Medicaid agencies in 18 states are currently participating in one or more multi-payer medical home initiatives. One of the most crucial steps in developing and implementing a multi-payer medical home initiative is convincing health care payers and purchasers to participate. Although each state is unique in terms of both payer mix and the relationships among stakeholders, there are overarching strategies that conveners can use when making the case to potential payers and purchasers. By building trust among competitors, leveraging existing infrastructure, using the market to drive demand, striking the necessary balance between flexibility and consistency, and illustrating the value of the model, payers and purchasers may become more willing to participate. States and other stakeholders will also need to be mindful of a number of key considerations as they develop their program, including the potential role of legislation, the constant evolution of medical home standards, the time necessary to implement system reforms, and the importance of data.

Since 2006, a majority of states have implemented medical home initiatives in their Medicaid and Children’s Health Insurance Programs as a means of containing cost, improving health outcomes, and increasing both patient and provider satisfaction.¹ A medical home is designed to provide team-based care—led by a primary care provider—that is comprehensive, patient-centric, coordinated, assessable, and committed to quality and safety.² Many national health plans, including WellPoint, Aetna, Humana, UnitedHealth Group, and Blue Cross Blue Shield, have also embraced the patient-centered medical home model over the past few years.³ Eighteen states are participating in one or more multi-payer medical home initiatives in conjunction with other public and private payers and purchasers,⁴ and Medicare has currently joined Medicaid as a payer in 15 different multi-payer initiatives.⁵

Securing payer and purchaser participation—both public and private—is one of the most critical and challenging aspects of implementing a multi-payer medical home initiative. This brief summarizes five overarching strategies that states or other conveners can use to engage additional payers and purchasers in a new or existing multi-payer medical home program. Most of the approaches identified in this issue brief have been successfully applied in one or more existing multi-payer initiatives; novel or underutilized strategies identified by state and national experts are also discussed.
**Why Multi-Payer?**

Engaging multiple payers in medical home initiatives has many advantages. Practice transformation is time consuming and expensive; however, transformation becomes increasingly viable as more payers pay practices to provide medical homes for their patients. When providers transform their practice and redesign care workflows, these changes benefit all patients, regardless of their source of insurance. Having multiple payers engaged in a medical home initiative results in providers receiving reimbursement for a larger proportion of their patient panel. By including all of the payers in a region, an initiative is able to avoid the economic ‘free rider problem’ of one or more payers or purchasers benefiting from the care transformations without sharing in the financial investment.

Additionally, convening multiple payers more widely distributes the costs associated with developing a medical home initiative, including state- or region-wide administrative and infrastructural investments and additional practice-level payments to support care coordination services and practice transformation.

Ultimately, the goal of a multi-payer initiative is to transform care delivery in a state or region through a coordinated strategy and consistent messaging to primary care practices in terms of payment, scope, qualification standards, reporting metrics, and desired outcomes.

**Making the Case to Payers and Purchasers**

According to Michael Bailit, President of Bailit Health Purchasing, making the case to payers and purchasers to participate in a medical home initiative is both easier and harder than it has been in the past. On one hand, the rapid adoption of medical homes across the country has improved the model’s credibility and many papers and industry reports show the model has led to improvements in Triple Aim goals. The Seattle-based Group Health Cooperative reported a 1.5:1 return on investment and Wellpoint reported a return ranging from $2.50-$4.50 for every dollar spent. More recently, CareFirst reported $98 million in savings in the second year of their medical home program, and Blue Cross Blue Shield of Michigan reported $155 million in savings between July 2008 and June 2011. On the other hand, some may not be swayed by the evidence, as much of it is self-reported and did not meet the statistical rigor required to be included in a meta-review recently issued by the Agency for Healthcare Resources and Quality.

Still, conveners of multi-payer initiatives must be ready to provide reasons as to why stakeholders should participate in a new demonstration. Bruce Sherman, Medical Director at the Employers Health Coalition, Inc., noted that “too many employers feel that health is just a cost to be managed, not a strategic business investment in workforce human capital.” In 2004, Bailit and Mary Beth Dyer established the business case for investing in health care quality improvement, which included direct financial considerations (e.g., return on investment), strategic considerations (e.g., image or reputation), and internal organizational considerations (e.g., relevance to an organization’s mission). Although each payer and purchaser is unique, the business case applies to all organizations—health plans, employers, and state agencies.

