



State Involvement in Multi-Payer Medical Home Initiatives

November 2009

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State Convening entity Project name Statut. Authority: Y/N Contact	Status	Payers	#practices/ # physicians # covered lives *	Practice qualificati on	"Mechanism to integrate with community resources"	"Integration with state wellness/ disease prevention efforts"	Evaluation	<ul style="list-style-type: none"> • Administrative Entity/Ongoing mngmnt of budgetary impact • Attribution/tracking of beneficiaries to PCPs • Quality msmnt/perfor tracking 	Payment model	Multi- payer Data base Y/N	Support to practices: data, team care
Colorado CO Clinical Guidelines Collaborative CO Multi-Payer, Multi-State PCMH Home Pilot Stat utory Authority: N	Underway: 5/1/09- 4/30/11	Aetna, Anthem- Wellpoint, CIGNA Humana, UnitedHealt hcare, Medicaid, CoverColor ado	16/54 19,000 Developing strategies to garner additional ASO lives to reach a minimum of 30,000 lives.	NCQA PPC- PCMH	Building Medical Neighborhoods & Utilizing a Patient Navigator expert to help our practices find the resources in their area as well as offer them a list of known resources in Denver Metro	Pilot practices are accessing community programs provided by the Health Department, community resources (i.e. Healthier Living) , & non-health care related support services (i.e. faith- based organizations).	Independent evaluation using a Matched Comparison Group Methodology to evaluate the effectiveness of PCMH qualities on cost, quality and satisfaction for both provider office and patient.	Admin. entity/Ongoing mngnt: Colorado Clinical Guidelines Collaborative (CCGC) Attribution: Health Plans and Practices Quality msmnt: Colorado Clinical Guidelines Collaborative (CCGC)	3 Tier Payment System: <ul style="list-style-type: none"> • FFS • PMPM care coordination fee • P4P 	Y	T/A provided through on-site QI coaching, learning community webinars & learning collaborative. Practices submit monthly narrative progress reports & QI measures which span prevention, wellness and chronic disease. Practices must have registry functionality for pop. management & care coordinator. Areas of focus include: Patient-Centered Care, Access, Team-Based Care Delivery, Evidence-Based Guidelines, Care Coordination, Shared Decision Making & Self-Management QI.
Iowa Iowa Department of Public health Medical Home System Advisory Council Statutory Authority: Y	Formed stakeholder committee to begin initial phase of PCMH for Medicaid & CHIP with a plan to spread to all Iowans.	Medicaid & CHIP are first implemen- ta- tion phase per statute, plan to include commercial payers in spread.	TBD	TBD		Through statute, a Prevention and Chronic Care Management Council was formed. The two councils work together on coordination and integration.	TBD		TBD	N	Learning Collaborative

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Maine ME Quality Forum, Quality Counts & ME Health Management Coalition Stat utory Authority: N (Pilot result of Legisl. Comm.; in state health plan)	Practices have been selected & have submitted NCQA apps; completing agreement s; payments to begin 01/10	Anthem BCBS of Maine; Aetna; CIGNA; Harvard Pilgrim Health Care; Medicaid	26/221 75,000	NCQA PPC- PCMH	Pilot "Core Expectations" include commitment from practices to improve connections to local community & community resources	"Core Expectation" noted previously includes commitment from participating practices to connect with their local "Healthy Maine Partnership" (i.e. state-supported community coalition promoting disease prevention)	Independent evaluation aligned with 6 aims of IOM's quality of care including assessment of changes in clinical outcomes, cost/ resource use, patient experience, & practice teams / systems	Admin. entity/Ongoing mngnt: Quality Counts manages day-to-day operations Attribution: Plans and providers agreed to attribution methodology (commercial: claims based - any one with last visit to site in 2 year time period and member at end of period) Quality mngmnt: Practices commit to submitting clinical quality measures quarterly; claims data used to create q6mos quality & resource use feedback reports for practices	Prospective PMPM care coordination fee	Y	<ul style="list-style-type: none"> Practice teams supported by 1:1 Quality Improvement coaches using microsystems Practices required to participate in PCMH learning collaborative with 3 learning sessions/year Practices can access technical assistance from contracted experts for targeted key areas (e.g. HIT, involving patients in redesign efforts) Practices will receive claims- based quality & resource use feedback reports every 6 mos (being produced by HealthDialog)
Maryland Office of the Governor MD Multi-Stakeholder Medical Home Pilot Stat utory Authority: N (executive order; 2010 legislation TBD to resolve: antitrust issues, ensure self-insured employer participation, clarify privacy concerns)	Planning for up to 6 local outreach sessions with practices across state for Spring 2010 – focus on pediatric and adult practices 07/10 begin practice enrollment	All major private payers (Aetna, CareFirst, Coventry, UHC) and Medicaid, Will seek Medicare participatio n if permitted by CMS.	Target: 50/200 200,000	NCQA PPC- PCMH	Governor appointed MD Health Quality & Cost Council serves as the vehicle to mobilize state resources and pair with resources in local communities to improve health of those communities.	Integrate with Healthiest Maryland," a campaign aimed at "grasstop" local leadership across Maryland. A recognition program honoring participating state organizations that target behaviors to prevent diabetes & obesity and its complications	Independent evaluation TBD. To include: Clinical Quality, Cost, Patient Experience/Satisfac tion, Provider Experience/Satisfac tion	Admin. entity/Ongoing mngnt: Attribution: Patients will be attributed to a PCMH based on where the patient received the plurality of E&M services in the last 2 years. The participating physician will be responsible for enrolling eligible patients Quality msmnt: (planning): Pediatric practices: management # of specific conditions. Adult practices: management of specific chronic diseases	Payers use their traditional fee schedule + Reimbursement for E-visits and afterhours care included in care coordination PMPM. Year 2: Transition Practices to Shared Savings model (Yr 2) with no penalty for losses.	TBD	Goal: learning collaborative, On-site nurse care manager for each pilot site, shared for smaller practices

