

THE ROLE OF FEDERALLY QUALIFIED
HEALTH CENTERS IN STATE-LED MEDICAL
HOME COLLABORATIVES

By Mary Takach

JUNE 2009

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ACKNOWLEDGEMENTS

The National Academy for State Health Policy would like to extend its thanks and appreciation to Hunt Blair and Craig Jones of the State of Vermont, Christopher Koller of the Rhode Island Office of Health Insurance Commissioner and Phil Magistro of the Pennsylvania's Governor's Office of Health Care Reform, as well as the state primary care associations and federally qualified health center representatives from Pennsylvania, Rhode Island and Vermont who participated in the interviews, offered their insights and reviewed a draft publication of this report. In addition, the author would like to thank NASHP Senior Program Director Catherine Hess for her thoughtful guidance and feedback and NASHP Policy Analyst Elizabeth Osius for her research assistance.

This report was supported through a National Cooperative Agreement (Number U30CS09747-01-00) with the federal Health Resources and Service Administration's (HRSA's) Bureau of Primary Health Care. The author would like to thank both NASHP's primary care team members and members of the National Academy, who serve as project advisors for this National Cooperative Agreement and who provided ideas for this and other NASHP products and reviewed the paper in draft form.¹ Finally, the author would like to thank HRSA project officers Lynn Spector and Colleen Meiman for reviewing this report. This report and other project activities are intended to help inform state policy decisions that affect community health centers, in order to promote achievement of the shared goal of improving access to quality, affordable health care for our nation's most vulnerable populations.²

EXECUTIVE SUMMARY

The medical home is a model of care that is taking root in both public and private payer programs in an effort to improve quality, control costs and increase both patient and provider satisfaction. Since 2006, more than 30 states have been leading efforts to advance medical homes³ in their Medicaid and Children's Health Insurance Program (CHIP). Several states are leading multi-payer medical home collaboratives to spread this model in the private sector.⁴

States have used multi-payer collaboratives to convene disparate groups of purchasers, payers and providers to discuss health delivery system reform aimed at improving outcomes and lowering rising costs. Having the state as a neutral convener can allay both payers' and providers' fears that anti-trust issues will be raised by having a common effort.

Using telephone interviews with public and private stakeholders in Pennsylvania, Rhode Island and Vermont, this report will describe each state's multi-payer medical home collaboratives and the role that federally qualified health centers (FQHCs) play. We hope this report will be of value for other state policy makers looking to develop similar pilots, as well as describe opportunities for FQHCs, primary care associations and others who want to become engaged in state efforts to advance patient-centered medical homes.

Three state-led medical home collaboratives in Pennsylvania, Rhode Island and Vermont share many common elements. Each state included federally qualified health centers in the stakeholder planning process and valued the leadership they brought to the table, based on their experience with Health Disparities Collaboratives (HDC)⁵ and team-based comprehensive care. They also shared a common definition and recognition tool to help guide practices. The collaboratives diverged on elements such as patient populations, practice criteria, reimbursement and practice support.

PENNSYLVANIA

The origins of Pennsylvania's multi-stakeholder collaborative began with an executive order creating the Chronic Care Commission to help address the rising costs of caring for the chronically ill. The first rollout of the Chronic Care Initiative began in Southeast Pennsylvania, in May 2008, with plans to penetrate the rest of the state, region-by-region, by April 2009. The state is funding faculty and expenses for a yearlong learning session that focuses on the management of diabetes (adults) and asthma (children) for participating practices. State support includes practice coaches, web-based registry, data flow and evaluation.

The payers in the collaborative include six major commercial payers, Medicaid managed care and Medicare managed care. Participating payers make a three-year commitment to provide enhanced payments in the form of lump sums to participating practices. The payments are aligned with the stepwise achievement of the three National Committee for Quality Assurance (NCQA) Physician Practice Connections–Patient Centered Medical Home (PPC-PCMH)⁶ levels. In addition, payers are responsible for providing infrastructure development payments to help with the cost of practice transformation.

The Southeast rollout includes 32 practices, including three FQHCs and 11 sites. All practices that applied to participate were included; subsequent rollouts have a competitive application process. Practices agree to send a team to learning sessions on either diabetes or asthma, reach NCQA level 1 by year one, and provide monthly data reports to the state.

RHODE ISLAND

Rhode Island's multi-payer medical home pilot got its start because of a confluence of events: the state's strong culture of public/private collaboration; a chronic care collaborative driven by the state's Department of Health and HRSA's Health Disparities Collaboratives experience; the Office of the Health Insurance Commissioner (OHIC) statute that holds insurers responsible for addressing costs and quality; and a grant to cover project management to begin the Chronic Care Sustainability Initiative (CSI-RI) pilot. OHIC's role as convener has been pivotal to getting key stakeholders to the table and sustaining their involvement. In addition to OHIC, Quality Partners of Rhode Island, the state's Quality Improvement Organization, provides technical support to the project.

Participating payers represent 67 percent of insured residents, all Medicaid-contracted health plans and all Rhode Island-based commercial payers. Payers agree to sign a two-year contract with providers and pay fee for service plus \$3 per member per month to enhance services and to support the salary and benefits of a nurse case manager located in each practice.

The pilot began in October 2008 and includes five practices, including one FQHC. Providers agreed to reach NCQA level 1 by nine months and level 2 by 18 months. They also agree to participate in disease collaboratives and submit quarterly reports from an electronic medical record (EMR) or electronic registry on clinical measures for diabetes, coronary artery disease and depression. Practices also agree to conduct patient engagement and education activities.

VERMONT

Vermont's multi-payer medical home collaborative was spun from 2006 health care reform legislation that codified a statewide chronic disease management program called Blueprint for Health. In 2007, additional legislation called for a small number of pilots to test the efficacy and sustainability of payment reform across *all* payers (public and private), focusing on three chronic conditions and the health management of the general population, to prevent chronic conditions from occurring.⁷ Through a competitive application process, three communities were chosen to participate. The first pilot began in July 2008 in the St. Johnsbury community. It includes four FQHCs, and two other community pilots are underway.

Legislation defines the state's role, provides pilot funding and requires all insurers to participate. The Blueprint pilots have a strong emphasis on community prevention that integrates the traditionally distinct cultures of public health and healthcare delivery.⁸ Each pilot has a Community Care Team that includes a Public Health Prevention Specialist (state-funded). Providers can access a state-funded web-based registry called the Health Information Exchange Network, as well as Clinical Microsystems training.

