 19 operated a separate program and 21 operated both types of programs.⁵⁶ Medicaid expansion programs must follow federal Medicaid rules, so these programs have the same opportunities as those described previously. Separate programs, however, follow a different set of federal rules. These rules offer states more flexibility in defining what services they will cover and how they will deliver services.

- States' CHIP coverage must be comprehensive. But it is defined against a benchmark benefit (such as that offered to state employees) and not against a list of mandatory and optional services. States can, however, choose to extend the EPSDT, TCM and disease management services described in the previous section to children participating in a separate program.
- States have greater ability to mandate enrollment into managed care—and indeed, among the 39 separate programs operating in 2005, 26 enrolled CHIP participants into MCOs that deliver a comprehensive set of services and 13 enrolled them into PCCM programs.⁵⁷

The flexibility to design benefit packages and service delivery systems provides opportunities for states seeking to advance medical homes for children—but the capped funding may present a potential barrier.

APPENDIX B: OVERVIEW OF ACTIVITY IN SELECTED SUMMIT STATES

State	Overview	Target Start Date	Target Population	Delivery System
Colorado	Colorado has developed standards and is working on the systems piece to maximize the number of children enrolled in Medicaid or SCHIP (Child Health Plan Plus) who have a medical home.	July 1, 2008	Colorado Department of Health Care Policy and Financing has the target population of Medicaid and Child Health Plan Plus children, while the Colorado Department of Public Health and Environment is focused on all children in Colorado. Adult multi-payer pilot is being planned.	Fee-for-service for initial pilot
Idaho	The “Target for a Healthy Idaho” initiative will provide each person access to a medical home under the direction of a primary care provider. The state plans to concurrently address multiple system weaknesses, including a shortage of primary care physicians and supporting professionals. Idaho will focus first on technology to provide the foundation for patient-centered medical homes through the Idaho Health Data Exchange (IHDE). IHDE has connected three hospitals as of March 2009. Also, reimbursement is being reviewed to determine how to better support the medical home model. The initiative is supported by a stakeholder group including Medicaid, Blue Cross, Regence Blue Shield, Governor’s Office, legislators, and medical providers.	Phase 1 for the Health Data Exchange began Fall 2008; medical home pilot dates are targeted for 2009-2010.	Every state citizen	Primarily fee-for-service with some primary case management (PCCM) and managed care organizations (MCOs)

State	Overview	Target Start Date	Target Population	Delivery System
Louisiana	<p>In 2007, the legislature directed the state to develop and pilot a medical home system of care to increase access, improve quality, and provide sustainability in medical care for the Medicaid and uninsured populations. This effort will build on the:</p> <ul style="list-style-type: none"> Existing CommunityCare program (state's PCCM program); and Planned Care Coordination Networks (CCN), an organized health system operated by health system/providers offering an integrated system of care. 	<p>The Department of Health and Hospitals submitted its Medicaid waiver application, including the CCN initiative, to HHS in December of 2008 and is awaiting federal response. However other medical home projects are underway.</p>	<p>Medicaid beneficiaries are the target population for the CCNs and current PCCM program. 38 safety net clinics in the greater New Orleans area have been recognized by NCQA as patient-centered medical homes. The aggregate patient mix of the clinics is: 26% Medicaid, 45% uninsured, 5% Medicare, and 24% commercial.</p>	<p>Currently a fee-for-service program with PCCM, other managed care structures are to be used in CCN.</p>
Minnesota	<p>Recent legislation has prompted the state to begin policy planning and drafting state plan amendments for medical home services to Medicaid enrollees as well as a substantial proportion of the privately insured. The state is working with provider and patient communities to develop specific criteria and certify providers who meet those criteria to provide comprehensive care coordination and care plan development. Legislative criteria include participating in a learning collaborative, using an internal registry for patient population management, and keeping updated care plans. Criteria valued in Minnesota include having parent/patient representatives on care teams as well as collaborative learning.</p>	<p>July 1, 2009</p>	<p>Medicaid beneficiaries (adults and children) and all fully-insured patients in the private sector, beginning with those with chronic or complex conditions.</p>	<p>Both fee-for-service and through contracts with MCOs.</p>

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State	Overview	Target Start Date	Target Population	Delivery System
New Hampshire	<p>The New Hampshire Multi-Payer Medical Home Project is a pilot involving all payers (including Medicaid and Medicare), providers, and subject experts. These stakeholders plan to create primary care medical homes for adults with disabilities. The state hopes that primary care provider-directed teams will more comprehensively address patient needs and provide care management to improve Medicaid beneficiary health outcomes, optimize the appropriate use of medical services and minimize the loss to follow-up and churn of these needy patients. The state will shift the existing disease management budget, about \$1.3 million/year, to the program and use its Comprehensive Healthcare Information System (CHIS) in evaluation.</p>	<p>The private sector pilot began January 1, 2009. Medicaid participation will begin in late Fall 2009.</p>	<p>Adults with disabilities.</p>	<p>Fee-for-service (Medicaid).</p>
Oklahoma	<p>The Medical Advisory Task Force (MAT) recommended that the Oklahoma Health Care Authority (OHCA) modify the service delivery model to pure PCCM, while embracing the patient-centered medical home approach. OHCA's primary goals are to:</p> <ul style="list-style-type: none"> • guarantee the availability of a medical home with a primary care provider for all SoonerCare Choice members that will: • enhance patient choice and participation in health decisions; • assure all members receive all necessary preventive and primary care; • reduce inappropriate emergency department visits and hospitalizations; • realign payment incentives to improve cost effectiveness and quality; and • promote the use of health information. 	<p>January 1, 2009</p>	<p>Populations approved for 1115 managed care demonstration: pregnant women and infants under age 1, children 1-18, adults with children in TANF, ABD- TEFRA children, and breast and cervical cancer prevention and treatment women.</p>	<p>PCCM</p>