Employers, often the hardest group of purchasers to engage, may be enticed to participate when presented with a rationale that participation is an investment. Data shows that greater primary care utilization can lead to better health outcomes and lower hospital and specialist utilization, which leads to lower costs. According to Sherman, employers are often surprised to find out how little of their health care spending...
actually goes to primary care; many expect that primary care accounts for 15 to 25 percent of their spending, when in reality it is closer to 5 percent. Furthermore, the medical home model could lead to greater workplace productivity through reduced absenteeism (i.e., missing work due to illness), presenteeism (i.e., attending work while sick), and higher employee satisfaction.

**Key Strategies to Engage Payers and Purchasers**

Every state is unique in both the relationships among payers, employers, providers, and government and the politics that shape those relationships. As such, no two multi-payer programs are exactly alike. Local and regional variation, even within a single state, renders a one-size-fits-all approach or turnkey solution impossible. However, there are a number of overarching strategies that a state or another convener can use to expedite and ease the planning process. The five primary strategies that will be discussed in this brief are:

1. Build trust among competitors;
2. Leverage existing infrastructure;
3. Use the market to drive demand;
4. Balance the needs of payers and providers; and
5. Illustrate the value in proving the model.

**Build Trust Among Competitors**

National and state experts consistently cited having a strong convener as a key building block to successfully developing a multi-payer initiative. The convener needs to be able to build upon existing relationships and foster trust among various stakeholders in order to elicit their participation. As Bailit noted, personal—not just organizational—relationships can often help drive commitment to the initiative’s mission and goals.

The state may be the most logical choice as a convener, because of its existing relationships with many payers and purchasers in the state, including the commercial payers contracted through Medicaid managed care and state employee health plans. A variety of state departments and agencies have served this role, including state departments of health (e.g., New York) and insurance (e.g., Rhode Island). As convener, the state may also bring added benefits, such as providing antitrust protection. However, there are unique advantages to choosing a non-state actor to serve as the central convener; specifically, the initiative may be more likely to be seen as apolitical and changes in political administration are less likely to create uncertainty.

Through strong relationships, the convener can bring corporate and clinical leadership from payers and purchasers to the table—the individuals that have the power to make decisions on behalf of the stakeholder entity. These individuals include:

- The Medicaid Director and Medicaid Medical Director;
- Clinical and network executives from commercial health plans (e.g., chief medical officers, chief executive officers, chief operating officers);
- The State Employee Health Plan Administrator; and
- Employer executives, benefit personnel and human resources staff.

Conveners and other stakeholders should not underestimate the value of human resources staff when engaging employers. Benefit administrators are in a unique position to help make the value proposition to employers about the internal advantages of better employee health on employee self-reported cognitive function, productivity, absences, and job satisfaction.

In addition to representatives from the potential payers and purchasers, the larger stakeholder group should also include providers and other local partners (see text box) to demonstrate a wide breadth of community commitment. Large national commercial payers and employers especially need to see the intrinsic value to multi-payer medical home initiatives at a local level.
Large, national employers and health plans often do not think of their role in fixing the health care system on a community-by-community basis. Getting them to do so requires local collaboration and leadership, something that coalitions can provide within their communities.\textsuperscript{21}

Clear and consistent messaging on the initiative’s mission and goals from the outset are integral to building trust and commitment among stakeholders. Current multi-payer initiatives have found workgroups or advisory groups to be effective in eliciting input from all stakeholders when developing program standards. Workgroups can also ease the burden on any one stakeholder, spreading the time and staff commitment across a number of organizations and state agencies.