All three major commercial insurers and the state Medicaid program participate and share proportionally in the costs of the enhanced provider payments and Community Care Teams. The state will also subsidize Medicare's share of the cost. Providers receive enhanced payments up to \$2.39 per member per month, based on the points scored on the NCQA PPC-PCMH. Providers must also report data through the registry and incorporate Clinical Microsystems training in their delivery of care.

CONCLUSION

States play an instrumental role in initiating, convening, and sustaining multi-payer medical home collaboratives. Collaboratives in Pennsylvania, Rhode Island and Vermont all involved FQHCs in the stakeholder planning process. Each state found that the FQHC culture of care provided insight and leadership to the

stakeholders, based on their experience with HDC, comprehensive care to populations at risk and care integration.

FQHCs have benefited from their involvement in medical home collaboratives by way of enhanced reimbursement for care they are already delivering. In addition, FQHCs gained additional infrastructure support (registry, care coordinators and practice coaches), ongoing education and an enhanced working environment. Most FQHCs had little trouble attaining level 1 on the NCQA scale, but many found that reaching higher levels requires significant upgrades of existing EMR systems to interface with multi-payer databases and to use web-based electronic health records.

All three state medical home collaboratives are undergoing extensive evaluations to determine whether their investments will yield improved patient outcomes, provider and patient satisfaction and a reduced rate of growth in health care costs. Waiting for the outcome of the evaluations may not deter some states from further investing in primary care to improve health system delivery reform.

INTRODUCTION

The medical home is a model of care that is taking root among public and private payers in an effort to improve quality, control costs and increase both patient and provider satisfaction. This model has the potential to better support the primary care workforce, which suffers from chronic shortages caused by pay disparities between specialty and primary care and by job dissatisfaction and disillusionment.⁹ Both can be improved through enhanced reimbursements and infrastructure practice support.

State efforts that emphasize a primary care-oriented system through the provision of medical homes, often begin with Medicaid and CHIP, which covered more than 64 million poor and low-income people in 2006.¹⁰ Since then, more than 30 states have been seeking to improve these programs by adopting the medical home model.¹¹ Many states are advancing medical homes as a core component of comprehensive health care reform, and several are using their clout to drive changes that advance medical homes in state health benefit plans, the private sector and multi-payer collaboratives.

Multi-payer collaboratives can be critical to gaining provider and purchaser support for medical home initiatives. Providers are more likely to adopt a system of care that treats all patients the same regardless of payers. Purchasers of care—including insurers, employers and states—want to share the cost and risk of up-front investments in enhanced provider rates and other elements of primary care practice redesign. This risk, they hope, will yield a return on investment that can be demonstrated through evaluations of both patient outcomes and the costs of delivering care. Multi-payer collaboratives have a larger provider and patient base, which allows for more thorough evaluations on whether this model improves care and contains costs.

FQHCs have helped to plan and implement several state-led multi-payer collaboratives. They bring valuable insight to the stakeholder table, based on their participation in chronic care collaboratives (see text box, page 8) and efforts to deliver team-based comprehensive primary care, which are core aspects of the medical home. According to the states interviewed for this report, FQHCs are often best positioned and most enthusiastic about medical home practice transformation, and states hope this will translate to better outcomes. According to the FQHCs interviewed, not only do enhanced payments improve participation, but FQHCs gain needed support for learning collaboratives, dedicated nurse care managers, health information technology with information sharing, population management, documentation and other support.

This report will describe three states—Pennsylvania, Rhode Island, and Vermont—that have well-developed, state-led multi-payer medical home collaboratives, which provide insight into the role that FQHCs play in these initiatives. This report was produced using telephone interviews with state officials, primary care associations and FQHC representatives from each state, and through web-based research. We hope this report will provide useful lessons for other state policy makers looking to develop similar pilots, as well as describe opportunities for FQHCs, primary care associations and others who want to become engaged in state efforts to advance medical homes.

BACKGROUND

First advanced by the American Academy of Pediatrics (AAP) in the 1960s, the concept of the medical home initially referred to a central location for archiving a child's medical record and for connecting the many disparate practitioners who treat children with special health care needs.¹² AAP evolved the medical home concept to become an accessible, continuous, comprehensive, family-centered, compassionate and culturally effective place of health care.¹³ It is clear now that the medical home concept has further evolved to include a broader expanse of patients, particularly those with limited resources and the greatest health care needs.

DEFINING A MEDICAL HOME

Medical homes are often described in terms of valued principles or characteristics. Although states do not agree on one definition of a medical home,¹⁴ most definitions reflect these core primary care values:

- Having a personal physician or provider who provides first contact care or a point of entry for new problems,
- Providing ongoing care over time,
- Offering comprehensive care, and
- Coordinating care across a person's conditions, providers and settings.¹⁵

In 2007, four major physician groups joined large employers, commercial insurers and other organizations to form the Patient Centered Primary Care Collaborative (PCPCC) and agreed to a common Patient-Centered Medical Home (PCMH) model.¹⁶ The PCMH model is defined by seven "Joint Principles" (Appendix A). Eleven states have adopted or based their medical home definition on these principles.¹⁷ This broad agreement on the medical home definition, along with new resources to advance its adoption, has presented opportunities for states.

RECOGNIZING PRACTICES AS MEDICAL HOMES

Public and private payers that reimburse medical practices as high functioning medical homes need to translate a medical home definition into measurable standards and then develop a process for recognizing which practices meet those standards. Without that, payers will not know which practices to reimburse, or they will spend money on practices that are not high functioning medical homes. Defining and recognizing a medical home helps establish concrete expectations that can motivate practices to improve how they deliver care.

There are a variety of tools that states can use to identify practices that meet medical home standards. No single tool has been identified as ideal, but there is general agreement that the tools or processes used should recognize and measure the four pillars of primary care: access (first contact care), continuity (longitudinality), comprehensiveness and coordination.¹⁸

Standards and recognition processes are shaped by a state's medical home definition. The Physician Practice Connections-Patient Centered Medical Home (PPC-PCMH) is probably the most widely used in recent medical home initiatives. The National Committee for Quality Assurance (NCQA) developed this tool in collaboration with the PCPCC, which also developed and promotes the Joint Principles. (See text box, page 7)

National Committee for Quality Assurance PPC-PCMH Tool

The PPC-PCMH builds on many elements developed by the Chronic Care Model. It 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 electronic communications. Within each standard there are between two and five structural elements, all with point values, which indicate the kinds of documentation required to pass or achieve points. There are some elements that practices must pass before receiving certain recognition levels.