State	Overview	Target Start Date	Target Population	Delivery System
Oregon	<p>Under new legislation, Oregon will partner with consumers, providers, purchasers, and payers to provide every Oregonian with an integrated health home. More specifically, Oregon will:</p> <ul style="list-style-type: none"> • create and support interactive systems of care (real and virtual) which connect health homes with community-based services, public health, behavioral health, oral health, and social services to improve population health; • provide the health care workforce with resources, training, and support needed to transform practices into integrated health homes; • develop and evaluate strategies to empower consumers to become more involved in their own health; and • strengthen the role of the safety net in delivering services to vulnerable populations. • These efforts build on multiple ongoing efforts in both the public and private sectors to pilot medical home initiatives. 	Recommendations to the Governor and Legislature by Fall 2008.	All Oregonians.	PCCM and MCO in Medicaid, and working with the private sector via public employees.
Washington	<p>The Medical Home Initiative is a series of public-private efforts supported by multiple state agencies and the legislature, and with leadership from the Governor's Office. Public and private stakeholders are working together to improve health outcomes by expanding access to primary care providers and medical homes. Medical homes for Medicaid beneficiaries are being developed and implemented in conjunction with current chronic care management programs. In addition to pilots for Medicaid beneficiaries, state employees, and others, the state has committed to conducting two collaboratives.</p> <ul style="list-style-type: none"> • The 2008 Collaborative features learning sessions for providers focused on improving systems of care for patients with chronic diseases and for children with special health care needs via medical homes. • The 2009 Collaborative will focus on expanding availability of medical homes for adults and children, and study reimbursement approaches that support and promote medical homes. • Additionally, a reimbursement study to be conducted in 2008 will result in a report to the legislature. 	January 1, 2009	First, adults and children who qualify for Medicaid due to age or disability, including those who receive SSI. Ultimately, stakeholders envision including all citizens of the state.	Fee-for-service, PCCM, and MCO.

STATUS OF SUPPORT AND PARTNERSHIPS

State	Legislative Action	Governor's Action	Groups or Committees that Include State Representatives	Other Relevant Activity
Colorado	Legislation enacted.	The governor signed the medical home bill (SB 07-130) and SB 07-211, which supported the creation of metrics related to medical homes. The governor also supported funding for enhanced reimbursement for a select group of pilot providers.	<ul style="list-style-type: none"> • The Medical Home Initiative supported state wide implementation of medical home. • Colorado Patient Centered Medical Home Multi-Payer Pilot. • Performance Measure Advisory Group. 	<ul style="list-style-type: none"> • The 2003 National Initiative for Children's Healthcare Quality (NICHQ) grant to support technical assistance for the development of the Medical Home Initiative included an active medical home learning collaborative and Parent Practice Partnerships (P3) support to foster communication and partnering between providers and parents. • The Colorado Children's Healthcare Access Program (CCHAP) refined a medical home model for CSHCN. • HRSA Systems Integration Grant for local implementation. • Developmental Disability Council adopted health as a priority area. • State agency representatives are members of a variety of committees focused on children's health and well-being.
Idaho	The Health Quality Planning Commission is already in statute. SB1158 (pending).	<ul style="list-style-type: none"> • Initiated "Target for a Healthy Idaho". • Created Select Committee on Health Care by executive order. 	<ul style="list-style-type: none"> • The Health Quality Planning Commission will review quality standards and information technology and pilot the Idaho Health Data Exchange. • The Select Committee on Health Care is developing policy recommendations for the Governor. • The legislative Health Care Task Force addresses health reform, including the medical home. 	<ul style="list-style-type: none"> • Medicaid embedded the medical home requirement in the Idaho Medicaid State Plan, participates on the Health Quality Planning Commission and the Select Committee, and advises the Legislative Committee. • SB1158 mandates primary care medical homes for certain medically indigent persons.
Louisiana	Legislation enacted.	<ul style="list-style-type: none"> • Signed legislation. • Funding was included in the Governor's Budget for the establishment of the Care Coordination Networks. 	The Louisiana Health Care Quality Forum was established to convene all public and private stakeholders to advance quality initiatives in the state, including the medical home.	<ul style="list-style-type: none"> • The Department of Health and Hospitals (DHH) prepared for implementation of the medical homes through the Care Coordination Networks development. • DHH provided a \$3.21 million, 3-year contract to the Quality Forum. • The Quality Forum won a CMS EHR demonstration award.