- The \textit{Idaho} Medical Home Collaborative established workgroups, which included payers, state officials, providers, and patient and employer representatives.\textsuperscript{22}

- The \textit{Rhode Island} Chronic Care Sustainability Initiative attributes its ability to gain consensus among stakeholders in part to its strong advisory structures, which consist of providers, hospitals, and insurers.\textsuperscript{23}

Interviewees repeatedly noted that engaging self-insured employers in multi-payer initiatives was challenging because employers want to see proven return on investment before they invest company reserves to bear the financial load of the initiative, including administrative and practice transformation costs.\textsuperscript{24} Commercial plans serving as Third Party Administrators (TPAs) or in an Administrative Services Only (ASO) role might consider sharing risk with their self-insured clients at the outset of the initiative as a way to build trust and encourage employer participation—employers would still bear the risk for their employees, but the TPA/ASO could pay the initial costs associated with participating in the pilot.\textsuperscript{25}

Furthermore, payers and purchasers may be wary of investing in practice transformation and infrastructure costs that are disproportionate to the number of their members enrolled to participating providers. To address this, Pennsylvania’s Chronic Care Initiative prorated these costs based on the proportion of each carrier’s members attributed in a practice’s patient panel.\textsuperscript{26}

\textbf{Leverage Existing Infrastructure}

Multi-payer initiatives require substantial investments in time, infrastructure, and capital. Payers and purchasers may be more inclined to invest if they can leverage existing public and private infrastructure or payment reform efforts. There are successful examples in each direction: North Carolina provides an example of a state where employers leveraged Medicaid’s infrastructure,\textsuperscript{27} while Michigan provides an example where Medicaid leveraged a commercial plan’s infrastructure by opting to participate in an existing program.\textsuperscript{28} Alternatively, some states, including Rhode Island\textsuperscript{29} and Maine,\textsuperscript{30} convened stakeholders to build entirely new programs.

Multi-payer medical home programs may align with payment and benefit design reforms already underway by commercial payers and employers—one of which is value-based insurance design. Value-based insurance design (VBID) marries current payment reform efforts aimed at controlling health costs with delivery system reforms. These reforms are inherently aligned—although they are not always associated together—as VBID attempts to shift patient demand for services from those of low value (e.g., certain elective surgeries), to those of high value (e.g., diabetic screenings); the medical home model attempts to increase the supply of providers delivering high-value care that is both comprehensive and patient-centric.\textsuperscript{31} Oregon’s Public Employees’ Benefits Board provides a strong example of a payer promoting medical homes through insurance design (see text box, next page).

Another opportunity that a state could leverage while designing a program is to find ways to build on the work employers currently have underway to provide better care

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**Additional Partners Who Can Help Make the Case**

- Business Coalition
- Chamber of Commerce
- Health Plan Trade Associations
- Provider Associations (e.g., local American Association of Family Physicians chapters)
- Patient Advocacy Organizations
- State Legislators
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for their employees, such as workplace wellness initiatives and on-site workplace clinics. In Cincinnati, Ohio, General Electric Aviation engaged other employers and commercial payers to support the medical home model for on-site clinics and other community providers; the region was later selected to participate in the Center for Medicare & Medicaid Innovation's Comprehensive Primary Care initiative. Employers may be more likely to participate in a multi-payer initiative when their investments in these types of facilities are included in the multi-payer home program.

USE THE MARKET TO DRIVE DEMAND

Insurers have multiple lines of business, and securing participation for a plan's commercial line may not necessarily mean that they will make the payments for their Medicaid or employer-sponsored clients. Bruce Sherman introduced a Catch-22 that states must overcome in developing any initiative that includes employers; it's unlikely for insurers to invest in medical homes without employer demand, but employers are not likely to look at the model if the carrier does not offer it. Paul Grundy, Global Director of Healthcare Transformation at IBM, noted that a key strategy to solving this dilemma is prioritizing the engagement and education of large employers—or coalitions of smaller employers—that have the size and clout to transform the marketplace. Once there is a large enough demand, health plans will begin to offer plans designed to promote medical homes, which in turn become available to all employers. As the market shifts, the smaller and less-engaged purchasers will eventually be brought into the program.

The nation's largest employer, the federal government, is actively promoting medical homes for their employees. In carrier letters released in 2012 and 2013, the United States Office of Personnel Management made clear that they expected their contracted health plans to promote the adoption of medical homes to ensure that all Federal Employee Health Benefits members be enrolled in a practice that has achieved medical home status. Both the Federal Employees Health Benefits Program and TRICARE (military health plan) are participating in Maryland's Multi-Payer Patient-Centered Medical Home Program, which also includes major commercial payers and state employees. Grundy noted that states have an opportunity to leverage this momentum by engaging the other major employers, including state and municipal employees, colleges and universities, large health care systems, and private employers that operate in their state.