NCQA administers the recognition process. Practices that choose to undergo the process may be awarded one of three recognition levels. A fee based on the number of physicians in a practice is required for the survey tool license, NCQA review and recognition, each level advancement and recognition renewal.¹⁹ The three recognition levels are:

- Basic level 1 recognition: the practice scores must be within 25-49 and include 5 out of 10 “must pass” elements;
- Intermediate level 2 recognition: the practice scores must be within 50-74 and include all 10 “must pass” elements; and
- Advanced level 3 recognition: the practice scores must be within 75-100 and include all 10 “must pass” elements, as well as a fully functional electronic medical record.²⁰

FORMING MULTI-STAKEHOLDER COLLABORATIVES

States play a key role in advancing medical homes. Most, however, have found that they cannot do this alone and are partnering with other stakeholders, such as payers, primary care providers (including FQHCs) and the organizations that represent them (including Primary Care Associations), patients, and advocacy groups. These stakeholders play a variety of roles in program design, implementation and operation.

Partnering with other payers in multi-stakeholder collaboratives helps spur provider buy-in and increases practice penetration while spreading transformation costs. Practices are more inclined to participate if they can treat all patients the same, regardless of payers, and report on common measures. Some state agencies are convening the collaboratives, while some states are joining efforts convened by other stakeholders.

Pennsylvania, Rhode Island and Vermont are three states with multi-stakeholder collaboratives in which the state is the lead convener. This has given these states extra leverage in forming and sustaining the collaboratives. Having the state as a neutral convener can allay payers' and providers' fears that anti-trust issues will be raised by their common effort.

PARTNERING WITH FQHCs

Federally qualified health centers have been at the stakeholder table in Pennsylvania, Rhode Island and Vermont's multi-payer medical home collaboratives. Rhode Island and Vermont also included the state's

Health Disparities Collaborative (HDC)

In 1998, HRSA's Bureau of Primary Health Care partnered with the Institute for Healthcare Improvement (IHI) to form the Health Disparities Collaboratives. The goal was to eliminate disparities in health care through better chronic disease management. FQHCs typically spend 12–13 months learning and applying new models of care designed to decrease or delay complications of disease, decrease the economic burden for patients and communities and improve access to quality chronic disease care for underserved populations.²¹ Eighty-eight health centers formed the first HDC focused on diabetes.

HDCs have three main components adapted from IHI's Breakthrough Series:

1. *Learning model:* The learning model is the education component that trains interdisciplinary teams from each health center, using learning sessions, monthly conference calls and progress reports.
2. *Chronic care model:* This six-part component employs patient self-management; clinical decision support (such as evidence-based guidelines); clinical information system (for instance, the use of a registry for population management); delivery system design; organization of health care (such as involving executive leaders in the collaboratives); and community resources (including the use of space, resources and education).
3. *Improvement model:* This component trains teams to use the Plan, Do, Study, Act (PDSA) methodology to test and implement positive changes quickly before they are finalized.²²

primary care associations in the planning process. Each state found that FQHCs brought valuable experience based on their participation in HRSA's Health Disparities Collaborative, which often caused other providers' "jaws to drop" at the stakeholder table. Learning collaboratives have been an important part of the FQHC learning culture, and FQHC providers were eager to continue in that direction.

In addition, the FQHCs in Pennsylvania, Rhode Island and Vermont were generally ahead of other practices in their use of electronic medical records (EMRs)—a fundamental criteria in the NCQA PPC-PCMH qualifications. Although FQHCs widely employed EMRs, each state found that infrastructure and technology assistance were still needed to get most FQHCs' systems to interface with multi-payer databases and make use of web-based registries.

PENNSYLVANIA: CHRONIC CARE INITIATIVE

The origins of Pennsylvania's multi-stakeholder collaborative began with an executive order from Gov. Edward Rendell, creating the Chronic Care Commission. Data that illustrated the staggering cost of caring for those with avoidable chronic illnesses helped embolden the commission's work.

This data included:

- In 2007, Pennsylvania hospitals charged \$4 billion for avoidable hospitalizations for those with chronic conditions, and
- Eighty percent of medical expenses go to 20 percent of the population with chronic illnesses.²³

The commission is charged with establishing an infrastructure to change the way chronic care is delivered. The 37-member commission represents a broad cross section of health care-related fields and represents all geographic areas of the state. In addition, the secretaries of health, public welfare and insurance, as well as the director of the Governor's Office of Health Care Reform (GOHCR), serve as *ex-officio* members. Several FQHCs' representatives are members as well.

The commission met for three months in 2007 and developed a strategic plan that called for implementing the Chronic Care Model developed by Dr. Ed Wagner and the MacColl Institute in all primary care practices across the state. In the initial discussions, this model was not linked to any medical home efforts. After discussions with payers, it became clear that a tool was needed to validate practice transformation to justify additional provider payments. The NCQA PPC-PCMH became a useful tool for the state to help establish a framework for supplemental payments based on a practice's level of achievement.

The first rollout of the Chronic Care Initiative began in Southeast Pennsylvania in May 2008. The state plans to penetrate the rest of the state region-by-region by November 2009. The policies for each region will vary to allow for flexibility. In the Southeast rollout, all 32 practices that applied to participate, including three FQHCs with seven sites, were included. In subsequent rollouts, there is a competitive application process based on funding and other limitations placed by payers.

One of those limitations is ensuring that participating providers have a proportional mix of payers to help spread the transformation costs. With a high dependence on Medicaid as a payer, FQHCs have been challenged to participate in subsequent rollouts. The South Central rollout did not include any FQHCs, although the Southwest rollout does. In addition, the Chronic Care Initiative seeks to focus efforts on practices that are not yet transformed, and many of the Pennsylvania FQHCs are much further along in this process than other practices because of their participation in HDC and their use of electronic medical records. The state's primary care association agrees that many FQHCs already are functioning as advanced medical homes, but it believes that the stakeholder process requires leaders or champions in the room to share lessons learned: "It's one thing to say 'do this'—but another to say 'it can be done. I've done it.'"

STATE RESPONSIBILITIES

The state is providing faculty and facilities for a yearlong learning collaborative that focuses on the management of diabetes (adults) and asthma (pediatrics) for participating primary care practices. Practice support includes providing practice coaches through Improving Performances in Practices (IPIP) (a state-based, nationally led quality improvement initiative) to help practices implement the required action steps.