State	Legislative Action	Governor's Action	Groups or Committees that Include State Representatives	Other Relevant Activity
Minnesota	Legislation enacted.	Signed 2007 and 2008 legislation.	<ul style="list-style-type: none"> Academy Health/Commonwealth Fund Quality Improvement Institute. 	Federal Maternal Child Health Bureau (MCHB) and state funded Medical Home Learning Collaborative for children with special health care needs.
New Hampshire	No legislation.	Launched the New Hampshire Citizens Health Initiative (CHI).	The CHI Medical Home Workgroup includes senior leadership from major payers, as well as the New Hampshire Medicaid program.	<ul style="list-style-type: none"> In 2009, the Medicaid Medical Home will have dedicated Medicaid funding of \$1.3 million per year. Comprehensive Healthcare Information System, an all-payer claims database, will facilitate program evaluation. New fiscal agent required to launch program (July 2010 program start).
Oklahoma	Legislation enacted.	Signed legislation creating the Patient-Centered Medical Home Task Force.	The Medical Advisory Task Force (MAT) collaborates with the Oklahoma Health Care Authority and is scheduling town meetings for providers.	Legislation requires study of concept for both government-supported and non-government-supported health insurance, with report due by December 1, 2009.
Oregon	Legislation enacted.	Signed The Healthy Oregon Act in 2007.	Oregon Health Fund Board (OHFB) created committees that have included over 100 key stakeholders and consumers.	<ul style="list-style-type: none"> The legislature approved two primary care home pilots in February 2008. A large Medicaid managed care plan with four pilots has been ongoing for the past year. Efforts are underway in the Public Employees Benefit Board.
Washington	Legislation enacted: <ul style="list-style-type: none"> HB 2549 	Formed a Blue Ribbon Commission (BRC) to develop a five-year plan.	<ul style="list-style-type: none"> The Rethinking Care Initiative. Washington State Collaborative to Improve Health. AcademyHealth / Commonwealth Fund Quality Improvement Institute formed a public-private work group that includes legislative, executive branch, carriers, and provider representatives. Primary Care Coalition. Puget Sound Health Alliance. 	<ul style="list-style-type: none"> The Children's Healthcare Improvement System (CHIS) promotes medical homes for children. Emergency Department Diversion Grant from CMS. Patient Navigator pilot program. Existing chronic care management program. Health information technology expansion.

STATE DEFINITION FOR MEDICAL HOME

State	Definition	Source of Definition	Who in State Can Serve as a Medical Home
Colorado	<ul style="list-style-type: none"> • Children’s population: “Medical home” means an appropriately qualified medical specialty, developmental, therapeutic, or mental health care practice that verifiably ensures continuous, accessible, and comprehensive access to and coordination of community-based medical care, mental health care, oral health care, and related services for a child. A medical home may also be referred to as a health care home. If a child’s medical home is not a primarily medical care provider, the child must have a primary medical care provider to ensure that a child’s primary medical care needs are appropriately addressed. All medical homes shall ensure, at a minimum, the following: <ul style="list-style-type: none"> (a) health maintenance and preventative care; (b) anticipatory guidance and health education; (c) acute and chronic illness care; (d) coordination of medications, specialists, and therapies; (e) provider participation in hospital care; and (f) twenty-four hour telephone care. • The adult pilot uses the Joint Principles of the Patient-Centered Medical Home. 	<ul style="list-style-type: none"> • Children: 2007 legislation. • Adult pilot: Patient Centered Primary Care Collaborative (PCPCC). 	Certified providers and health plans.
Idaho	The Joint Principles of the Patient-Centered Medical Home.	Patient Centered Primary Care Collaborative (PCPCC).	Any practice that meets the definition.
Louisiana	The Joint Principles of the Patient-Centered Medical Home (modified).	Patient Centered Primary Care Collaborative (PCPCC).	Certified providers including nurse practitioners.

State	Definition	Source of Definition	Who in State Can Serve as a Medical Home
Minnesota	<p>Abstracted from 2008 Minnesota statutes:</p> <p>The standards developed by the commissioners must meet the following criteria:</p> <p>4.12 (1) emphasize, enhance, and encourage the use of primary care, and include the use of primary care physicians, advanced practice nurses, and physician assistants as personal clinicians;</p> <p>4.15 (2) focus on delivering high-quality, efficient, and effective health care services;</p> <p>4.16 (3) encourage patient-centered care, including active participation by the patient and family or a legal guardian, or a health care agent as defined in chapter 145C, as appropriate in decision making and care plan development, and providing care that is appropriate to the patient's race, ethnicity, and language;</p> <p>4.20 (4) provide patients with a consistent, ongoing contact with a personal clinician or team of clinical professionals to ensure continuous and appropriate care for the patient's condition;</p> <p>4.23 (5) ensure that health care homes develop and maintain appropriate comprehensive care plans for their patients with complex or chronic conditions, including an assessment of health risks and chronic conditions;</p> <p>4.26 (6) enable and encourage utilization of a range of qualified health care professionals, including dedicated care coordinators, in a manner that enables providers to practice to the fullest extent of their license;</p> <p>4.29 (7) focus initially on patients who have or are at risk of developing chronic health conditions;</p> <p>4.31 (8) incorporate measures of quality, resource use, cost of care, and patient experience;</p> <p>4.32 (9) ensure the use of health information technology and systematic follow-up, including the use of patient registries; and</p> <p>4.34 (10) encourage the use of scientifically based health care, patient decision-making aids that provide patients with information about treatment options and their associated benefits, risks, costs, and comparative outcomes, and other clinical decision support tools.</p>	2008 Minnesota Statute.	Classification as a medical home will be open to providers that meet all the service definitions of statewide criteria. This includes physicians, nurse practitioners, and physician's assistants as potential medical home site leaders. While it may be more challenging for a specialty provider to serve as a medical home, they are not precluded so long as they comprehensively serve the patient's acute, chronic, and preventative service needs.

