



**BUILDING MEDICAL HOMES:
LESSONS FROM EIGHT STATES WITH EMERGING PROGRAMS**

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December 2011

ABSTRACT: Many states are strategically engaging public and private payers in the design of medical home programs as a means of achieving better health outcomes, increasing patient satisfaction, and lowering per capita health care costs. The eight states profiled in this report—Alabama, Iowa, Kansas, Maryland, Montana, Nebraska, Texas, and Virginia—are at different stages in the development and implementation of a medical home program and have relied on different strategies to encourage primary care providers to adopt the model, including developing state medical home qualification standards instead of adopting national standards. As a whole, their experiences demonstrate that states can play a critical role in convening stakeholders, helping practices improve performance, and addressing antitrust concerns that arise when multiple payers come together to create a medical home program.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. To learn more about new publications when they become available, visit the Fund's Web site and [register to receive e-mail alerts](#). Commonwealth Fund pub. no. 1569.

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ACKNOWLEDGMENTS

The authors wish to thank the eight state teams that participated in the Second Consortium to Advance Medical Homes for Medicaid and CHIP Participants. Their diverse and impressive range of accomplishments reflects their commitment, talent, and dedication to building better health care systems. The authors also gratefully acknowledge their review of a draft of this report in November 2010. Core team members included:

- Alabama—Cathy Caldwell, Y. Paige Clark, R.N., Kim Davis-Allen, Marsha Raulerson, M.D., and Robert Moon, M.D.
- Iowa—David Carlyle, M.D., Bery Engebretsen, M.D., Thomas Evans, M.D., Beth Jones, and Jennifer Vermeer
- Kansas—Susan Kang, Barbara Langner, M.D., Elizabeth Peterson, M.D., and Margaret Smith, M.D.
- Maryland—John Folkemer, Virginia Keane, M.D., Karen Rezabek, Tricia Roddy, Ben Steffen, and Grace Zaczek
- Montana—Mary Dalton, Rachel Donahoe, Michael Huntly, R.N., Mary LeMieux, Mary Noel, Wendy Sturn, and Nancy Wikle
- Nebraska—Joan Anderson, Nebraska State Senator Mike Gloor, Jenifer Roberts-Johnson, Pat Taft, and Robert Wergin, M.D.
- Texas—Michelle Erwin, Anita Freeman, Jose Gonzalez, M.D., Lesa Walker, M.D., and Leslie Weems
- Virginia—Colleen Kraft, M.D., Tom Lawson, Meredith Lee, Daniel Plain, David Selig, and Bryan Tomlinson

The authors also thank the officials from leading states who served as mentors, as well as the experts who gave generously of their time to consult with the second consortium states. Their efforts had significant impact, and helped make the progress of the second consortium states possible. The authors thank Charles Townley, research assistant at NASHP, for helping to edit and research this paper.

Finally, the authors thank Melinda Abrams and The Commonwealth Fund for making this work possible. Ms. Abrams' guidance proved invaluable throughout the project, and her assistance is gratefully acknowledged.

Editorial support was provided by Sarah Klein.

EXECUTIVE SUMMARY

There have been numerous efforts by payers and providers to improve patient access to high-functioning medical homes—an enhanced model of primary care that offers whole-person, comprehensive, ongoing, and coordinated patient- and family-centered care. Public payers, especially Medicaid, have been leaders in these efforts, with the hopes of preventing illness, reducing wasteful fragmentation, and averting the need for costly emergency department visits, hospitalizations, and institutionalizations. With the support of The Commonwealth Fund, the National Academy for State Health Policy (NASHP) has fostered these efforts through the Consortia to Advance Medical Homes for Medicaid and CHIP Participants. In 2007–09, NASHP provided its first round of assistance to eight states—Colorado, Idaho, Louisiana, Minnesota, New Hampshire, Oklahoma, Oregon, and Washington—that were seeking to build medical homes in their Medicaid and CHIP programs. This assistance consisted of an in-person kick-off meeting, a series of regular group technical assistance webinars, and ongoing individualized consultation with experts.

Drawing on the combined experiences of these states and a small group of states that already had programs, NASHP developed a framework that other states could follow to implement medical home programs. The framework consists of five broad steps:

1. Strategically engage partners.
2. Set performance expectations and implement a process to identify practices that meet expectations.
3. Compensate and motivate practices through enhanced payment.
4. Help practices meet expectations and improve performance.
5. Evaluate program performance.

In 2009–10, NASHP supported the efforts of a second group of states—Alabama, Iowa, Kansas, Maryland, Montana, Nebraska, Texas, and Virginia—as they sought to develop new medical home programs. The work of these states reinforced the importance of following the five key steps. From this work a number of common themes emerged, which are of relevance to states that are considering or are already promoting medical homes.

- **Tailoring the definition of “medical home” to reflect state needs, priorities, and circumstances.** As they craft their definitions, state policymakers are frequently looking to national definitions and other states’ existing definitions to conceptualize their priorities. For example, Montana’s definition emphasizes the importance of culturally effective, community-based care.
- **Using payment policy to foster collaboration among primary care and specialty care physicians, as well as other service providers.** As an example, Iowa is paying primary care providers for remote consultations with hospital-based specialists, while Alabama is paying more to practices that collaborate with their local community networks. The Alabama networks will help practices function as medical homes. Among other responsibilities, network staff will help primary care providers coordinate care for high-need and high-risk patients and teach self-management skills.
- **Using payment policy to reward more capable and better-performing medical homes.** State medical home programs are rewarding practices that meet more demanding standards—such as effectively using a registry—with higher medical home payments. They are also distributing savings based on practice performance, with greater shares going to those that perform better on preselected performance measures.
- **Helping practices improve performance.** In addition to offering enhanced payment, states are supporting practices by providing electronic health record systems, registries, and data as well as support in implementing these new tools. They are also offering learning collaboratives to bring teams from practices together to work toward common improvement goals and deploying coaches to help practices become high-performing medical homes.
- **Providing support for care coordination.** States use various strategies to help primary care providers improve care coordination. Some states are explicitly directing participating practices to use a portion of their medical home payments to hire staff who coordinate care. Other states are developing community resources that link practices and patients to other services in the community and augment the primary care providers’ care coordination activities.
- **Easing the evaluation burden for medical home providers.** Although there is evidence that medical homes improve quality and contain costs in Medicaid, each state needs to assess whether the medical home—as implemented in their state—succeeds. States are looking to assess improvements within primary care practices by monitoring changes in acute care utilization, cost containment, and patient and

provider experience. When possible, medical home programs are relying heavily on data collected as a function of providing and paying for services (e.g., claims data) in their evaluation designs. This minimizes the extra reporting work that practices must do. Initiatives are also drawing measures from national data sets and incorporating information that practices must already report to other programs.