Practices can use a patient registry through IPIP if they do not have an EHR or if their EMR does not have registry functions. The state is responsible for coordinating the flow of supplemental payments to the practices, as well as coordinating the data collection, evaluation and reporting activities through IPIP. At 18 and 36 months, a formal evaluation will be conducted to assess whether the rollouts are achieving desired quality and cost containment goals and whether the program should be continued.

PAYER RESPONSIBILITIES

The payers in the collaborative include 16 major commercial payers, Medicaid managed care and Medicare managed care. Payers make a three-year commitment to provide enhanced payments in the form of lump sums to participating practices. The payments are aligned with stepwise achievement of the three NCQA recognition levels. Payments are proportionate, based on the percentage of the payer's beneficiaries diagnosed with either asthma or diabetes. FQHCs continue to receive wrap-around payments from Medicaid to cover the difference between the managed care FFS payment and their cost-based reimbursement rate. The commission is charged with determining a common set of performance pay measures that insurers may use to help sustain and spread practice transformation.

Payers are also responsible for providing infrastructure development payments that include support for data entry to the registry, the cost of the NCQA survey tool and the application fee, as well as lost revenue for attending seven days of learning collaborative meetings in the first year.

PRACTICE RESPONSIBILITIES

All practices must sign a three-year commitment to participate and, in year one, send a practice team to seven days of learning sessions. Within 18 months, practices must apply for NCQA level 1 recognition and provide monthly data reports to the state. Practices report on either the asthma or diabetes measures (asthma for pediatrics and diabetes for family practice and internal medicine). They must manage that population the same regardless of payer and track patient care through a registry. FQHCs declare that they do not pay attention to payer type and treat all patients the same, including those who are uninsured and Medicare FFS (although they do not submit data on these patients).

All supplemental payments need to be reinvested into the practice site, including adding case management services when practices do not have that resource in place.

DISCUSSION

The Governor's Office of Health Care Reform (GOHCR) found that FQHCs provide a great deal of leadership as members of the Chronic Care Commission, based on their experience participating in HDC, providing comprehensive primary care, often under one roof, and using a team-based model of care. However, the GOHCR found that FQHCs have faced challenges adapting to a business model that requires, for example, finance and office practice redesign to eliminate waste and streamline workflow.

Two of the participating FQHCs in the Southeast Pennsylvania rollout are nurse-managed health centers. There are more than 250 nurse-managed health centers in the U.S. that are run by nurses, operate in partnership with their communities and offer a full range of comprehensive primary care services.²⁴ Pennsylvania's Family Practice & Counseling Network represents one of the nurse-managed FQHCs in the Southeast rollout. The executive director agreed that their experience with HDC and their overall model of delivering care has brought valuable insight to the commission's work. In addition, all of the network's practices use electronic medical records and participate in continuous quality improvement activities—criteria emphasized in NCQA recognition.

Although the state offers practices use of a registry that provides many new and desirable features, adapting to the new registry has been a challenge for some of the Family Practice & Counseling Network health centers. They hope to address this barrier by updating their own EMR to provide similar features to the collaborative's registry. They also want to provide new features, such as providing patients with access to their lab results online.

Another challenge for nurse-managed FQHCs is that NCQA only recognizes physician-led practices. GOHCR was able to gain NCQA acceptance to score the nurse-managed FQHCs' applications and provide the results that were used to qualify the FQHCs for supplemental payments. The Family Practice & Counseling Network hired a part-time Master of Public Health-level employee to assist with the application process, at a cost of approximately \$25,000.

The health centers also had trouble offering patients access to the provider of their choice—another NCQA requirement. In many of the nurse-led practices, nurse practitioners are part-time, balancing work and family, but this is something that FQHCs are working to address in order to meet continuity requirements.

The state's primary care association has been an active stakeholder on the regional rollout committees. (The Chronic Care Commission limited stakeholder involvement to providers but not their representative associations.) The PCA actively sought membership on the steering committees and has played a role educating other providers and insurers about the Chronic Care Model. The PCA also found many misconceptions about FQHCs among providers and insurers. Having a stakeholder role helped address these misconceptions and ensure that subsequent rollouts do not include parameters that preclude the participation of FQHCs. The PCA values the role that the state played as a convener, particularly in its ability to get agreement on common reimbursement and measurement strategies. Although there are major insurers at the table, the PCA noted there are still many who have declined to participate.

RHODE ISLAND: CHRONIC CARE SUSTAINABILITY INITIATIVE

Rhode Island's multi-payer medical home pilot started after a confluence of events. First, Rhode Island has a strong culture of public/private collaboration on quality improvement activities; one noteworthy example is the Rhode Island Chronic Care Collaborative (RICCC).

In 1997, a partnership between the Department of Health and Thundermist Health Center (an FQHC) began with the HDC for diabetes. From this early partnership, a statewide collaborative developed, adding 10 more FQHCs and a hospital-based practice.²⁵ In 2003, the Department of Health and Quality Partners of Rhode Island (the state's quality improvement organization) received a grant from the Robert Wood Johnson Foundation to train more physician practice teams based on the HDC model, and RICCC was launched. Although RICCC showed promising results, many providers struggled to sustain the work in the fee-for-service environment.

Second, unique to Rhode Island is the Office of the Health Insurance Commissioner (OHIC).²⁶ Under OHIC statute, the commissioner is charged with holding insurers accountable for efforts to improve affordability, accessibility and quality in the health care system,²⁷ providing leverage to convene payers.

Finally, securing a grant from the Center for Health Care Strategies (CHCS) provided financial support for project management to begin the multi-payer pilot known as the Chronic Care Sustainability Initiative (CSI-RI).

In July 2006, OHIC convened purchasers, payers and providers to translate medical home principles into a payment pilot. Purchasers include the state's two largest employers, Medicaid and state employees. Participating payers represent 67 percent of insured residents, Medicaid-contracted health plans and Rhode Island-based commercial payers (Medicare FFS is not included). OHIC wanted a mix of the providers participating in the pilot to include private practices, academic/teaching settings and FQHCs. Also at the table are organizations that represent providers, including the Rhode Island Health Center Association (the state's PCA), as well as other provider groups. Technical assistance and project management is provided by Quality Partners of Rhode Island, based in large part on their experience with the RICCC.