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State	Definition	Source of Definition	Who in State Can Serve as a Medical Home
New Hampshire	<ul style="list-style-type: none"> The Center for Medical Home Improvement defines a medical home as a community-based primary care setting which provides and coordinates high quality, planned, family-centered health promotion, acute illness care, and chronic condition management. The Joint Principles of the Patient-Centered Medical Home. 	<ul style="list-style-type: none"> Center for Medical Home Improvement. Patient Centered Primary Care Collaborative (PCPCC). 	Any PCP providing medical services to the Medicaid disabled recipients can participate. PCP will be family practitioners, pediatricians or internists providing primary care
Oklahoma	The Joint Principles of the Patient-Centered Medical Home.	Patient Centered Primary Care Collaborative (PCPCC).	The SoonerCare Choice partially-capitated program will be transformed beginning January 2009 to a more enriched medical home model. Classification as a medical home will be open to individual physicians, physician assistants and advanced nurse practitioners as contractors, as well as groups of practitioners. Specialties include family medicine, pediatrics, and OB/GYN.
Oregon	A primary care medical home can generally be characterized as a primary care practice which provides the following to its patients: a continuous relationship with a physician; a multidisciplinary team that is collectively responsible for providing for a patient's longitudinal health needs and making appropriate referrals to other providers; coordination and integration with other providers, as well as public health and other community services, supported by health information technology; an expanded focus on quality and safety; and enhanced access through extended hours, open scheduling, and/or email or phone visits.	The Medical Home Model of Primary Care: Implications for the Healthy Oregon Act (http://www.oregon.gov/OHPPR/docs/The_Medical_Home_Model_Final.pdf).	There are several different, grant-funded efforts underway (and several more starting up), with the definition of the medical home varying across these pilots. One of the Oregon Health Fund Board's recommendations to the state is to develop a set of standards that all payers would use to incentivize a medical home, or as the Board discusses, an "integrated health home." This would allow for multiple models as "the home" – medical focused practices or clinics, behavioral health focused practices or clinics, with appropriate collaboration with other disciplines. Standards would be based on national and local efforts already underway, and reflect the state's similar set of common quality standards.

State	Definition	Source of Definition	Who in State Can Serve as a Medical Home
Washington	<p>An approach to providing health care services in a high-quality, comprehensive, and cost cost-effective manner. The Washington State Department of Health describes core elements of a medical home as:</p> <ul style="list-style-type: none"> • Compassionate and Culturally Effective • Coordinated and Comprehensive • Family-Centered • Accessible and Continuous • Programs must be evidence-based; facilitate the use of information technology to improve quality of care; acknowledge the role of primary care providers (and include financial and other supports to enable these providers to effectively carry out their role in chronic care management); and improve coordination of primary, acute, and long-term care for clients with multiple chronic conditions. 	Senate Bill 5930 Chapter 259 (2007).	Physicians, physician assistants, advanced registered nurse practitioners and mental health providers.

 RECOGNIZING PRACTICES AND MEASURING PERFORMANCE

State	Status of Criteria Development	Approach to Recognizing Practices	Practice and System Level Measures under Consideration
Colorado	<ul style="list-style-type: none"> SB07-211 mandated performance measures related to the medical home legislation, while SB07-130 Medical Home Legislation (CO Appendix I) Adopted Colorado Medical Home set standards for use. 	<ul style="list-style-type: none"> Annual certification of each provider conducted by state Medicaid agency. Certification process includes: <ul style="list-style-type: none"> an office visit with providers and their staff; a parent satisfaction survey; and a review of, and training on, medical home regulations. Adult pilot will use practice coaches to assist with recognition through NCQA Physician Practice Connections Patient-Centered Medical Home Recognition Program (PPC-PCMH). 	
Idaho	Reviewing materials.	Reviewing materials.	
Louisiana	Agreed to use NCQA PPC-PCMH plus additional state criteria.	<ul style="list-style-type: none"> Quality Forum offering technical assistance to providers. Local projects aimed at building capacity and facilitating implementation. 	<ul style="list-style-type: none"> NCQA PPC-PCMH; HEDIS; American Psychiatric Association (APA) guidelines. Hospitalization for ambulatory care sensitive conditions.
Minnesota	DHS and MDH are working with provider and patient communities to develop proposed criteria for certifying providers.	Criteria proposed include <ul style="list-style-type: none"> participating in a learning collaborative, using an internal registry for patient population management, keeping updated care plans, and including parent/ patient representatives on care teams. 	
New Hampshire	Agreed to use NCQA PPC-PCMH.	Center for Medical Home Improvement (CMHI) is developing a gap analysis package designed to assist primary care sites in preparing themselves to both meet these requirements and improve performance.	NCQA PPC-PCMH will be used to identify a medical home. Practice level structure and process measures consistent with Medicare's Physician Quality Reporting Initiative (PRQI) program will likely be selected.