- **Basing medical home qualification criteria on models established by a national organization.** State medical home programs need ways to translate their medical home principles into concrete, measureable expectations. To that end, many states are convinced that there is value in leveraging national medical home qualification processes, such as those administered by the National Committee for Quality Assurance (NCQA) or the Joint Commission. Some states are adopting national qualification standards outright, while others are modifying them. Using national standards leverages investments made by widely known, respected, neutral organizations and eliminates the need to devote limited resources to developing and administering a new recognition process.
- **Balancing the desire for improved performance with the cost of the improvements.** The start-up and ongoing costs associated with transforming a standard primary care practice into a high-performing medical home can be significant for both practices and payers. Accordingly, some program leaders focus their resources on a limited number of practices at the start of a program and/or allow practices to receive medical home payments for a limited period before they achieve formal medical home recognition.
- **Addressing antitrust concerns that arise when multiple payers come together to create a medical home program.** States that are seeking to build multipayer programs have critical roles to play in providing antitrust protection for interested private payers, and they have multiple options for providing this protection. In many cases, neutral state agencies are supervising sensitive meetings. Additionally, states are enacting legislation that explicitly provides antitrust protection.

The state profiles contained in this report demonstrate that states can move forward with plans to improve primary care systems, even in the face of unprecedented budget constraints. The design of their projects has been greatly informed by the work of states that have already implemented medical homes. At the same time, states are innovating and learning lessons that can serve to advance the broader field.

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INTRODUCTION

There have been numerous efforts by payers and providers to improve patient access to high-functioning medical homes—an enhanced model of primary care that offers whole-person, comprehensive, ongoing, and coordinated patient and family-centered care. There are now pilots or programs in the private and public sectors, as well as a growing number of multipayer initiatives that include both public and private payers. For instance, the Medicare program is also joining eight states to participate in their multipayer, public–private medical home projects.¹ States have led many of these efforts and made major contributions to others. More than three-quarters of all states have now made efforts to advance medical homes for Medicaid or Children’s Health Insurance Program (CHIP) enrollees (Exhibit 1). Some of these states have well-established, mature programs that serve hundreds of thousands of patients, while others are just getting started.

This interest in the medical home model has much to do with promising data that link medical homes to improvements in access to care, quality outcomes, patient and family experience, and provider satisfaction. In addition to these benefits, payers, purchasers, and policymakers are intrigued by the model’s potential to produce significant savings.³

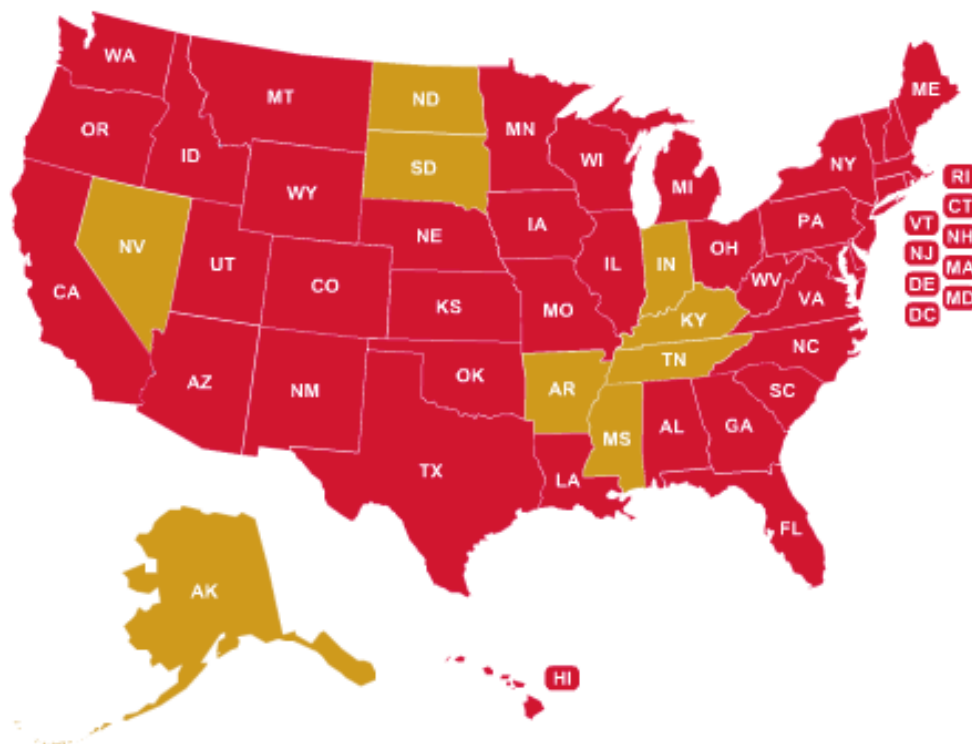
Since 2007, the National Academy for State Health Policy (NASHP), with support from The Commonwealth Fund, has fostered and studied state efforts to advance medical homes. Through the Consortia to Advance Medical Homes for Medicaid and CHIP Participants, NASHP has identified 41 states that have engaged in some effort to

What Is a Medical Home?

According to the four major primary care physician associations, care in the medical home is guided by the following principles:²

- Continuity—each patient has an ongoing, personal relationship with a physician
- Team-based care—collectively, a physician-directed team assumes responsibility for patient care
- Whole person orientation—the care team ensures that all patient needs are met, whether or not each specific service is offered by the practice
- Coordination—the medical home team organizes a patient’s care across the “medical home neighborhood,” and leverages nonmedical supports and services when appropriate
- Quality and safety—the medical home practice engages in continuous quality improvement, draws on evidence-based guidelines, reports on performance, promotes patient engagement, and uses health information technology as appropriate
- Enhanced access—first-contact and ongoing care is accessible to patients

Exhibit 1. The states shown in red have dedicated resources to advancing medical homes for Medicaid and/or CHIP enrollees between January 2006 and September 2011.



advance medical homes since 2006.⁴ In 2007–09, the organization worked with a small group of states—Colorado, Idaho, Louisiana, Minnesota, New Hampshire, Oklahoma, Oregon, and Washington—to identify the strategies they used or planned to use to improve the access of Medicaid and CHIP participants to high-performing medical homes.^{5,6} NASHP identified five key steps for advancing medical homes, which together form a framework that states can use to develop and implement medical home programs:

1. Strategically engage partners.
2. Set performance expectations and implement a process to identify practices that meet expectations.
3. Compensate and motivate practices through enhanced payment.
4. Help practices meet expectations and improve performance.
5. Evaluate program performance.