In October 2008, the two-year pilot began, involving five practices, one of them an FQHC. The pilot will serve at least 25,000 covered lives and include all adults diagnosed with diabetes, depression or coronary artery disease.

STATE RESPONSIBILITIES

OHIC's role as a convener has been pivotal in getting key stakeholders to the table and sustaining their involvement. OHIC provides project management, which includes organizing quarterly stakeholder meetings that provide input to the steering committee on project direction and developing consensus on key project decisions. The Rhode Island Department of Health and Department of Human Services is also at the table and brings expertise from its Primary Care Case Management program.

PAYER RESPONSIBILITIES

Participating payers sign a two-year contract with providers and pay using a common reimbursement method:

- FFS plus \$3 per member per month for enhanced services. The FQHC continues to receive wrap-around payments from Medicaid to cover the difference between the managed care FFS payment and their cost-based reimbursement rate.

- Payment for the salary and benefits for nurse case managers located in practices who serve all patients regardless of payer, share data and report measures regularly.

Payers also agreed to use common measures, including NCQA PPC-PCMH outcome measures for three chronic conditions (based on national standards) and cost and utilization measures, such as emergency room, prescriptions and inpatient admissions from plans.

PROVIDER RESPONSIBILITIES

Participating providers agree to reach NCQA PPC-PCMH level 1 by nine months and level 2 by 18 months, verified through a self-audit. Reaching these levels requires participation in the existing RICCC and its collaborative learning model, as well as quarterly reports—shared with one another—from an EMR or electronic registry on clinical measures for diabetes, coronary artery disease and depression.

Practices also agree to conduct patient engagement and education activities. The Department of Human Services provides assistance by placing patients in the Stanford Chronic Disease Self-Management Program patient workshops.

DISCUSSION

According to OHIC, Thundermist Health Center has contributed greatly to CSI-RI stakeholder meetings, especially by sharing its expertise around chronic care and population-based health management. The initial meetings of the project were focused on engaging private practices that had been the least engaged in the RICCC's work, and those that had found it particularly hard to sustain the work in a fee-for-service reimbursement environment. Also, OHIC's statutory authority is based in commercial insurance regulation. As the project took shape, the all payer imperative—including Medicare and Medicaid—became clearer. The value of including FQHCs in the project was recognized because of the depth of their experience with the Chronic Care Model, as well as the need to incorporate the treatment issues more common among FQHC populations in the all payer model. Participation by the Primary Care Association, all parties agreed, was important but not sufficient. Thundermist—by virtue of its leadership role in the RICCC and HDC, and its persistent interest in the project—was a logical choice.

The health insurance commissioner noted that both FQHCs and private practices do not have many convening opportunities, and the CSI-RI meetings allowed them opportunity to dispel myths, share experiences and collaborate on common goals. Thundermist Health Center's executive director stated that although stakeholder meetings are often long and tedious, participating in discussions at that level with other providers and policymakers is invaluable. She noted that it is an enormous benefit for FQHCs to be a part of health care reform efforts.

Participation in CSI-RI has enabled Thundermist Health Center to continue providing innovative services to its entire patient population—services that may have been eliminated with state budget cuts. In addition, providers have benefited tremendously from participating in RICCC, which contributes to higher provider satisfaction.

The Rhode Island Health Center Association stated that participation in CSI-RI has allowed it to rethink Joint Commission accreditation. FQHCs in the state have struggled with Joint Commission ambulatory accreditation, believing that it is not suitable and too expensive. Now Rhode Island FQHCs are leaning towards the NCQA as an accreditation model, based on Thundermist Health Center's participation in CSI-RI.

The new executive director of the Rhode Island Health Center Association perceived a “missed opportunity” in the early stakeholder meetings and did not actively advocate for more FQHCs to be included in CSI-RI. (One other FQHC was involved in stakeholder meetings, but it eventually stopped participating.)

There are 10 FQHCs in Rhode Island, and each already participates in RICCC. Six have robust EMRs, and all have registries. All RI FQHCs are poised for future involvement.

Rhode Island FQHCs may not have to wait long. OHIC wants to expand this model to other practices before the pilot ends. Although payers may be reluctant to approve an expansion until confirming a return on investment, OHIC is considering building primary care investments into health plan requirements for every insurer in the state to further spread expansion of medical homes.

VERMONT: BLUEPRINT INTEGRATED PILOT PROGRAM

Vermont's multi-payer medical home collaborative was built on Vermont's 2006 sweeping health care reform legislation. Known as the Blueprint for Health, the goal is to reform the state's health delivery system. Through a competitive process, six "Blueprint" communities (organized as hospital service areas) were selected to begin the transformation by improving diabetes care and prevention through provider training and incentives, expanded use of information technology, evidence-based process improvement through Clinical Microsystems training, self-management workshops and support for community activation and prevention programs.²⁸

In 2007, additional legislation called for a small number of pilots to test the efficacy and sustainability of payment reform across *all* public and private payers, as well as for several chronic conditions (diabetes, hypertension and asthma). This included health management of the general population to prevent chronic conditions from occurring.²⁹ The Blueprint wanted to test not only a financial model, but also a delivery model, so it considered different settings and practice types during its selection process. Through a competitive application process, three Blueprint communities from the original six were chosen to participate in the Blueprint Integrated Pilot Program.

Vermont has a strong history of fostering public-private collaboration. This culture was reinforced in the Blueprint for Health by legislation that mandated that the executive committee include a broad range of stakeholders, including a representative "serving low income or uninsured Vermonters."³⁰ The executive committee has had representation from an FQHC and additional representation is seen from FQHCs and the PCA in the five statewide workgroups that advise and assist Blueprint staff with planning and evaluation of the pilots. At the community level, each pilot site has its own stakeholder group. FQHC representatives stated that they were involved in the Blueprint pilot design and had considerable input throughout the whole process.

The first pilot began in July 2008, in the St. Johnsbury community of the Northeast Kingdom. The result of a partnership with the area hospital, the pilot includes four FQHCs and one hospital-owned medical practice. The second pilot began in October 2008 in the Burlington community (no FQHC included). The third pilot is in the Bennington community (details regarding the practice sites are not yet available).

STATE RESPONSIBILITIES

The Blueprint for Health operates under the umbrella of the Department of Health, which is responsible for implementing the Blueprint pilots. The legislature provided funding for the pilots, including support for building the infrastructure needed to make the pilots successful. The legislature set out an aggressive implementation timeline and requested to be updated with regular reports.