When developing a new multi-payer initiative, the payers and purchasers that would have the greatest impact on their health care marketplace should be identified first. This holds true in securing Medicaid's participation as well. If a state's Medicaid population is primarily enrolled in managed care, it may not make sense to include the fee-for-service population. When the Washington State Health Care Authority (Medicaid) joined the state's Multi-Payer Medical Home Reimbursement Pilot, the agency found the fee-for-service program could not administratively support the pilot due to the timing of the implementation of a new Medicaid Management Information System; additionally, with more than 70 percent of members in managed care when the pilot was being developed, the benefit of including the small fee-for-service population would not have justified the additional administrative burden. Alternatively, the larger the fee-for-service Medicaid population, the more important it is to include them in the program.

Oregon Public Employees' Benefit Board

The Oregon Public Employees Benefit Board (the Board) has designed and implemented a value-based benefit design specifically focused around members' health care needs. The process started in 2005 when the Board issued a request for proposals that piloted medical homes. Value-based benefits that reduced or eliminated patient cost sharing were introduced a year later, followed by higher copayments for lower-valued services. The health benefits are designed so that employees receiving care from medical homes have lower cost sharing than patients who are not affiliated with a medical home. In January 2013, the Board also began making enhanced payments to providers recognized under the state's Patient-Centered Primary Care Homes program for Medicaid enrollees. These strategies have resulted in approximately 70 percent of members selecting Oregon medical home providers.

**Balance the Needs of Payers and Providers**

Offering flexibility for payers and consistency for providers is challenging when making decisions around payment. Current multi-payer initiatives utilize various payment and reimbursement requirements. While some programs require each payer to pay the same amount, others have allowed payers to develop disparate payment amounts and methodologies. For example:

- In New York’s Adirondack Medical Home Demonstration, all participating payers agreed to pay an additional $7 per member per month.41
- In the Idaho Medical Home Collaborative, payers developed their own payment methodologies, which range from $15.50 to $42.00 per member per month.42

Idaho provides an example of how flexibility in certain programmatic features can increase and retain participating payers.43 Some payers may shy away from losing their competitive advantage by agreeing to reduce opportunities to differentiate their brand. Additionally, dominant payers may be reluctant to engage smaller payers in their market due to the simple fact that it would be easier for them to launch a single-payer initiative in which they retain full control of the design.44 By setting “guardrails” (i.e., allowable ranges in payment or other participation requirements), a state could better align the payers while still giving competitors an opportunity to differentiate themselves in the market. Setting guardrails for payment is a strategy that is particularly useful for states that have not obtained antitrust protections (see the text box for one example of how to set payment guardrails). Still, if it is feasible for a state, antitrust protection can facilitate and expedite the payment discussion, as well as serve as a platform for developing other shared resources across payers.45 It should also be noted that each market is different, and there are payers that have found that consistent payments ensure that everyone is paying their fair share.

Rather than setting guardrails, agreement across payers is likely necessary for other programmatic features, including initiative scope, practice qualification standards, and reporting metrics. These features should directly correlate to the goals clearly set for the initiative at the outset. According to nearly all of the key informants interviewed, clear and consistent requirements in these areas will ease the burden of participation on providers and promote the overall sustainability of the project. Failure to standardize these programmatic features could result in frustration for and lower participation by providers. Furthermore, having payers come to the table to develop a common set of quality metrics can be an effective way to engender trust and collaboration among payers and providers; this approach was well received in Ohio.46

**Illustrate the Value in Proving the Model**

As discussed earlier, many payers and purchasers have used the emerging evidence base of improved health and lower costs to justify their support of the medical home. Still, some payers and purchasers may be reluctant to participate without additional proof. Health care cost trends may help secure their participation. Between 1999-2008, health care premiums for employers rose 119 percent, well outpacing wage increases and inflation; left unchecked, premiums are expected to rise another 94 percent between 2008 and 2020.47 When presented with stark comparisons between participating and the status quo, some payers and purchasers may find the idea of doing something to be more beneficial than doing nothing.