From 2009 to 2010, NASHP worked intensively with teams from a second set of states—Alabama, Iowa, Kansas, Maryland, Montana, Nebraska, Texas, and Virginia—to use this framework to accelerate and guide the development and implementation of their

medical home programs. These eight states that make up the second consortium were selected through a competitive process that focused on their readiness for making improvements and commitment to doing so. The states received a program of technical assistance designed by NASHP that was based on the previously described framework—and delivered by NASHP staff, the teams’ peers in other states (including those pioneers whose early efforts led to the creation of the framework), and other experts. This assistance consisted of an in-person kick-off meeting, a series of regular group webinars with national experts and federal officials, and ongoing individualized consultation with state and national experts.

This second consortium of states adopted some of the policy options implemented by the pioneer states, and each also developed new options for implementing the five key strategies for advancing medical homes. This report focuses on the lessons they learned. For background, the [Appendix](#) presents basic information on each project. Additional information on each state’s project is available online at <http://www.nashp.org/med-home-map>.

In many instances, the second consortium states are following trails blazed by Colorado, Maine, Minnesota, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, and Vermont. Many of these states have developed medical home models that are showing early signs of success in three critical dimensions: quality, access and utilization, and cost.

In terms of quality, several mature state medical home projects are reporting improvements in rates of adherence to evidence-based guidelines.

- A 2009 study found that practices participating in the Vermont Blueprint for Health improved their performance on process measures such as lung-function assessment for patients with asthma and self-management goal-setting for patients with diabetes. Control practices did not show similar improvements.⁷
- A 2011 report showed that North Carolina’s medical home program, Community Care of North Carolina, ranks in the top 10 percent in performance on national quality measures for diabetes, asthma, and heart disease compared with Medicaid managed care organizations.⁸
- Oklahoma’s SoonerCare Choice medical home program has seen improvements in Healthcare Effectiveness Data and Information Set (HEDIS) quality measures—including increases in rates of HbA1c screenings for diabetics,

breast cancer screenings, and cervical cancer screenings—since implementing a medical home program in January 2009. Performance in 2009 and 2010 was better than performance in 2008.⁹

- Practices participating in Rhode Island’s Chronic Care Sustainability Initiative (CSI-RI) improved performance on process measures such as depression screenings and appropriate use of beta blockers between 2008 and 2009.¹⁰

Many states are hoping their medical home projects will improve access to and increase appropriate use of primary care. So far:

- Oklahoma saw complaints to the agency about access to same-day or next-day care decrease from 1,670 in 2007 (the year prior to medical home implementation) to 13 in 2009 (the year following implementation).¹¹
- A 2009 study found that 72 percent of children in Colorado’s medical home practices had had well-child visits, compared with 27 percent of children in control practices.¹²

States are also seeing decreases in acute care utilization, especially avoidable hospitalizations and emergency department visits.

- In the Vermont Blueprint for Health’s two longest-running pilot communities, Medicaid saw 21.3-percent and 19.3-percent decreases in the rate of change of emergency department visits between pilot launch in 2008 and June 2010. These decreases were greater than the decreases observed statewide.¹³
- Inpatient hospital admissions for aged, blind, and disabled (ABD) Medicaid beneficiaries participating in Community Care of North Carolina decreased 2 percent between 2007 and the middle of fiscal year 2010. Inpatient hospital admissions for the unenrolled ABD Medicaid population increased 31 percent over the same time period.¹⁴

Some state medical home initiatives are now reporting cost savings, largely because of averted acute care utilization.

- Vermont’s Blueprint for Health has seen cost savings in the longest-running pilot community, St. Johnsbury. There, overall per-person per-month costs for commercially insured individuals decreased by approximately 12 percent from 2008 to 2009. The second Blueprint for Health community, Burlington, has

shown an increase in costs of less than 1 percent over the same period.¹⁵ Information on cost savings is not yet available for the other pilot communities.

- According to an analysis prepared by Treo Solutions, Community Care of North Carolina saved nearly \$1.5 billion in costs between 2007 and 2009.¹⁶
- An evaluation of the Colorado Medical Home Initiative found a 21.5 percent reduction in median annual costs for children with a medical home (\$785, compared with \$1,000 for non-PCMH children) in 2009.¹⁷
- Oklahoma saw a decline in per capita expenses of \$29 per patient per year from 2008 to 2010.¹⁸

As detailed in the following sections of this report, the second consortium states used models that have adapted many features of the leading states' models and others to suit their specific needs, circumstances, and preferences. There is a great deal for policymakers in other states to learn by studying these unique, emerging projects.

METHODS OF STRATEGICALLY ENGAGING PARTNERS

Implementing a medical home program changes how primary care and other providers deliver services, how patients obtain services, and how Medicaid (and sometimes other payers) reimburse for services. Early adopters of the medical home model, such as Colorado and Oklahoma, have found that engaging stakeholders in program design enabled the agencies to make choices that achieve agency goals and enjoy stakeholder support. In addition, other partners can bring important resources to the table. Leading states such as Vermont and Minnesota have found that universities bring valuable expertise to their initiatives, particularly around evaluation. Leading states have also found that their local physician chapters can serve as a valuable resource. For instance, Oklahoma's chapter of the American Academy of Family Physicians provided an important communication link between Medicaid and physicians when Oklahoma launched its medical home initiative.

Leading State Profile: Colorado

As mandated by 2007 legislation,¹⁹ the Colorado Medical Home Initiative has established a statewide medical home program for children enrolled in Medicaid and the Children's Health Insurance Program (CHIP). The Colorado Department of Public Health and Environment leads the project, drawing on input from task forces and providers. The program pays qualified medical homes an enhanced fee-for-service visit rate for select well-child services. Providers receive on-site assistance in undergoing a state-developed qualification process that includes requirements to undergo quality improvement projects. There is no requirement that providers use electronic health records. The state conducts annual audits of providers to ensure compliance.²⁰

All eight second consortium states learned from their predecessors' experiences and formed new stakeholder groups (or enhanced existing ones) to help plan their new initiatives. All of these groups included physicians. Most also included other providers, patients or advocates, commercial insurers, and other state agencies, such as public health agencies. These stakeholder groups engaged in two distinct activities:

1. *Designing the program:* In Montana, for example, a diverse stakeholder group composed of Medicaid, commercial insurers, provider organizations, the state-employee benefits group, and others developed the state medical home definition and reached consensus on the process for recognizing which practices meet that definition.
2. *Building public support:* Alabama's stakeholder group was instrumental in building broad support for developing community networks to support primary care practices. The Alabama Medicaid program partnered with its physician-based advisory group to organize town hall meetings with local providers to gather their input and to build momentum for buy-in.