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<p>Massachusetts</p> <p>Executive Office of Health and Human Services (EOHHS) 4/10 x 2-3 years</p> <p>Massachusetts Patient-Centered Medical Home Initiative</p> <p>Stat utory Authority: Y</p>	Planning to select practices 04/10	All large commercial payers at the table, all Medicaid MCOs & Medicaid's PCCM plan	Total # of practices TBD on final payment model & financial commitment each payer is willing to make	TBD	<p>TBD:</p> <ul style="list-style-type: none"> Practice linkages to community-based resources employer consumer incentive programs Employer-based wellness & lifestyle support programs community-based wellness, lifestyle support, & peer support programs 		Independent evaluation being planned; evaluator contracted (UMASS Medical School)	<p>Admin. entity/Ongoing mngnt: EOHHS is the state entity overseeing initiative. EOHHS and the other payers had not planned to establish a separate Administrative Entity and it has been envisioned that; each payer would be responsible for their own patient attribution and payment processes for selected practices. Attribution: TBD – planned to be handled separately by each payer using a consistent methodology. Quality measurement: TBD</p>	<p>TBD:</p> <ul style="list-style-type: none"> Initial payment should build on FFS but with elements that support transition to comprehensive payment & align with state-led payment reform efforts. Upfront payment for infrastructure Ongoing, suppl. payments for care mngmnt, pop. mngmnt, & other non-reimbursed activities Shared savings linked to access & quality meas. 	N	<p>1st learning collaborative 09/10, then quarterly over next year.</p> <p>Provision of electronic patient registry with reporting functionality for population tracking and analysis with patient-specific reminders.</p> <p>Practice coaching.</p>