State	Status of Criteria Development	Approach to Recognizing Practices	Practice and System Level Measures under Consideration
Oklahoma	Developed a tiered reimbursement system with requirements stratified to reflect the advancement of the practice as a medical home.	Providers will conduct a self-audit when recontracting to identify the applicable medical home tier for the practice.	Quarterly excellence calculations will be reported to contractors.
Oregon	In anticipation Oregon Health Fund Board recommendations to Legislature, a common set of measures and standards for both public and private sectors, are being developed especially to inform payment reform efforts.	Ongoing coordination with state and national quality measurement efforts (including NCQA). The state wants to avoid burdening providers with “certification,” but rather focus on outcomes.	<ul style="list-style-type: none"> • NCQA PPC-PCMH; HEDIS; American Psychiatric Association (APA) guidelines. • Hospitalization for ambulatory care sensitive conditions. • State’s own work around Common Measures via Aligning Forces grants.
Washington	<ul style="list-style-type: none"> • Under development. Performance measures will be developed following a decision regarding reimbursement mechanisms, which may include performance based reimbursement. • Considering using Puget Sound Health Alliance’s provider guidelines and quality of care measures. • As part of the 2009 Medical Home Collaborative, performance measures will be defined. • Structure, process, and outcome measures are defined in Comprehensive Healthcare Information System (CHIS). 	Undetermined; examination of NCQA PPC-PCMH standards underway.	<p>Combination of structure, process, and outcome measures to include:</p> <ul style="list-style-type: none"> • The number and rate of clinics that: <ul style="list-style-type: none"> • Implement and maintain 24/7 access. • Do any of the following with Electronic Medical Records (EMRs): <ul style="list-style-type: none"> • receive state grants for EMR purchase, • successfully implement EMRs, • implement a care coordination function within the EMR, or • implement registries for chronically ill individuals. • Rate of adherence to clinical practice guideline performance measures. • Parent assessment of medical home through annual clinic-based patient surveys. • Rate of emergency department (ED) utilization for non-emergent and emergent/ primary care-treatable care. • Rate of hospitalizations for ambulatory care sensitive conditions. • Parent perception of quality of care.

RESTRUCTURING REIMBURSEMENT

State	Status of Reimbursement Structure
Colorado	<ul style="list-style-type: none"> • Children’s medical home program will offer enhanced reimbursement for EPSDT/ well-child visits. • Has funding to provide enhanced reimbursement to Medicaid and CHP <i>Plus</i> providers meeting medical home standards, but exact structure is still in development. Under consideration are: <ul style="list-style-type: none"> • Using a “pay for performance” mechanism for enhanced reimbursement. • A per member per month (PMPM) payment structure for health plans and primary care case. • Supportive payment to health plans for CHP <i>Plus</i>.
Idaho	<ul style="list-style-type: none"> • Medicaid currently pays medical home providers for identifying their diabetic patients on a registry and enhanced payments for evidenced-based procedures. • Medicaid pays medical home providers an administrative fee of \$3.50 PMPM in addition to reimbursing on a fee-for-service basis for face-to-face services. • Subcommittee working with major payers and Medicaid to design structure.
Louisiana	Waiver application includes a shared savings model or network ownership with providers, risk adjusted premiums with required disease management, and incentives for both providers and beneficiaries.
Minnesota	Payment per enrollee will vary according to the severity of the enrollee’s condition. Medical home providers will receive a higher fee for evaluation and management visits than other providers when the visit includes specified tasks and is provided to their patients who have five or more chronic diagnoses. The enhanced fee ranges from \$73.64 to \$458.52 based on the number of chronic diagnoses and the type of primary care provider. Certified medical home providers may receive no more than one enhanced fee per qualified patient every six months
New Hampshire	<ul style="list-style-type: none"> • Overall medical home reimbursement structure under consideration will likely include a prospective monthly payment (PMPM) and pay-for-performance payments. New Hampshire is seeking funds to assist practices in their NCQA applications and for care management staffing. • The Medicaid Medical Information System, to begin in 2010, will be capable of creating a medical home designation, patient assignment, and prospective and incentive payments.
Oklahoma	<ul style="list-style-type: none"> • Will combine traditional fee-for-service office visits with: • A monthly care coordination payment for the provider’s work that falls outside of a face-to-face visit and for the health information technologies needed to achieve better outcomes. • A visit based fee-for-service component that maintains an incentive for providers to see patients in an office-visit when appropriate. • A performance-based component that recognizes achievement of quality and efficiency goals. • Considering transition payments to assist some primary care providers with the shift from partial capitation payments to traditional fee-for-service.