Stakeholder meetings are important for gathering input to guide program development, but states also used other strategies to seek input from wider audiences. For example, Maryland held a series of provider symposia²¹ and most the states in this group established public Web sites.²²

Engaging Multiple Payers

A NASHP review of all states' Medicaid medical home efforts in 2009 revealed that at least 12 states were actively planning or pursuing multipayer projects.²³ In eight of these states, Medicare has also joined these efforts.²⁴ Multipayer projects are advantageous because they reduce the administrative burden on primary care practices by creating consistent goals, expectations, and payment policies. Multipayer projects also spread transformation costs among all payers seeking to improve both quality and costs.

Maryland and Montana are participating or plan to participate in multipayer projects. Like most of the leading multipayer states, they sought to avoid antitrust concerns, which can occur when payers gather to discuss common payment terms. A state's ability to address antitrust issues is a unique and important contribution to multipayer initiatives. These states' actions illustrate two options to address antitrust concerns.

Leading State Profile: New York

New York's Adirondack region encompasses a land area the size of Connecticut, but contains a fraction of Connecticut's population. The area faced an impending primary care workforce shortage, and payers and other stakeholders also wanted to improve quality and slow cost growth. Medical homes were seen as a solution. Legislation created the Multipayer Demonstration, and provided antitrust protection for commercial payers to work together on a common payment methodology. Medicaid and the commercial payers began making payments in 2010; CHIP plans and Medicare fee-for-service joined in 2011. Practices are expected to meet modified NCQA standards, and each practice has developed a customized work plan for transformation. Practices are receiving health information technology implementation assistance, practice coaching, and care coordination services from shared health teams known as "pods" to assist them in functioning as medical homes.²⁶ New York is also pursuing a Medicaid-only medical home program outside of the Adirondack region.²⁷

State serves as a neutral convener: Similar to the role of the Rhode Island Health Insurance Commissioner, the Montana Commissioner of Securities and Insurance is planning and convening a multipayer effort in Montana. Montana's commissioner took over the leadership role from Medicaid for its multipayer medical home effort in September 2010. This strategic decision to develop the program through a state-led process can help provide assurances that antitrust concerns are being addressed, enabling the payers and providers to work together to reach common goals.

State legislation: Maryland's governor tasked the Maryland Health Care Commission (a state agency that does not, itself, pay for services) to work with the Medicaid agency to develop and implement the medical home program. These agencies worked to engage commercial insurers, Medicaid managed care plans, and other stakeholders in their efforts. Both the Medicaid plans and commercial insurers raised concerns that a joint payment model for medical homes would violate federal antitrust law. Like legislative efforts in Minnesota, New York, and Vermont, the 2010 Maryland legislature passed SB855/HB929 to provide the antitrust protection that Maryland payers needed to participate in this pilot.²⁸ (The legislation also required all payers with premium revenues of over \$90 million to participate.²⁹)

Leading State Profile: Rhode Island

Rhode Island's Chronic Care Sustainability Initiative, first launched in October 2008, is unique among established programs in that the Office of the Health Insurance Commissioner has taken the lead in convening the pilot. Participating payers now include Medicaid managed care plans, all state regulated commercial insurers, several large employers, and Medicare Advantage plans. Medicare fee-for-service is joining as well. Practices are expected to meet NCQA standards and participate in a learning collaborative. In exchange, practices receive a flat per-member per-month fee (in addition to standard payments) as well as the support of on-site nurse care managers.²⁵

SETTING PERFORMANCE EXPECTATIONS AND IMPLEMENTING A PROCESS TO IDENTIFY PRACTICES THAT MEET EXPECTATIONS

A majority of the leading states and the second consortium states began their medical home journey by reaching agreement on a definition of a medical home to clearly establish the vision of what one is and what it should do. Qualification processes establish concrete performance expectations to let practices know what they need to do to meet that vision. Together, definition and qualification standards should:

- Establish common principles and terms to build a medical home initiative;
- Establish concrete expectations for practices, providers, and patients;
- Reassure payers that practices that receive enhanced payments are providing high-quality primary care; and
- Reassure practices that investments they make to improve the way they deliver care will be rewarded.

Defining the Medical Home

Among the second consortium states, all but Virginia have developed their own state-specific definition rather than adopt a national one. All align with the national definitions, including those developed by the American Academy of Pediatrics and the organizations that created the Joint Principles of the Patient Centered Medical Home.^{30,31,32} Most wanted a definition firmly rooted in local values and standards of practice. Two examples of state-specific definitions follow.

- *Kansas*: “Medical home” means a health care delivery model in which a patient establishes an ongoing relationship with a physician or other personal care provider in a physician-directed team, to provide comprehensive, accessible and continuous evidence-based primary and preventive care, and to coordinate the patient’s health care needs across the health care system in order to improve quality and health outcomes in a cost-effective manner.³³
- *Montana*: A patient-centered medical home is health care directed by primary care providers offering family-centered, culturally effective care that is coordinated, comprehensive, continuous, and, when possible, in the patient’s community and integrated across systems. Health care is characterized by enhanced access, an emphasis on prevention, and improved health outcomes and satisfaction. Primary care providers receive payment that recognizes the value of medical home services.³⁴

The Qualification Process

Seven out of eight second consortium states and all of the leading states have adopted or plan to adopt medical home qualification standards to support their initiatives. The qualification processes selected by these states fall into one of three categories.

Use of a process established by a national organization: There are currently several national organizations that have developed medical home qualification criteria. These organizations include the National Committee for Quality Assurance (NCQA),³⁶ The Joint Commission,³⁷ the Accreditation Association for Ambulatory Health Care (AAAHC),³⁸ and URAC (formerly the Utilization Review Accreditation Commission).³⁹

Like many of the leading states, including Rhode Island and Vermont, Iowa has decided to use recognition standards developed by NCQA. (The Joint Commission's process was not completed at the time Iowa established this policy, but providers in Iowa can now choose to use that standard.) Virginia is also considering this approach. Among other reasons, both states found using national processes attractive because they leverage investments made by widely known, respected, neutral organizations and eliminate the need to devote limited resources to developing and administering their own recognition process.