Another strategy a state can use to secure the participation of reluctant purchasers and payers is to build a strong evaluation component into their program. If payers and purchasers want to see more data, they may see value in having an opportunity

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**The Comprehensive Primary Care (CPC) Initiative Approach**

The CPC initiative is a multi-payer demonstration where commercial and other public payers joined Medicare to transform the primary care delivery system in seven regions. For this program, Medicare announced their proposed program design, which served as an example to which commercial health plans were expected to align. Payers that applied to participate submitted their proposals independently to CMS, which then selected the payers that most closely aligned to their model. A similar approach may be beneficial for those states that have not secured antitrust protections for their payers or in cases where payers cannot agree to standardize payments.

The CPC solicitation can be found at: [http://innovation.cms.gov/Files/x/Comprehensive-Primary-Care-Initiative-Solicitation.pdf](http://innovation.cms.gov/Files/x/Comprehensive-Primary-Care-Initiative-Solicitation.pdf)
to add to the evidence base themselves. By participating, the payers and purchasers also have an opportunity to ensure that the data being collected is meaningful to them.48

**Key Considerations**

With the five overarching strategies above in mind, there are a few key considerations that remain:

- Legislation is a facilitator, not a requirement for success. The lack of legislation in and of itself should not be seen as a barrier. Many states, including Colorado,49 have successfully formulated and implemented a multi-payer program without the need for a mandate. However, states that are having trouble getting and keeping payers at the table may find legislation useful in starting the process. Still, state legislation alone is not enough to bring self-insured employers to the table due to ERISA preemption.50

- The medical home model is constantly evolving. States and other stakeholders should keep in mind that medical home standards look very different in 2013 than they did in 2006. Finding ways to allow a program to grow and adapt is an important consideration that may prevent payers from leaving a multi-payer effort to implement a new set of standards as part of a single-payer effort.

- Stakeholders should not underestimate the amount of time that planning and implementation can take. Convening stakeholders, practice transformation, honing the attribution model, and collecting meaningful data all take time. Giving the participating payers and purchasers an equal voice in setting specific milestones with a realistic timeframe can make all the difference in keeping payers engaged and at the table.

- Stakeholders will need to remember that patient costs may actually rise in the first year of a program, as patients who were underutilizing the health care system begin to receive the care they need but have not been receiving. One of the goals for a medical home program is to actually increase the primary care spend, which, as described in the Making the Case section, has the potential to lower overall health care costs. Stakeholders may find it more useful to focus on process or patient satisfaction metrics for the first year or two of the program and shift to health outcomes and cost measures beginning in year three.

- There are a number of organizations and programs dedicated to engaging payers and purchasers in advancing patient-centered delivery system reforms. Resources developed by the Patient-Centered Primary Care Collaborative’s Employers and Purchasers Stakeholder Center, the Robert Wood Johnson Foundation’s Buying Value and Aligning Forces for Quality initiatives, and the Catalyst for Payment Reform—among others—can help provide conveners and other stakeholders with additional information to inform program development and implementation.51

**Operationalizing Agreement**

Once agreement among stakeholders is reached, the question remains as to how that agreement will be operationalized (e.g., contracts or memorandums of understanding). Similar to the medical home programs themselves, there is no one-size-fits-all approach.

- In Colorado, antitrust concerns required each plan to develop their own contracts with practices; the convening organization, HealthTeamWorks, worked to reduce fragmentation by developing suggested contract language that each plan could adapt.52

- In Idaho, each member of the Idaho Medical Home Collaborative, which included representatives from all of the participating payers, signed a Charter agreeing to “make every effort to ensure [the pilot’s] success.”53 The participating providers signed a separate memorandum of understanding.54

- In New York’s Hudson Valley Medical Home Program, the stakeholders used an informal consensus-based approach that did not require any memorandums of understanding.55 Once the region was selected to participate in the Comprehensive Primary Care initiative, the Centers for Medicare & Medicaid Services provided a template memorandum of understanding; payment methodologies are considered confidential and are included as an appendix to each memorandum of understanding.56

- In Pennsylvania, the state’s Department of Health developed a single participation agreement that
In its role as a purchaser and a payer, states have opportunity to combine the purchasing power of Medicaid and the Children’s Health Insurance Program with the state employee health plan to shift the market by driving demand. States can also bring unique benefits in its role as a convener, such as legislative and regulatory authority to grant antitrust protection, existing business relationships with private insurers through Medicaid managed care and state employee health plans, and the clout of a governor’s or insurance commissioner’s office.