State	Status of Reimbursement Structure
Oregon	<ul style="list-style-type: none">• Overall medical home reimbursement structure under consideration, especially in Medicaid.• The Oregon Health Fund Board recommends that payment reform should be designed to incentivize desired outcomes: quality, efficiency, health outcomes, and care coordination.
Washington	<p>Multiple methods under consideration; may test several through pilots. Methods include:</p> <ul style="list-style-type: none">• pay for primary care through capitation or global fee,• pay for performance and other incentive-based mechanisms,• Diagnosis Related Groups (DRG) and case management fees,• Ambulatory Patient Groups (APG) and risk factor adjustments,• base payment and incentives for quality, and• capitation and risk factor adjustment.

 RELEVANT PRIVATE SECTOR ACTIVITY, INCLUDING MULTI-PAYER

State	Activity
Colorado	<ul style="list-style-type: none"> The Colorado Patient Centered Medical Home Multi-Payer Pilot is developing medical homes for adult populations. This initiative is under development in Denver and the Front Range. The Steering Committee includes local and national representatives of business groups and employers, health plans, and physician organizations. Committed health plan participants include Anthem-WellPoint, Aetna, CIGNA, Humana, Rocky Mountain Health Plan, United, and Medicaid. The guiding principles for the pilot are the Joint Principles for Patient Centered Medical Home, and more specifically the three-tier reimbursement model of fee-for-service, Enhanced Care Management Fee, and a pay-for-performance model. The NCQA PPC-PCMH tool will be used for measurement. The pilot evaluation will include analysis of cost; quality; and provider, provider office, and patient satisfaction. The Colorado Clinical Guidelines Collaborative is serving as the convening organization and providing technical assistance for practice transformation. Practice transformation is based on the national Improving Performance in Practice program. Through a HRSA grant, CDPHE is contacting other Colorado communities interested in implementation.
Idaho	<ul style="list-style-type: none"> Two major commercial health plans rolling out pilot medical home models have agreed to work collaboratively with the committee on a statewide model. Two Idaho community health centers, its two family medicine residency programs, and two critical access hospital clinics are partnering to develop the medical home model.
Louisiana	<ul style="list-style-type: none"> Thirty-eight safety net clinics have been recognized by NCQA as patient centered medical homes. The Quality Forum is developing a private insurance mechanism to implement the medical home; implementation is anticipated in Central Louisiana within the year.
Minnesota	<ul style="list-style-type: none"> Current legislation requires medical homes be offered as part of private health plan coverage in Minnesota beginning in 2010. There is unified health plan, provider, and patient support for this effort
New Hampshire	<ul style="list-style-type: none"> The private sector portion of the New Hampshire Multi-Payer Medical Home Project pilot will begin on January 1, 2009, and run for two years. It will focus on five to ten health care delivery systems in the state. The New Hampshire Medicaid program will harmonize with the New Hampshire Multi-Payer pilot with respect to attribution, medical home definition, and performance measures to the extent possible.
Oklahoma	
Oregon	<ul style="list-style-type: none"> The Oregon Health Care Quality Corporation has received a three-year Aligning Forces for Quality grant from the Robert Wood Johnson Foundation. This grant is allowing the Quality Corp to use statewide and Willamette Valley market forces to help the chronically ill receive high quality health care. The Oregon Better Health Initiative is reaching out to providers in Oregon and nationwide to change the culture of the delivery system, to embrace the medical home, and to work with policy makers to adopt policies that promote change. CareOregon and the Oregon Primary Care Association are working together in assisting CHCs with implementing the primary care home, developing criteria for what a primary care home is, and aligning financial incentives to support medical home criteria. The Oregon Business Association supports a pilot program of the robust medical home model of delivering healthcare.

State	Activity
Washington	<ul style="list-style-type: none"><li data-bbox="289 207 1913 237">• Endeavors by privately sponsored groups have identified potential options for reimbursement approaches that support and promote medical homes.<li data-bbox="289 250 1367 279">• The Puget Sound Health Alliance has worked on provider guidelines and quality of care measures.<li data-bbox="289 292 583 321">• Primary Care Coalition.<li data-bbox="289 334 1457 363">• Collaboration with the Washington Health Care Authority on reimbursement models and program change.