Modification of a process established by a national organization: Two second consortium states (Maryland and Montana) have adopted or plan to adopt the NCQA medical home standards with modifications, an approach pioneered by the leading states of Maine, New York (Adirondack region), and Pennsylvania. All of these states are involving commercial payers, and they recognize that their commercial partners are

Leading State Profile: Maine

Maine's multipayer Patient-Centered Medical Home Pilot includes the participation of the state's major commercial payers and Medicaid. Medicare fee-for-service will begin making payments in 2012. The project conveners conducted consumer focus groups and maintained a diverse working group to ensure the program was responsive to stakeholder priorities. Practice transformation support, which now includes a learning collaborative and coaching, started in 2009. Per-member per-month payments began shortly thereafter. As a condition of participation, practices are expected to achieve NCQA recognition and meet 10 additional core expectations, which include reducing waste and partnering with local public health organizations.⁴⁰

Leading State Profile: Vermont

Under Vermont's multipayer Blueprint for Health, all state-regulated payers and Medicare offer enhanced reimbursement to practices that meet NCQA standards. Recognized practices in pilot communities receive per-member per-month payments in addition to standard fee-for-service reimbursement. In addition, all payers share in the costs for local community health teams that support patients and practices through services such as health and wellness coaching and care management. Policymakers have found the early results sufficiently compelling to mandate statewide expansion by October 2013.³⁵

generally familiar with NCQA and receptive to using the program. But these states value customization. Maryland, for example, is requiring practices to meet some NCQA elements that are optional under NCQA, such as having dedicated staff who work with patients on treatment goals, assess patients’ barriers to meeting their goals, and follow-up with patients after visits; providing 24-hour phone response for urgent needs; performing medication reconciliation at every visit; and maintaining a patient registry that identifies care opportunities and diagnoses. The elements were selected based on their potential for reducing acute care utilization—an outcome of great interest to payers.

Creation of a process administered by the state: Kansas, Nebraska, and Texas took their cues from states such as Colorado and Minnesota in developing their own state medical home qualification standards. Their decision frequently arose out of concerns that national standards are too demanding and costly and thus discourage practice participation. There may also be concern that national tools may not be rigorous enough or may not sufficiently emphasize important elements such as patient-centeredness.

Balancing the Desire for Improved Performance Against the Cost of Improvements

Meeting qualification criteria, regardless of the process, almost certainly requires an investment by practices. Paying practices for meeting those criteria requires an investment by the state and any other partnering payers. States, providers, and other payers (if applicable) need to balance the desire for improved performance against the cost of these investments. States and partnering payers also have limited resources to invest and need to know that their investments are paying off. To address these challenges, second consortium states pursued one or both of the following options.

Limiting the number of practices that participate at the start of a program:

Because of limited resources, several states launched modest pilots with a small number of practices. Many of the leading states, including Minnesota, North Carolina, Pennsylvania, and Vermont, have similarly started small and expanded the projects over time. The approaches of the second consortium states vary. In Alabama, for example, the state has limited participation to

Leading State Profile: Minnesota

Minnesota’s multipayer Health Care Home Program requires all state regulated payers to pay for health care homes in a “consistent” manner. The state statute specified a definition for health care home, and the state engaged a broad group of stakeholders to develop Minnesota-specific practice certification standards. The resulting standards require ongoing participation in learning collaboratives. Certified practices receive enhanced payments for each patient with one or more chronic conditions. Payment amounts vary by the patient’s number of chronic conditions and an additional payment is provided if the patient or caregiver has a language barrier or a mental illness. The state audits the practices and provides transformation support through learning collaboratives. Medicare joined the program in 2011.⁴¹

three regions. A more common approach is limiting the pilot to a predetermined number of sites, such as in Nebraska (two sites), Texas (proposed pilot had eight sites), or Maryland (50 sites). The small pilots tend to attract or specifically seek out practices that have demonstrated a commitment to testing the medical home model, and in some cases, already dedicated resources to improving office systems or processes of care. In most instances, the states plan to expand these modest programs after the pilots have demonstrated the ability of the model to improve outcomes and control costs. Small pilots

Leading State Profile: North Carolina

In the Community Care of North Carolina program, primary care providers and 14 locally operated networks receive per-member per-month payments to offer medical home support services to patients and providers. These services include care management, pharmacy support, and hospital discharge planning. Practices and network staff receive key data such as real-time hospital and emergency department censuses, pharmacy claims, medical claims, and lab results. Providers can also view condition-specific patient registries, and they receive regular feedback on their performance. As a condition of participating in the program, practices must meet state-developed standards. (In regions where Medicare is participating, practices must meet NCQA standards.) First launched in 1998, the program now serves Medicaid patients statewide. In addition, other payers (Medicare, Blue Cross Blue Shield of North Carolina, the state employees plan, and certain self-insured groups) are participating in select regions.⁴²

also provide opportunities for the payers and stakeholders to identify and cultivate local champions; test recognition, payment, and practice support systems; and refine reimbursement and practice support strategies to make the best use of resources.

Allowing a grace period for sites to meet medical home qualification criteria: In recognition of the upfront cost to the practices of transforming how they deliver care, some states are not requiring that participating practices meet medical home

criteria before receiving enhanced payment. Rather, payments are conditioned upon providers meeting the criteria within a specific amount of time. This approach was adopted by leading states such as Pennsylvania and Rhode Island, but it is important to note that states using this approach—including Iowa, Nebraska, and Texas—carefully selected practices to ensure that they were committed. States also devoted resources to work extensively with selected practices to make necessary improvements.

Iowa, for example, plans to give participating FQHCs in the pilot one year to achieve NCQA recognition, while Nebraska allowed six months to achieve criteria through the state process, which is administered by TransforMED. (TransforMED, a subsidiary of the American Academy of Family Physicians (AAFP), provides consultation to support primary care practice transformation.)⁴³ The proposed Texas pilot planned to dedicate all of its resources to practice transformation—requiring each practice to complete the transformation within two years, but making no commitment to ongoing payments.