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Minnesota MN Department of Health and MN Department of Human Services Health Care Home (HCH) Stat utory Authority: Y	Collecting letters of intent for certification Statewide provider certification process to launch in late 2009 Providers payments 07/10	Medicaid (FFS and managed care); individual and fully-insured private insurance; state employees	Exact # TBD. Initial outreach to practices & patients completed. Open to all clinics. Statewide clinic capacity assessment done.	State developed HCH certification standards. Draft rule: http://www.health.state.mn.us/healthreform/standards/proposedrule090706.pdf	Certification standards require the establishment of linkages with community resources. Significant opportunities to leverage additional partnerships focused on seniors.	Broader state health reform legislation includes significant investment in public health through the State Health Improvement Program (SHIP): http://www.health.state.mn.us/healthreform/ship/index.html	TBD. HCH Outcomes Measurement Work Group: developing outcomes measurement implementation strategies & making recommendations on how HCH outcomes measurement can work within the broader statewide reporting structure.	Admin. entity/Ongoing mngnt: Developing statewide data submission process for outcomes measurement; formal evaluation (incl. budget impact) required by state legislature; claims submission to participating payers individually under a common methodology. Attribution: Providers prospectively ID & enroll patients using common patient complexity strata for payment Quality msmnt: Evaluating outcomes under the IHI "Triple Aim" framework. State-led outcomes measurement linked to certification.	Per-person, complexity-adjusted, care coordination payments added to FFS structure to certified providers and clinics. Rates will reflect non-billable services provided over a defined period of time & will increase with individuals' degree of care coordination need.	Y (outcomes msmnt)	Learning Collaborative (state supported) required as a condition of provider/clinic participation. Ongoing opportunities for practices to develop toward certification, learn from one another and engage in QI activities.
New Hampshire Citizens Health Initiative Multi-Stakeholder PCMH Pilot http://www.steps.org/ Stat utory Authority: Y	Underway: Pilot sites submitted apps to NCQA 5/09; Payments began 6/09	Harvard Pilgrim Health Care, MVP, CIGNA, Anthem, Medicaid	11/63 39,000	NCQA PPC-PCMH			Independent evaluation aligned with six aims of IOM quality of care. Using clinical outcomes consistent with CMS group practice demonstration metrics, patient experience of care, resource use/costs.	Admin. entity/Ongoing mngnt: Attribution:) Quality msmnt:	Prospective PMPM fee that increases with NCQA Recognition Level paid every 6 months. Existing P4P programs for improvements in quality & cost.	Y	Sites have added registry functions, care coordinators and other staff. All have eRx and can import ER, hospital, lab and radiology data into medial record.

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New York New York State Department of Health Adirondack Medical Home Demonstration Statutory Authority: Y (authorizing legislation)	Planning to begin Jan 2010. Payments will be retroactive to January 2010 but may not start until March/April 2010	8 payers including Medicaid and state employees	30/150 150,000	NCQA PCMH + other require- ments	Governance board to include community representatives (public health, business, employers);	Measures of success, and measures for NCQA recognition consistent with prevention agenda for state	Internal evaluation by participants using quality, access, experience of care (patient and provider) and cost/utilization; seeking external, independent evaluator as well	Admin. entity/Ongoing mngnt: Governance body consisting of payers, providers, state (chair) as well as community members Attribution: Combination of payer lists using attribution algorithm (for non-HMO members) and provider lists shared with payers (with reconciliation process) Quality msmnt: Common metrics for quality, access, experience of care, and cost/utilization	PMPM case management fee with possible component of 'pay for performance' in out years	Y	Significant financial support for EHR/HIT/HIE through separate grant from Department, including training and shared care management infrastructure between practices; e- prescribing incentives through Medicaid

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Pennsylvania Governor's Office of Health Care Reform (GOHCR) Chronic Care Initiative Statutory Authority: N (executive order)	Underway: 5/08 SEPA 2/09 SCPA 5/09 SWPA 11/09 NEPA	16 commercial payers that include Medicare Advantage & Medicaid managed care	SEPA: 32/165 176,000 SCPA: 25/78 136,317 SWPA: 23/86 154,435 NEPA: 30/ 94 193,035	NCQA PPC- PCMH	<ul style="list-style-type: none"> Piloting consumer incentive programs Coordinating with behavioral health providers & PCPs to integrate physical & behavioral health care 	Working with Department on Health on a number of chronic disease initiatives such as education & prevention of diabetes, COPD, etc. DOH is helping to fund practice coaches to support practice transformation.	Independent evaluation: 1. Engaged providers 2. Patient self-care knowledge and skills 3. Patient function and health status 4. practice satisfaction 5. Appropriate and efficient utilization of services 6. Clinical quality of care 7. Cost of care	Admin. entity/Ongoing mngnt: GOHCR is coordinating the flow of data and funds to practices Attribution: based on PCPs 990 percentage by payer Quality msmnt: GOHCR is funding data collection, evaluation and reporting activities through a contracted 3rd party	SEPA: Payments for Registry licensing fee, support for data entry to registry, cost of NCQA survey/app. fee, lost revenue time to attend learning collaboratives (\$21,170/ practice); Enhanced payments to FFS/capitation-- 1 st 3 yrs, lump sum payments aligned with stepwise achievement of 3 NCQA levels; Transition to P4P SCPA and SWPA: up to \$20,000/ practice, prorated by carriers, for Year 1 learning collaborative, working with practice coaches, timely reporting, entering data into registry, etc. NEPA: Funds for practice management beginning Month 1; funds to hire on-site care coordinators beginning Month 4; additional funds from shared savings	N	Learning collaboratives, Web-based patient registry, Practice coaching