INFRASTRUCTURE PLANS TO PROVIDE INFORMATION TO PROVIDERS

State	Best Practices	Individual Provider/ Practice Performance	Individual Patient's Health History and Health Status
Colorado	Colorado Medical Home Initiative (MHI) task forces, especially the Provider Task Force and the Family Task Force.	<ul style="list-style-type: none"> • Provider Hotline supported by Family Voices Colorado, Colorado Children's Healthcare Access Program (CCHAP), and the Department of Health Care Policy and Financing (HCPF). • EPSDT Outreach and Case Management will support providers with information. • Colorado Health Care Program for Children with Special Needs (HCP) regional offices will also provide training and outreach on the Colorado Medical Home Standards. 	<ul style="list-style-type: none"> • MHI is reviewing the options of parent controlled electronic health records. • Colorado Immunization Registry. • Develop comprehensive website for providers at www.MedicalHomeColorado.org. • Specific training for parents.
Idaho	In discussion.		
Louisiana	Quality Forum.	<ul style="list-style-type: none"> • Quality Forum Quality Measurement Committee initiatives. • Louisiana Right to Know Act. 	<ul style="list-style-type: none"> • EHR demonstrations and stimulus funds. • DHH disease management initiative. • Primary Care Access and Stabilization Grant • Care Coordination Networks
Minnesota	Proposed learning collaborative.		
New Hampshire	Plans to develop a statewide HIE system are under discussion with the Citizens Health Initiative.	Providers will be asked for voluntary participation, with direct outreach to high volume providers.	<ul style="list-style-type: none"> • Pharmacy and fiscal agent claims level data will be directly available to providers from Medicaid program vendors, with a likely start date of 2011. • Provider access to pharmacy history is currently available through e-prescribing program.
Oklahoma			

State	Best Practices	Individual Provider/ Practice Performance	Individual Patient's Health History and Health Status
Oregon	Learning collaborative in place via CareOregon, one of Oregon's Medicaid managed care plans. The state is looking to expand this program.	Quality Corp's Common Measures is being implemented, and individual plans are providing feedback.	Public Employees Board has discussed how to best work with its commercial plans to improve this information flow, including developing its Public Health role via the Oregon Health Fund Board.
Washington	<p>One MCO (Community Health Plan) provides performance data (immunizations, well child care visits and ED utilization) to contracted RHCs and FQHCs.</p> <p>Washington Medicaid fee-for-service identifies clients over-using narcotics and provides data to all prescribing providers.</p>	<ul style="list-style-type: none"> • Combination of structure, process, and outcome measures as described in Comprehensive Healthcare Information System (CHIS). • <i>Rethinking Care Initiative</i> provides historical utilization data on chronically ill individuals used by contractors to ensure clients have a medical home and, if appropriate, care management services. 	<ul style="list-style-type: none"> • Whatcom County WHInet allows providers to go online to check results of patients' hospitalization and lab work; send legible scripts to the pharmacy; track diabetic patients; review medical references; and receive alerts regarding duplicate therapies, medication conflicts, and allergies. • A large provider network is building on electronic medical records by building a common, care management internet tool.

PLANS TO SUPPORT PATIENTS

State	Providing Patients with Information on Provider Performance	Providing Patients with Information to Manage own Care	Initiatives to Support Consumer Activation in Medical Homes
Colorado	<ul style="list-style-type: none"> Website created for consumers to review provider credentials and complaints. Strong efforts within network of family advocacy groups to support anecdotal reporting. Access to the Medical Home Initiative (MHI). 	<ul style="list-style-type: none"> Redesign of the EPSDT Outreach and Administrative Case to better support the Colorado Medical Home Standards is underway. HCP Regional offices offer clinic systems and support for families, including a website. Linkages with other state agencies and community based organizations such as Family Voices and Family Resource Center are in place. Messaging Task Force is currently developing orientation materials. 	Under consideration; no formal plan developed.
Idaho	In discussion		The Governor's Select Committee on Health Care is taking a global approach. A subcommittee of this group is discussing the details, bringing together other groups, and working on a pilot with the two major private payers and Medicaid.
Louisiana	Louisiana Right to Know Act	<ul style="list-style-type: none"> Louisiana Right to Know Act. Quality Forum Outreach. Education Committee's health literacy and patient empowerment initiatives. 	Consumer incentives will be incorporated into the development of the Care Coordination Networks. Additionally, the Quality Forum has a focus on consumer education and the empowerment of consumers to understand what they should expect from a medical home.
Minnesota			Requirement in place to measure patient engagement. General consensus reached in the state that patients should be involved in medical home team quality improvement.

State	Providing Patients with Information on Provider Performance	Providing Patients with Information to Manage own Care	Initiatives to Support Consumer Activation in Medical Homes
New Hampshire	Plans to develop a statewide HIE system are under discussion with the Citizens Health Initiative.	<ul style="list-style-type: none"> • Pharmacy and fiscal agent claims level data will be directly available to providers from Medicaid program vendors. Planned start in 2011. • Patient access to pharmacy history will be available with the next pharmacy benefits administrator program, beginning in January 2011. 	Support coordinators will play this role. The current disease management program manger will run the program internally. At the PCP level, practices will hire or otherwise dedicate a care manager to coordinate patient needs via a team approach.
Oklahoma			A pilot was approved in the legislature. More information will be available as this develops.
Oregon	Quality Corp's Aligning Forces and the state have been working on making provider performance data accessible to patients. Data on hospital performance is already publically available. The Oregon Health Fund Board will recommend increasing efforts, including HIT efforts.	Will develop and evaluate strategies to empower consumers to become more involved in their own health and health care by partnering and engaging with integrated health homes.	Public Employees' Benefit Board and one Medicaid managed care plan are both starting to look at this, but primarily more from an education perspective, not with incentives. There have been preliminary discussions on the use of incentives.
Washington	<ul style="list-style-type: none"> • The Puget Sound Health Alliance (PSHA) published, "<i>Community Checkup</i>," a report to the community on health care performance across the region. It was developed with the cooperation and participation of Puget Sound physicians, clinic leaders, and others, including patients and employers. The report establishes a baseline for understanding health care quality in the local area. • Consumer survey data is provided to MCO enrollees to aid in plan selection. 	<ul style="list-style-type: none"> • The Health Care Authority is working with patients to maintain their own medical record. • The PSHA offers health literacy information called "Health in Plain Terms" to help guide health care decision-making for patients as they work with their doctors to prevent and manage illness and better manage their own care. The initiative includes information for patients on how to access health information in local libraries. • The Patient Activation Measure is a survey tool used in the Rethinking Care Program to assess client readiness for changing behavior. 	In the Rethinking Care program, patient activation coaching and educational materials are provided to clients.