COMPENSATING AND MOTIVATING PRACTICES THROUGH ENHANCED PAYMENT

Medicaid agencies can use a number of different reimbursement strategies to encourage, support, and reward primary care providers for functioning as high-performing medical homes. Most states use a combination of strategies.

As of September 2011, five of the second consortium states had selected a payment model. Four (Alabama, Iowa, Maryland, and Nebraska) base their model in a per-member per-month payment to the practice to compensate for the ongoing costs of functioning as a medical home. This approach has been used by nearly all of the leading states.

Like many of the leading states (North Carolina, Oklahoma, Minnesota, Vermont, and Pennsylvania), Alabama, Iowa, Maryland, and Nebraska vary their payments by at least one factor that they believe to either differentiate among the capabilities of all recognized medical homes or reflect the intensity of resources that will be needed in varying circumstances.

For example, Maryland has established a maximum per-member per-month fee that varies based on payer type (i.e., commercial plans, Medicaid plans, or Medicare Advantage plans). Within each type, practices receive different per-member per-month payments that vary based on “medical homeness,” allowing higher payments for higher NCQA recognition levels. Rates also vary on practice size, with smaller practices receiving higher payments. The state’s rationale for paying higher per-member per-month fees to smaller practices is twofold. First, they will generally have proportionately higher fixed transformation costs than larger practices. Second, smaller practices are more likely than larger practices to experience greater fluctuations in shared savings payments because of chance. Including small practices in the Maryland pilot was important to the state, and planners felt that higher per-member per-month payments would make the program more attractive.

Leading State Profile: Pennsylvania

An executive order from the state’s governor created the Pennsylvania Chronic Care Commission in 2007. The Chronic Care Commission developed a plan that combines the chronic care model and medical home and includes multipayer support. The state’s Southeast rollout of the Chronic Care Initiative was launched in May 2008. Six additional regions were added subsequently. Later rollouts benefited from lessons learned in the earlier rollouts: the state refined its approaches to practice payment and practice recognition on the basis of previous experience. One refinement, for instance, included allowing additional time (18 months, rather than 12) for practices to obtain modified NCQA recognition. The program supports practices through learning collaboratives and practice coaching. In select regions, practices are eligible for performance-based payment. Medicare plans to join the program in 2012.⁴⁴

Using Payment to Reward More Capable and Better-Performing Medical Homes

Several leading states including Oklahoma⁴⁵ and select regions of Pennsylvania use performance-based payment. Alabama, Maryland, and Nebraska also have implemented payment strategies that reward medical home practices that meet more demanding recognition criteria or achieve better performance.

Alabama and Maryland will share the savings produced by the program with participating medical home practices.

Alabama plans to share a greater portion of the savings with practices that meet or exceed performance outcomes and that serve more Medicaid beneficiaries.

Maryland plans to provide a greater share of savings to practices that produce more savings, report on a greater number of quality measures, and achieve more utilization performance goals.

Nebraska Medicaid pays an initial per-member per-month payment to medical homes that participate in their medical home pilot. When a practice achieves recognition as a “Tier 1” medical home, its per-member per-month payment is increased. Any practice that chooses to meet the higher standard of “Tier 2” continues to receive the per-member per-month payment and is also paid 105 percent of the standard fee-for-service rates that Medicaid pays to other practices for certain preventive and evaluation and management services.

Leading State Profile: Oklahoma

Oklahoma implemented a Medicaid-wide medical home program called SoonerCare Choice in 2009. Operating under an expectation of budget neutrality, the state shifted its primary care case management program from a partially capitated approach to a combination of fee-for-service payments, per-member per-month payments that are adjusted for population, and pay-for-performance payments. To receive enhanced payment, all participating practices must meet state-developed medical home recognition standards. The recognition system is tiered, and practices that achieve higher levels of recognition are rewarded with higher per-member per-month payments. Oklahoma Medicaid audits the practices and provides practice coaching if requested.⁴⁶

Using Payment to Foster Links Between Primary Care and Other Service Providers

Alabama and Iowa have adjusted per-member per-month payment strategies to foster collaboration among different service providers. Alabama plans to make per-member per-month payments to regional care networks that will support primary care providers who agree to serve in the Medicaid agency’s medical home pilot. Their project is modeled on the Community Care of North Carolina program. As in North Carolina, primary care providers located in one of Alabama’s network catchment areas and participating in the pilot will receive a special per-member per-month payment. In Alabama, this per-member per-month payment will reach up to \$3.10—an increase from the standard

maximum of \$2.60 per-member per-month. Networks will receive \$5 per-member per-month for each aged, blind, and disabled (ABD) enrollee and \$3 per-member per-month for other enrollees.⁴⁷ The networks are intended to link providers, care coordinators, and resources at the local level.

To improve care for complex patients, Iowa is paying primary care providers for remote consultations with hospital-based specialists. This is also an important strategy for coordinating the care of hospitalized patients in remote areas of the state where face-to-face consultations between hospitals and medical home practices are impractical.

HELPING PRACTICES MEET EXPECTATIONS AND IMPROVE PERFORMANCE

Appropriate payment is an important tool for recognizing and supporting practice improvement. However, states also provide other resources to support improvements in the delivery of care. The second consortium states offer three types of support to medical home practices seeking to improve their performance.

Supporting the use of electronic health records, registries, and data: Alabama, Iowa, Maryland, and Nebraska are providing support to adopt technology and use data to improve care. In many ways, they are learning from and replicating aspects of North Carolina's work in this area. (See [profile](#) on page 11.) Alabama is working with providers to help them adopt an electronic health record (the Q-Tool) and also provides quarterly utilization reports to medical home practices. Iowa has explicitly directed participating practices to use a portion of the per-member per-month payment made by the state to establish and maintain a registry for tracking key information and develop a system for sharing clinical information with a key hospital. Nebraska is offering medical home practices funding for a patient registry and assistance in implementing it. This state is also providing medical home practices with access to data from Medicaid claims for services provided to their patients.

Using learning collaboratives: Iowa and Nebraska are offering some form of learning collaboratives, as are the leading states of Maine, Minnesota, Pennsylvania, Rhode Island, and Vermont. Learning collaboratives are typically short-term (six- to 15-month) learning systems that bring together teams from participating practices to seek improvement in a particular area. Learning collaborations rely on face-to-face learning sessions, monthly conference calls, and progress reports and not only help practices improve in key focus areas, but also familiarize practices with a process they can use to improve performance in other areas.⁴⁸ Topics for learning sessions can include themes such as change management, leadership, and waste reduction.