There are several distinguishing characteristics about the Blueprint pilots. One is the emphasis on community prevention, which integrates the traditionally distinct cultures of public health and healthcare delivery.³¹ Each Blueprint pilot has a Community Care Team (funded by the payers) that includes a public health prevention specialist (funded by the state) based in local Department of Health district offices. The public health prevention specialist works closely with the healthcare delivery members of the Community Care Teams and other key stakeholders in their community to:

- Provide structured assessments of the risk factors and conditions that contribute to the prevalence of morbidity from chronic disease, and

- Plan and implement interventions that are designed to reduce the prevalence and impact of chronic disease.³²

Blueprint will continue to support Healthier Living Workshops, Vermont's version of the Stanford Chronic Disease Self Management Program, which are offered throughout the state. Future work will involve training multi-disciplinary teams to support practices to help patients set self-management goals, such as achieving a healthy weight.

Another distinguishing characteristic is the state's plan to establish a health information environment that will support patient care and population management. There are many components to this plan that involve collaboration with private partners:

- A web-based registry (DocSite), supported by the Blueprint and Vermont Program for Quality in Health Care (VPQ), which will produce reports for all health maintenance and chronic disease measures integral to clinical operations, population management and program evaluation. Providers without an EMR can use DocSite to support individual patient care.
- A health information exchange network, developed with Vermont Information Technology Leaders (VITL), Blueprint and technology teams at each organization. The network will establish data transmission from available sources (such as EMRs and hospital data warehouses) to DocSite, and
- Clinical Microsystems³³ and VPQ Coordinated Training³⁴ to affect practice transformation (part of the initial groundwork laid by the six original Blueprint Communities).

The state Blueprint budget is funding the NCQA practice audit. An independent reviewer will assess providers at six-month intervals.

PAYER RESPONSIBILITIES

All payers, including Medicaid, proportionally share the costs of enhanced provider payments and Community Care Teams. The state is subsidizing Medicare's share of the cost.

Providers receive enhanced payments based on the points scored (not the level reached) on the NCQA-PPC-PCMH. This allows practices to be rewarded for smaller incremental changes every six months. Practices must score at least level 1 recognition (25 points, which includes 5 out of 10 must pass elements) to trigger a \$1.20 per member per month payment. They may earn up to \$2.39 for scoring 100 points.

Payers also share the cost of the local Community Care Teams, whose function is to engage the entire community in effective health maintenance, prevention and care for chronic disease.³⁵ The team composition varies by community, but payers generally fund a chronic care coordinator at each practice site, a community health worker and a care integration coordinator. Other teams may include new or existing practice staff, such as medical social workers, behavioral health specialists and dietitians. The care integration coordinator runs the team and works across practices with Medicaid, social services, etc., as well as the public health prevention specialist. It is the hope that after the Blueprint pilot concludes, insurers will be able to shift expenditures from their current disease management services to support statewide expansion of the Blueprint Integrated Pilot program.³⁶

PROVIDER RESPONSIBILITIES

Providers must agree to become advanced medical homes through NCQA PPC-PCMH recognition. All practices must score at least level 1 to receive enhanced reimbursement, which FQHCs had very little difficulty achieving. Three out of four FQHCs scored level 3 on the NCQA scale. Providers must also report

data regularly through the DocSite registry and incorporate Clinical Microsystems training in their delivery of care.

DISCUSSION

According to state officials, FQHCs have partnered with an area hospital and played a leadership role throughout the entire Blueprint development. They provided testimony to the legislature, describing the challenges that primary care practices—especially fee-for-service practices (non-FQHCs)—would face becoming advanced medical homes without significant financial reform. This testimony helped craft the 2007 Blueprint pilot legislation. During state workgroup meetings, the FQHCs helped break some of the resistance by stakeholders reluctant to change and contributed to the design of the Blueprint pilots.

Although the Northern County Health Centers in the St. Johnsbury Community share a common EMR, they have a number of issues that require extensive system updating before taking part in the data exchange and getting them to do high-level population management. The state provided financial and technical support for this revamping. FQHCs explained that the Blueprint has high expectations and asked providers to track more than 100 clinical elements. Many providers have been resistant to taking the time to do this. This is compounded by the existing pressure—or “push and pull”—of a payment system that rewards providers who see more patients yet expects them to spend more time tracking and managing patient care. In response, Blueprint leaders have visited FQHCs to explain how these data will help with the vision for a healthier state.

From the FQHC perspective, the addition of the Community Care Teams has relieved some of this pressure. One FQHC representative stated that they have contributed greatly to their mission by giving their patients “a better chance of improving their lives.” The additional funding, used to hire a care integration coordinator, add more hours to an existing behavioral health specialist’s schedule and access a public health prevention specialist, has contributed greatly to problem solving and identifying resources to help patients. As one FQHC representative summarized, the Community Care Teams have made addressing difficult patient problems like hitting the “easy button.” FQHCs also found that having a state-funded, independent auditor for NCQA accreditation has been a tremendous help in getting through the laborious recognition process. Blueprint pilot FQHCs are working to help other Vermont FQHCs prepare for NCQA recognition.

In that same vein, the Bi-State Primary Care Association has been securing federal and state funding to form a network called the Vermont Rural Health Alliance. The alliance was developed in partnership with the Department of Health and the state and federal Offices of Rural Health to support participation in the Blueprint for Health and other quality improvement initiatives. Membership includes Bi-State Primary Care Association, FQHCs, a critical access hospital, other community clinics, VPQ and VITL. The alliance provides support to Blueprint pilot providers to “stretch their Blueprint dollars” and to give providers not part of Blueprint Communities an opportunity to participate in “virtual Blueprint Communities.” For the latter group, the alliance hopes to take the lessons learned in the Blueprint Communities and prepare providers for future Blueprint initiatives.

CONCLUSION

There are a number of lessons to be shared from the three state-led multi-stakeholder medical home collaboratives.

Leadership and commitment is needed from the top. The Pennsylvania Chronic Care Initiative began with an executive order; Rhode Island's Chronic Care Sustainability Initiative was empowered by an Office of the Health Insurance Commission statute; the Vermont Blueprint was launched by the governor in 2003; and the Integrated Pilot Program has a legislative mandate. Being the lead convener has given these states extra leverage in forming and sustaining the collaboratives. Rhode Island and Vermont had statutory or legislative authority, respectively, requiring insurers to participate in their collaboratives. Vermont initially tried to accomplish payer reform voluntarily, without success. Having the state as a neutral convener can allay payers' and providers' fears that anti-trust issues will be raised by having a common effort.