 PLANS TO SUPPORT CARE COORDINATION

State	Technology	Other
Colorado	<ul style="list-style-type: none"> • State building infrastructure to support the increased use of HIT through enhancements and changes to the Medicaid Management Information System (MMIS). • Developing the Colorado Regional Health Information Organization (CORHIO). • CHP <i>Plus</i> MCO system upgrades to support medical home. • Medical Home Website for both providers and patients to support the entire community. • Reviewing models of patient-controlled electronic health records. 	<ul style="list-style-type: none"> • Redesigning the EPSDT Outreach and Administrative Case Management program to become a “medical home navigators” model (implementation due July 1, 2009). • SB211 requires development of care coordination and case management measures. • Universal Care Plan developed for providers. Training is provided by MHLC. • Linking and aligning mental health care coordination within local communities. • CDPHE is finalizing a paper on overall care coordination. • Project Bloom is finalizing a paper on care coordination for the early childhood system.
Idaho	<p>Will pilot the Idaho Health Data Exchange (IHDE) beginning this fall. The IHDE provides the capacity to electronically move health care information between different healthcare information systems.</p>	<p>Medicaid will implement its new MMIS (Medicaid Management Information System) in January 2010, which will provide greater flexibility for tracking data on medical home performance.</p>
Louisiana	<ul style="list-style-type: none"> • Federal stimulus dollars will support HIT, promote EHR adoption, and health information exchange. DHH is initiating disease management programs. • The Quality Forum won a CMS EHR demonstration award to promote adoption of EHRs and quality reporting by primary care practices statewide. 	<ul style="list-style-type: none"> • Other care coordination include: • comprehensive disease management, • an integrated approach with the CCNs and primary care clinics (including Primary Care Access and Stabilization Grant), and • a Behavioral Pharmacy Management Program.

State	Technology	Other
Minnesota	Each PCC practice will create and maintain an electronic, searchable registry and a care plan for each PCC patient.	<ul style="list-style-type: none"> The state is working with the provider and patient communities to develop specific criteria and certify providers to provide comprehensive care coordination and care plan development. 2007 legislation gave DHS the authority to pay for provider directed care coordination. CMS has approved Medicaid payment for provider directed care coordination as a state plan service attached to a face to face visit for complex patients in the fee for service part of the program. Criteria calls for each practice to designate a care coordinator, who works in the practice, has protected time and space to do the work, and has the ability to communicate well with patients across medical and community disciplines.
New Hampshire	Will launch Medicaid Medical Information System in the summer of 2010. Both providers and patients will have access to claims history through new agent, potentially in 2011. New Hampshire providers have been early adopters of EHRs, with fully functional systems at both the DHC and all of New Hampshire's community health centers.	The State's Comprehensive Healthcare Information System (CHIS) will facilitate program evaluation and benchmarking to the private sector and other state Medicaid programs.
Oklahoma		
Oregon	<ul style="list-style-type: none"> The Governor has appointed a HIT Advisory Committee to develop recommendations for widespread HIT adoption and interconnectivity, building on previous efforts under federal HISPC activities, and a current Medicaid Transformation Grant to Oregon for a Health Record Bank. FCC money has recently been obtained to lay cable to rural portions of the state to assist with HIT adoption among rural providers. 	The Oregon Health Fund Board will be recommending increased funding to support HIT adoption and interconnectivity.
Washington	<p>Washington is promoting the use of:</p> <ul style="list-style-type: none"> the Chronic Disease Electronic Management System (CDEMS), a registry for patients and providers to help in care planning and patient management; and HIT in medical clinics by awarding grants to clinics participating in the Washington Department of Health Collaborative. 	<p>The 2008 Collaborative focused on improving systems of care for patients with chronic diseases and for children with special health care needs (via medical homes).</p> <p>Legislation mandates that the state improve coordination of primary, acute, and long-term care for clients with multiple chronic conditions. This is a central goal of the medical home expansion pilots.</p> <p>Care coordination is supported in the Comprehensive Healthcare Information System (CHIS).</p> <p>The <i>Rethinking Care</i> initiative has a care coordination focus.</p>

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