Deploying practice coaches: Maryland and Nebraska are securing practice coaches—a strategy adopted by nearly all of the leading states. Practice coaches are consultants (or other individuals) who offer on-site technical assistance to a practice to identify what it needs to change and how it will make those changes. The practice coach can also provide ongoing support to refine and maintain the improvements and/or help practices meet state or national medical home recognition standards. Coaches can also help practices better integrate information technology resources such as registries and electronic health records to improve care processes.

Providing Support for Care Coordination

States have placed a high priority on ensuring that patients and practices have access to dedicated care coordinators—professionals who specialize in organizing care across settings to make sure patients get the right care at the right time. States expect that the medical home payments they make to practices will be used to pay for care coordination. Iowa has made this expectation explicit, directing participating providers to use a portion of the per-member per-month payment from the state to hire a dedicated care coordinator. In addition, Alabama, Maryland, and Nebraska plan other funding or supports for care coordination. Specifically:

- Alabama’s networks, which are modeled after Community Care of North Carolina networks, are designed to provide a platform for practices to share care coordination resources.
- Nebraska is making a payment to participating practices that is explicitly directed to fund care coordinators. Similarly, Pennsylvania and Rhode Island are making payments that are specifically targeted to pay for care coordinator or care manager services.
- The Maryland Health Care Commission is working with the Community Health Resources Commission (an independent commission established by the legislature) to explore with several other states how to use area health education centers (AHECs) and other state organizations to train care coordinators. North Carolina is one state that has informed Maryland’s efforts. North Carolina’s AHEC has worked directly with primary care providers to promote electronic health record adoption and the effective use of health information technology to improve quality.

EVALUATING PROGRAM PERFORMANCE

State Medicaid agencies are making the investments described in this report with the expectation that high-performing medical homes will produce improved clinical outcomes, increased patient satisfaction, and contained costs. There is evidence that medical homes do produce these returns.⁴⁹ As detailed in the first section of this report, there is also evidence from more mature Medicaid medical home programs that these investments produce similar results in Medicaid programs. However, Medicaid agencies need to know that their medical home programs are succeeding to justify continued funding that would allow broader spread of the model.

Although most of the second consortium states have not yet identified the specifics of their measurement and evaluation plans, six (Alabama, Iowa, Maryland, Nebraska, Texas, and Virginia) have identified the key outcomes they plan to measure. Many of these outcomes are the same as or similar to the outcomes that leading states are tracking. These outcomes can be grouped into the four major categories, which are described below.

Improvements within primary care practices: Alabama, Iowa, Maryland, Nebraska, Texas, and Virginia intend to assess the effect of their programs on primary care, particularly the program's impact on access and clinical processes. Here are some examples of the targets and measures these states are considering:

- At least 75 percent of all members enrolled in pilot practices have had their smoking status documented (Iowa);
- 100 percent of all members referred to the University of Iowa Hospitals and Clinics for secondary and tertiary care should be tracked via a referral tracking system (Iowa);
- Wait time to get an appointment for both urgent and routine care (Nebraska);
- Use of appropriate medication for asthma (Maryland); and
- Adoption of health home model: progress as measured by the Medical Home Index Quotient, a tool developed by TransformMED to gauge the capabilities of primary care practices (Texas proposed pilot).⁵⁰

Effect on services delivered by other providers: All states identified above plan to examine the effects of their programs on other aspects of the delivery system. While many of these services are not under the direct control of primary care providers, states believe that empowered primary care can lead to improved patterns of utilization. Among the measures the states are monitoring:

- Percentage decrease from the baseline in emergency department visits per 1,000 members (Year 2, 2 percent decrease; Year 3, requirement increases to 4 percent) (Maryland);
- Number of inpatient hospital admissions for ambulatory care–sensitive conditions: chronic obstructive pulmonary disease, congestive heart failure, diabetes, and pediatric asthma (Nebraska); and
- Decreased hospitalizations and emergency department utilization (Virginia).

Cost containment: Many of the specific measures and targets already listed were chosen because improvements in these areas should produce significant cost savings for Medicaid. In addition, these states plan to measure actual changes in Medicaid costs, most often as a change in the per-member per-month cost of care.

Patient and provider experience: Alabama, Nebraska, and Texas seek to examine patient satisfaction and experience. Alabama further specified that they plan to use the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tool.⁵¹ Nebraska reported that they will examine provider satisfaction.

Seeking to Ease the Evaluation Burden for Medical Home Providers

The second consortium states are seeking to ease the burden of evaluation and performance measurement on medical home providers, in ways described below.

Relying upon data generated during the course of providing and paying for services: All the states are working to minimize the resources that practices will need to devote to measurement. To this end, states are looking to potentially rich data sources that already exist for other purposes, such as claims databases and practice registry data. Maryland plans to use claims data from its multipayer database to assess its multipayer initiative, as are the leading states of Maine, Vermont, and soon, Rhode Island.

Drawing measures from national data sets: States are also seeking to ease and enhance evaluation by drawing measures from national data sets. This potentially reduces the burden of producing the measures. In some cases the same measure may serve multiple purposes. As an added benefit, measures developed by an organization that specializes in that activity add to the credibility of the results. Common sources of measures include those developed by NCQA or those endorsed by the National Quality Forum.

Selecting measures that practices must already report to other programs: The states are also seeking to align measurement and evaluation activities across programs. In Alabama, for example, the Alabama Healthcare Improvement and Quality Alliance Workgroup—a public–private effort—is working to establish measures based on national standards to assess progress on all programs throughout the state. The Maryland Health Care Commission is working with the Medicaid and CHIP programs to ensure that the measures used in the medical home program are drawn from those already in use when possible.

SUMMARY

The eight states profiled in this report demonstrate the role of the state in improving primary care systems through the medical home model. Budget pressures in three of these states (Kansas, Virginia, and Texas) have resulted in delayed implementation. Across the consortium, project design has been greatly informed by the work of states such as Colorado, Maine, Minnesota, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, and Vermont. At the same time, emerging states are developing innovations and learning lessons that can serve to advance the broader field.

All states that are building medical homes have faced a multitude of key decision points and design considerations. Throughout the United States, these questions are being addressed differently. From the stakeholders at the planning table to the nature of practice qualification standards, from the number of participating payers to the type of practice support systems, these projects are unique. This makes sense given the differences in delivery systems across the country, as well as the diversity in state and stakeholder goals. But there is much in common. States that are building medical homes have their eyes on the same broad vision: strong primary care systems that deliver better outcomes while helping to rein in unsustainable cost growth. In other words, states want better value from their health care systems, and they are finding that the medical home model is part of the answer.