"[FQHCs] bring assurance that we're building a model that can work for a whole population, not just for people who have the money to go get the best. That's invaluable. We are bringing the safety net health system into the same model that is being driven by commercial businesses—having it work is a real test to the model."

Vermont state policymaker

FQHCs participation in stakeholder and workgroup meetings brings valuable experience to the medical home collaboratives. Each state wanted a variety of practices to test their models. Including an FQHC was intended from the start. One state policymaker explained, "They bring assurance that we're building a model that can work for a whole population, not just for people who have the money to go get the best. That's invaluable. We are bringing the safety net health system into the same model that is being driven by commercial businesses—having it work is a real test to the model."

State policymakers were surprised by the misconceptions other providers had about FQHCs during the stakeholder process. Their images about both the services FQHCs provide and the people they serve were often far from reality. FQHC representatives benefited from these stakeholder meetings as well, because they do not often have the opportunity to share what they do with private practices and do not always appreciate the pressures unique to a fee-for-service practice. One state policymaker noted that another benefit of an all-payer project is to permit private practices, FQHCs and practices in other kinds of primary care settings to identify and focus on common concerns—such as the adequacy of funding for primary care services—possibly creating a broader primary care provider coalition out of groups generally defined by specialty or FQHC status.

Each state policymaker agreed that FQHCs' culture of care, reinforced by their experience with the Health Disparities Collaboratives, comprehensive services and care integration, provided significant leadership and helped persuade other stakeholders to consider the patient-centered medical home model.

FQHCs benefit from their involvement in medical home collaboratives. Most notably, they receive added payments for care they believe they are already delivering. Each state differed in their payment amounts, but all used the NCQA-PPC-PCMH to develop the payment framework. Most FQHCs had little trouble attaining level 1 on the NCQA scale. But most FQHCs interviewed found that reaching higher levels will require significant upgrades of existing EMR systems. In addition to enhanced reimbursement, FQHCs gained additional infrastructure support (including registry, care coordinators and practice

coaches), ongoing education through learning collaboratives and improved working environment. All three state Primary Care Associations wanted more FQHCs to be involved at the start, but looking ahead, they are preparing FQHCs to be ready for state spread of the collaboratives.

Evaluations are important, but investments in primary care are needed. All three states have extensive evaluations in place that they hope will document improved patient outcomes, cost-containment and improved patient and provider satisfaction. They hope that these factors will be enough to sustain the payers' ongoing commitment. Pennsylvania is evaluating its program at 18 and 36 months to assess whether the rollouts should be continued. Vermont is hoping that the investment return from the Blueprint pilots will be able to convince payers to shift expenditures from their current disease management services and spread the approach statewide. Rhode Island is convinced that the investment in primary care is the right direction and may not wait for the pilot's evaluation. The health insurance commissioner is considering building primary care investments into health plan requirements for every insurer in the state to further spread expansion of medical homes.

APPENDICES

APPENDIX A: JOINT PRINCIPLES OF THE PATIENT CENTERED MEDICAL HOME

The “Joint Principles” that define the Patient Centered Medical Home model 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*—a 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*—a 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. This includes care for all stages of life: acute care, chronic care, preventive services and end of life care.
4. *Care is coordinated and/or integrated* across all elements of the complex health care system. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it, in a culturally and linguistically appropriate manner.
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. This framework would reflect the value of physician care management work that falls outside of a face-to-face visit. It would pay for services associated with coordination of care, support adoption and use of health information technology for quality improvement and support provision of enhanced communication access. It would also recognize the value of physician work associated with remote monitoring of clinical data (using technology), allow for separate fee-for-service payments for face-to-face visits, and recognize case mix differences in the patient population being treated within the practice.

APPENDIX B: THE ROLE OF FQHCs IN STATE-LED MULTI-PAYER
MEDICAL HOME COLLABORATIVES

	Pennsylvania	Rhode Island	Vermont
Lead State Agency	Governor's Office of Health Care Reform	Office of Health Insurance Commissioner	Blueprint for Health Vermont Department of Health
Dates	<ul style="list-style-type: none"> • May 2008 (1st rollout of statewide plan) • May 2009 (3rd rollout in southwest PA) • 3 years to implement each roll out 	<ul style="list-style-type: none"> • October 2008 • 2 year pilot 	<ul style="list-style-type: none"> • July 2008 (Pilot 1) • 2 year pilot
Origins	<ul style="list-style-type: none"> • Executive Order created Chronic Care Commission 2007 • Commission developed a strategic plan to merge PCMH with Chronic Care work 	<ul style="list-style-type: none"> • OHIC statute to direct health plans to work on affordability issues • FQHC/HRSA work in Health Disparities Collaboratives. • Chronic Care Collaborative begun by QIO • CHCS grant to convene payers and provide financial support for project management 	<ul style="list-style-type: none"> • Grew from 2006 legislation (Act 191) establishing 6 original Blueprint communities charged with improving health care and prevention for the most prevalent chronic conditions. • Legislation in 2007 (Act 204) called for multi-payer approach (sustainable financial reform) including mandate for commercial insurers to participate.
FQHC and/or PCA stakeholder participation	<ul style="list-style-type: none"> • Governor's Chronic Care Commission • Steering Committees 	<ul style="list-style-type: none"> • Chronic Care Sustainability Initiative (CSI) stakeholder group • Steering Committees 	<ul style="list-style-type: none"> • Executive Committee for the Blueprint • Blueprint Advisory groups • Local workgroups
Payers	<ul style="list-style-type: none"> • 16 commercial payers that include Medicare Advantage & Medicaid managed care 	<ul style="list-style-type: none"> • Medicaid FFS, Medicaid Managed Care, all RI-based commercial payers, Medicare Advantage 	<ul style="list-style-type: none"> • Medicaid, Medicare (costs subsidized by state), 3 major commercial insurers
Diseases Targeted	<ul style="list-style-type: none"> • Asthma (pediatrics) or diabetes (adults) 	<ul style="list-style-type: none"> • Diabetes, depression, coronary artery disease (adults) 	<ul style="list-style-type: none"> • Diabetes, hypertension, and asthma. In addition, health management for general population

	Pennsylvania	Rhode Island	Vermont
<p># practices/ FQHCs</p> <p>Selection of practices</p>	<ul style="list-style-type: none"> In first roll-out (Southeast PA) 32 practices including 3 FQHCs (Family Practice & Counseling Network, Philadelphia Health Management Corporation, Quality Community Health Care) In first roll-out, all practices that applied were accepted. Subsequent rollouts have competitive process. 	<ul style="list-style-type: none"> 5 practices including 1 FQHC (Thundermist). Practices self-selected. 	<ul style="list-style-type: none"> 3 Blueprint communities (hospital service areas). One community includes 4 of the 6 FQHC sites of Northern Counties Health Care and a provider-based RHC, Corner Medical. Practices selected through a competitive process.
<p>Infrastructure support</p>	<ul style="list-style-type: none"> Learning collaboratives Web-based patient registry Practice coaching 	<ul style="list-style-type: none"> Chronic Care model training (collaborative) EHR or Electronic Disease Registry Practice coaching Care management nurse at each practice Evidence-based guidelines embedded in clinical practice Self-management support for patients 	<ul style="list-style-type: none"> Chronic care model training Funding for expanded EMR use including population management/data sharing/web-based clinical tracking system with eRx Practice coaching Care Integration Coordinator at each practice Each practice has support through multidisciplinary community care teams including VDH Public Health Prevention Specialists
<p>Reimbursement</p>	<ul style="list-style-type: none"> In Southeast PA lump sum payments on proportionate share of payer mix based on NCQA level achieved. Payment varies per region/practice based but up to \$4 PMPM for NCQA level 3 Infrastructure development payments (includes funding for lost revenue time for teams to attend collaboratives, NCQA application cost, data entry cost) 	<ul style="list-style-type: none"> \$3 PMPM Shared payer support for nurse care manager at each practice 	<ul style="list-style-type: none"> Varies based on NCQA score. Up to \$2.39 PMPM. Shared payer support for Community Care Teams State subsidizes Medicare share of payment

	Pennsylvania	Rhode Island	Vermont
Expectations of Providers	<ul style="list-style-type: none"> • Go through Chronic Care Model Collaborative • Progressive level of NCQA PPC-PCMH recognition (self audit). Must reach Level 1 PLUS (includes care management) by 18 months. • Track care through registry or EMR linked to registry • Report data through registry 	<ul style="list-style-type: none"> • Go through Chronic Care Model Collaborative • Progressive level of NCQA PPC-PCMH recognition (self audit). Must reach Level 1 by 9 months. Level 2 by 18 months. • Report data through registry or EMR linked to registry • Patient engagement and education activities 	<ul style="list-style-type: none"> • Go through Clinical Microsystems training • Progressive level of NCQA PPC-PCMH recognition (independent audit). Must reach Level 1 to trigger first payment. Reassessed every 6 months. • Track care through registry or EMR linked to registry • Report data through registry or EMR linked to registry
Evaluation	<ul style="list-style-type: none"> • Multi-payer database • Engaged providers • Patient self-care knowledge and skills • Patient function and health status • Primary care practice satisfaction • Appropriate and efficient utilization of services • Clinical quality of care • Cost of care 	<ul style="list-style-type: none"> • Multi-payer database • PCMH process measures (NCQA PPC-PCMH score) • Health outcomes for 3 chronic conditions • Patient experience of care • Clinical quality of care • Cost of care 	<ul style="list-style-type: none"> • Multi-payer database • PCMH process measures (NCQA PPC-PCMH score) • Health status measures using age, gender, preventive assessments • Clinical quality of care • Cost of care

ENDNOTES

1 As part of NASHP's National Cooperative Agreement from HRSA's Bureau of Primary Health Care, six states were selected through a competitive process to help guide and participate in the project work of this grant. The six states chosen were Missouri, New Mexico, Oregon, Pennsylvania, Rhode Island and Tennessee. In addition, 10 of our academy members, all state officials, serve as project advisors.

2 The contents of this document are solely the responsibility of the author and do not necessarily represent the official views of HRSA/BPHC.

3 National Academy for State Health Policy, *Results of State Medical Home Scan* (Portland, ME: National Academy for State Health Policy, 2008) Accessed 13 March 2009 http://www.nashp.org/_docdisp_page.cfm?LID=980882B8-1085-4B10-B72C136F53C90DFB

4 Many states use the term "health home" or "health care home" rather than medical home to include a greater range of providers and a broader array of health care services.

5 To read more: <http://www.healthdisparities.net/hdc/html/home.aspx>

6 National Committee for Quality Assurance Physician Practice Connections-Patient Centered Medical Home. For more information, please see: <http://www.ncqa.org/tabid/631/Default.aspx>

7 Vermont Senate Bill 283, Acts of 2007, Act 204, section 7. Accessed 13 March 2009. <http://www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2008/acts/ACT204.HTM>

8 Vermont Department of Health, *Vermont Blueprint for Health: 2008 Annual Report* (Montpelier, VT: Vermont Department of Health, January 2009). Accessed 13 March 2009. <http://healthvermont.gov/admin/legislature/documents/BlueprintAnnualReport0109.pdf>

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13 Ibid

14 Many states use the term "health home" or "health care home" rather than medical home to include a greater range of providers and a broader array of health care services.

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- 18 Ann O'Malley, *How do we know a practice is a PC-MH?* (PowerPoint presentation for National Academy for State Health Policy webcast, Center for Studying Health System Change, April 2008). Accessed 13 March 2009 http://www.nashp.org/Files/PCMH_Infrastructure_April2.pdf
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- 25 Rhode Island Quality Partners, Rhode Island Department of Health, et al. *Rhode Island Chronic Care Collaborative* (Providence, RI: Rhode Island Quality Partners, 2007) Accessed 13 March 2009. http://www.riqualitypartners.org/2/Site/CustomFiles/Qty_DocMgr/EXsummFINAL.pdf
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- 34 Vermont Program for Quality in Health Care (VPQ) developed the VPQ Learning Community, which coincided with the initiation of the Blueprint for Health and funding for provider training in six Blueprint communities. This enabled VPQ to accommodate small practices unable to attend the Learning Sessions but that wanted to incorporate and spread the quality improvement methods into their daily work. VPQ Learning Community consists of three components: centralized, statewide Learning Forums; multiple, community based mini-learning sessions (the Collaborative on Wheels); and a virtual Learning Community dimension. <http://www.vpqhc.org/2008QR/LearningCommunity.htm>
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