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Rhode Island Office of Health Insurance Commissioner (OHIC) Chronic Care Sustainability Initiative (CSI-RI) Stat utory Authority: Y	Underway: 10/08	Medicaid FFS, Medicaid Managed Care, all RI-based commercial payers, ASO employers, Medicare Advantage	5/28 28,000 Doubling in Phase 2 in q1 2010	NCQA PPC-PCMH (Level 1 attained by 6 months) Ongoing site participatio n tied to attaining higher levels of recognition)	Payer-agnostic Nurse care manager funded at each participating site. Addn'l community resources in phase 2.	Major State employee purchasers part of steering group. Practice training in Phase I supplied by Health Department Division of Primary Care and Prevention.	Independent evaluation: 1. PCMH process measures (NCQA PPC-PCMH score and survey of practice organization) 2. Claims-based quality measures 3. Patient experience of care 4. Cost of care	Admin. entity/Ongoing mngnt: OHIC with community based Project Management contractor and multi-stakeholder Steering Group Attribution: Plans and providers agreed to attribution methodology (commercial: claims based - any one with last visit to site in 2 year time period and member at end of period) Quality msmnt: Sites self-measure and report based on standardized measures for each of three conditions. Standardized health plan utilization reporting. Data analysis by Harvard SPH.	<ul style="list-style-type: none"> \$3 PMPM for all members in pilot sites Shared payer support for nurse care manager at each practice Shared payer support for Project Management contractor Training supplied by Health Dept. and QIO 	Y	Mandatory practice participation in chronic care model collaborative based on CDC and HRSA-funded experience. Nurse Care Manager training curriculum. Pilot-wide work groups on practice quality reporting, health plan data reporting and practice improvement.
Vermont Blueprint for Health Vermont Department of Health Stat utory Authority: Y	Underway: 7/08 Pilot 1 10/08 Pilot 2 1/10 Pilot 3	Medicaid, Medicare (costs subsidized by state), 3 major commercial insurers	12/40 60,000	NCQA PPC-PCMH	Pilots linked to: • Vermont 211 • Environmental & policy strategies • Broad community assessments	Each practice has support through multidisciplinary community care teams including VDH Public Health Prevention Specialists & linked with community-wide prevention efforts	Independent evaluation: 1. PCMH process measures (NCQA PPC-PCMH score) 2. Health status measures using age, gender, preventive assessments. 3. Clinical quality of care 4. Cost of care	Admin. entity/Ongoing mngnt: Blueprint - Vermont Department of Health Attribution: By agreement between insurers and practices Quality msmnt: Multi-level evaluation plan with data collection and analysis by VDH, UVM, and outside contractors	Varies based on NCQA score. Up to \$2.39 PMPM. <ul style="list-style-type: none"> Shared payer support for Community Care Teams (5 FTEs) State subsidizes Medicare share of payment 	Y	Chronic care model training & Clinical Microsystem training (collaborative); 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

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West Virginia West Virginia Health Improvement Institute Statutory authority: N	Recruiting providers; training to start 01/10	Medicaid, WV Public Employees Insurance Association, Mountain State Blue Cross, UniCare, WVCHIP; Health Plan of Upper Ohio Valley	25/50 35,000	NCQA PPC- PCMH	A subset of the pilot includes a shared care coordinator model.	These opportunities are being explored but not yet developed.	TBD	Admin. entity/Ongoing mngnt: WV Health Improvement Institute is coordinating and will manage distribution of incentive pool Attribution: Providers will submit list of patients during last 2 years with assumed payer; WVH staff will consolidate and verify membership with payers. Savings calculation only includes continuous membership for pre- and post evaluation periods. Quality msmnt: Providers will be expected to use web system to report monthly on aggregate standard measures for all patients	Shared savings model; payers contribute to a pool; methodology for distribution not final but based on performance measures	N	Learning Collaborative; web knowledge management system to support resource sharing and communication; web reporting system; practice coaches

* There are variations in the ways that # covered lives may be reported. Some states report # patients that are covered by enhanced reimbursements. Others may report the # patients on a physician's panel or # patients in a pilot site that receive the benefits of practice changes -- this may be a significantly larger number.