**Appendix. Medical Home Programs in Second Consortium States
(as of August 2011)**

State	Program Overview and Status
Alabama	Alabama is enhancing its Medicaid primary care case management program, Patient 1st, through community networks. These entities, referred to as the Patient Care Networks of Alabama, will support primary care practices in functioning as medical homes. Among other responsibilities, the network staff will help primary care providers coordinate care for high-need and high-risk patients and teach self-management skills. Alabama consulted with North Carolina, a state with much experience in this model. Alabama’s Medicaid program identified local champions and built broad provider buy-in through a series of regional town hall meetings and webinars. Through a request-for-proposal process, the state identified three county organizations to serve as network hubs on a pilot basis. The Centers for Medicare and Medicaid Services (CMS) approved a state plan amendment in May 2011, and Alabama began making network payments in August 2011. Alabama’s share of Medicaid funding for this project came from monies that would otherwise be available for Patient 1st shared savings payments. The program aims to cover about 80,000 Medicaid beneficiaries, and it has been structured as a two-year pilot. Depending on results, the state may expand the initiative statewide. ⁵²
Iowa	Iowa has legislative backing to establish and spread the medical home model as a standard of care for all citizens. Legislation in 2010 provided the Medicaid agency with the authority to transform IowaCare (a §1115 Medicaid demonstration waiver program that offered a limited benefit package to low-income childless adults) into a medical home program based in Federally Qualified Health Centers (FQHCs). Participating FQHCs are required to attain medical home recognition and work with the state, hospitals, and each other to deliver excellent primary care. Iowa has developed a new Medicaid payment model for IowaCare’s FQHC sites that aligns with medical home recognition. State funding for payments has come from reallocating existing IowaCare funding. In addition to enhanced payments, IowaCare sites are receiving support through a learning collaborative. ⁵³ The program was launched with two FQHCs in October 2010. By the end of 2012, the Medicaid agency plans to expand the program to 13 geographically dispersed FQHC sites capable of serving 39,000 members. ⁵⁴ (Iowa is also working with payers to establish a multipayer program for children.)
Kansas	Kansas Medicaid has led the state’s medical home initiative. The state has not set a launch date because of budget setbacks, but it continues to lay the foundation for a medical home program that the state plans to implement when fiscal matters improve. In 2010, the Medicaid agency reengaged a primary care provider stakeholder group and reached out to local foundations and private payers. They have also drafted practice recognition standards that implement their legislatively established medical home definition. The provider stakeholder group provided feedback on those standards.

Maryland	The Maryland Health Care Commission (MHCC) is leading implementation of a multipayer patient-centered medical home pilot. Legislation enacted in 2010 addressed antitrust concerns and brought the large commercial insurers to the table. Practices are receiving support through a learning collaborative to help them meet modified NCQA medical home standards. In exchange, they receive increased payment from all of the large commercial payers in the state and select Medicaid managed care organizations. Participating Medicaid managed care organizations are not receiving enhanced capitation payments from the state. Maryland has launched a learning collaborative to support practice transformation and will be conducting an independent evaluation of that effort. MHCC's initiative is designed to enroll 50 practices that together serve 200,000 patients. Payments for the three-year pilot began in July 2011. ⁵⁵
Montana	Montana has convened a large group of diverse stakeholders to plan a multipayer pilot. The stakeholders have agreed on a medical home definition, and consensus has coalesced around using a modified NCQA system for practice recognition. Initially, Medicaid convened the project; however, in order to more effectively engage commercial payers and address potential antitrust concerns, Montana's Commissioner of Securities and Insurance took the leadership role in September 2010. ⁵⁶ The stakeholder group, which includes all commercial payers, has developed and is now carrying out a work plan for implementing a multipayer initiative.
Nebraska	Consistent with legislation enacted in 2009, Nebraska is implementing a Medicaid medical home pilot. The governor-appointed Medical Home Advisory Council used a request-for-information process to select two pilot practices. Together, the two practices serve about 7,000 patients. Each is receiving enhanced payment from Medicaid in exchange for meeting state-developed medical home standards. The practices are also receiving support through state-funded practice coaches and embedded care coordinators. The pilot will last two years and, depending on results, the state may expand the program. The program operates under the authority of a Medicaid §1932(a) state plan amendment that CMS approved in January 2011. Nebraska's share of the Medicaid costs is funded with modest state start-up funds. ⁵⁷
Texas	Texas previously planned to develop a two-year, \$20.2-million Health Home Pilot project using funding from the settlement of a lawsuit over children's access to preventive services under Medicaid. The state had begun a request-for-proposals process to select practices. Each practice would have received cost-based reimbursement for expenses related to transformation. The state planned to evaluate several domains of practice transformation, including patient access and experience, provider experience and satisfaction, service utilization, clinical care quality, and annual and trended per-member per-month costs. Texas had planned on funding and evaluating about eight health home practices across the state, each using unique approaches, to determine which were the best models to replicate once the pilot concluded. In June 2011, the Texas Legislature did not appropriate funds for the pilot and the request for proposals was cancelled. ⁵⁸
Virginia	Virginia Medicaid is working to develop a medical home initiative with a rural, multisite FQHC. A stakeholder group is considering using a national recognition process. Options for increased payment commensurate with achieving recognition are being explored.

NOTES

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⁵⁴ Iowa Department of Public Health, “Medical Home System Advisory Council,” retrieved Aug. 2, 2011, see: http://www.idph.state.ia.us/hcr_committees/medical_home.asp.

⁵⁵ Maryland Health Care Commission. “Maryland Patient Centered Medical Home,” retrieved Aug. 2, 2011, see: <http://mhcc.maryland.gov/pcmh>.

⁵⁶ For additional information, please visit: www.followupfast.com/medhome/index.asp.

⁵⁷ Nebraska Department of Health & Human Services, “Nebraska Medicaid Medical Home Pilot Program,” retrieved Aug. 2, 2011, see: <http://www.hhs.state.ne.us/med/Pilot/index.htm>.

⁵⁸ Texas Health and Human Services Commission, “Medicaid Health Home Pilot Project RFP# 529-10-0057,” retrieved Sept. 12, 2011, see: <http://www.hhsc.state.tx.us/contract/529100057/announcements.shtml>.