There is a natural synergy to the individual work already underway by payers and purchasers to improve care and lower cost for their members or employees; states have an important role to play in fostering trust among competitors and leveraging existing programs or building consensus on new or expanded infrastructure. The key is to find the balance that gives payers the flexibility they require to stay at the table (keeping in mind that they may actually be amenable to agreeing on common payment) while ensuring that the program provides enough standardization to ease the burden on participating providers.

ENDNOTES


6 Michael Bailit. Phone interview with authors. July 2, 2013.

7 Marcia Nielson et al., Benefits of Implementing the Primary Care Medical Home: A Review of Cost & Quality Results, 2012.


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15 Bruce Sherman. Phone interview.

16 Ibid.

17 Michael Bailit. Phone interview.


19 Ibid.

20 Bruce Sherman. Phone interview.


22 Brian Peace. Phone interview with authors. June 20, 2013.

23 Christopher Koller, Troyen Brennan, and Michael Bailit, “Rhode Island’s Novel Experiment To Rebuild Primary Care From The Insurance Side,” Health Affairs 29, no. 5 (May 2010): 941-7.

24 Phone interviews with Brian Peace (June 20, 2013), Bruce Nash (June 26, 2013) and Anshu Choudhri (July 1, 2013).

25 Bruce Sherman. Phone interview.


36 Bruce Sherman. Phone Interview.


40 MaryAnne Lindeblad. Phone interview with authors. July 10, 2013.


43 Brian Peace. Phone Interview.

44 Anshu Choudhri, email correspondence with authors. August 20, 2013.

45 Michael Bailitt. Phone Interview.

46 Jeff Biehl, email correspondence with authors. August 23, 2013


48 For additional information on measures that are meaningful for employers, please see the PCPCC’s white paper titled Medical Home Performance Metrics for Employers


50 ERISA, the federal Employee Retirement Income Security Act of 1974, preempts state regulation of self-insured employer-sponsored health plans.


52 Harbrecht and Latts, “Colorado’s Patient-Centered Medical Home Pilot Met Numerous Obstacles, Yet Saw Results Such as Reduced Hospital Admissions.”

53 The charter can be found at http://imhc.idaho.gov/Docs/IMHC_Charter_-_signed_-_Web_site.pdf
Acknowledgments
The authors wish to thank the following individuals who served as faculty for the Denver meeting that served as a foundation for this issue brief: Melody Anthony, Oklahoma Health Care Authority; Guy D’Andrea, Discern Consulting; Perry Dickinson, University of Colorado; Patrick Gordon, Rocky Mountain Health Plans; Marie Mues-Yores, Minnesota Department of Health; and Julie Schilz, Wellpoint.

The authors also wish to thank the following individuals who generously gave their time to inform and review this paper: Michael Bailit, Bailit Health Purchasing; Jeff Biehl, Access HealthColumbus; Anshu Choudhri and Saiza Elayda, Blue Cross and Blue Shield Association; Chris Collins, North Carolina Office of Rural Health and Community Care; Paul Grundy, IBM; Marjie Harbrecht, HealthTeamWorks; Joan Kapowich, Oregon Public Employees’ Benefit Board; Mary Anne Lindeblad, Nathan Johnson and Stephen Lewis, Washington State Health Care Authority; Bruce Nash, Capital District Physicians’ Health Plan; Marc Nielsen, Patient-Centered Primary Care Collaborative; Rebecca Pasternik-Kard, Oklahoma Health Care Authority; Brian Peace, Meg Hall, and Heather Clark, Idaho Department of Health and Wellness; Bruce Sherman, Employers Health Coalition, Inc.; Susan Stuard, Taconic Health Information Network and Community; and Anne Timmons, Maryland Department of Budget and Management.

The authors also thank Neva Kaye, Tess Shiras, and Mary Takach from the National Academy for State Health Policy for their contributions to this paper. Finally, the authors thank Melinda Abrams of The Commonwealth Fund for making this work possible.

Citation: