

## Overview of Activity in Selected States

State	Overview	Target Start Date	Target Population	Delivery System
Colorado	<p>Colorado has developed standards and is working on the systems piece to maximize the number of children enrolled in Medicaid or our SCHIP program (the Child Health Plan <i>Plus</i>) who have a medical home.</p>	July 1, 2008	<p>Colorado Department of Health Care Policy and Financing has the target population of Medicaid &amp; CHP+ children, and possibly adults. Colorado Department of Public Health and Environment has the priority of all children in Colorado.</p>	Fee-for-service for initial pilot
Idaho	<p>"Target for a Healthy Idaho" initiative will provide to each person access to a medical home under the direction of a primary care provider. Plan to concurrently address multiple system weaknesses, including its current shortage of primary care physicians and the supporting team of professionals. Idaho will focus first on technology to provide the foundation for patient-centered medical homes. Also, reimbursement is being reviewed to determine how to better support the medical home model.</p>	Pilot for the Health Data Exchange begins Fall 2008; medical home pilot dates undetermined at this time	Every state citizen	Primarily fee-for-service with some primary case management (PCCM) and managed care organizations (MCOs).
Louisiana	<p>In 2007, the legislature directed the state to develop and pilot a medical home system of care to increase access, improve quality and provide sustainability in medical care for the Medicaid and uninsured populations. This effort will build on the,</p> <ul style="list-style-type: none"> <li>• Existing CommunityCare program (state's PCCM program).</li> <li>• Planned Provider Service Network (PSN), an organized health system operated by health system/providers offering an integrated system of care.</li> </ul>	The PSN initiative is expected to begin in January 2010, however other medical home projects are underway	Medicaid beneficiaries are the target population for the PSNs and current PCCM program. Through partnerships we also hope to expand medical homes to additional citizens.	Currently a fee-for-service program with PCCM, may use other managed care structures in PSN

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Minnesota	New legislation has prompted the state to begin policy planning and drafting state plan amendments for Medical Home services provided to Medicaid enrollees. State is working with provider and patient communities to develop specific criteria and certify providers who meet those criteria to provide comprehensive care coordination and care plan development. Legislative criteria include participating in a learning collaborative, using an internal registry for patient population management, keeping updated care plans. Out criteria valued in Minnesota include parent/patient representatives on their care teams.	July 1, 2009	Medicaid beneficiaries (adults and children) beginning with those with chronic or complex conditions and all privately insured patients	Both fee-for-service and through contracts with managed care organizations.
New Hampshire	The NH Multi-Payer Medical Home Project is a pilot involving all payers, including Medicaid and Medicare, providers, and subject experts. These stakeholders plan to create primary care Medical Homes for adults with disabilities. The state hopes that primary care provider-directed teams will more comprehensively address patient needs and provide care management to improve Medicaid beneficiary health outcomes, optimize the appropriate use of medical services and minimize the loss to follow-up and churn of these needy patients. The state will shift the existing disease management budget, about \$1.3 million/year, to the program and use its Comprehensive Healthcare Information System (CHIS) in evaluation.	The private sector pilot will begin January 1, 2009  Medicaid participation will begin July 1, 2009	Adults with disabilities	Fee-for-service (Medicaid)
Oklahoma	The Medical Advisory Task Force (MAT) recommended the Oklahoma Health Care Authority (OHCA) modify the service delivery model to pure PCCM, while embracing the patient-centered medical home approach. OHCA's primary goals are to: <ul style="list-style-type: none"> <li>• guarantee the availability of a medical home with a primary care provider for all SoonerCare Choice members; that will <ul style="list-style-type: none"> <li>▪ enhance patient choice and participation in health decisions;</li> <li>▪ assure all members receive all necessary preventive and primary care;</li> <li>▪ reduce inappropriate emergency department visits and hospitalizations;</li> </ul> </li> <li>• realign payment incentives to improve cost effectiveness and quality; and</li> <li>• promote the use of health information.</li> </ul>	January 1, 2009	Populations approved for 1115 managed care demonstration: pregnant women and infants under age 1; children 1-18; adults with children in TANF; ABD-TEFRA children; breast and cervical cancer prevention and treatment women.	PCCM

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

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## Status of support and partnerships

State	Legislative Action	Governor's action	Groups or committees that include state representatives	Other relevant activity
Colorado	Legislation enacted	<ul style="list-style-type: none"> <li>• Signed the medical home bill (SB 07-130) as well as SB 07-211 which supported creating metrics related to medical home</li> <li>• Supported funding to provide enhanced reimbursement to a select group of pilot providers</li> </ul>	<ul style="list-style-type: none"> <li>• Medical Home Initiative supported state wide implementation of medical home</li> <li>• Colorado Patient Centered Medical Home Multi-Payor Pilot</li> <li>• Performance Measure Advisory Group</li> </ul>	<ul style="list-style-type: none"> <li>• 2003 NICHQ grant to support technical assistance for the development of the Medical Home Initiative including the active medical home learning collaborative and Parent Practice Partnerships (P3) support communication and partnering between providers and parents.</li> <li>• Colorado Children's Healthcare Access Program (CCHAP) refined a medical home model for CSHCN.</li> <li>• HRSA Systems Integration Grant for local implementation.</li> <li>• Developmental Disability Council adopted health as a priority area.</li> <li>• State agency representatives are members of a variety of committees focused on children's health and well-being.</li> </ul>
Idaho	Health Quality Planning Commission already in statute	<ul style="list-style-type: none"> <li>• Initiated "Target for a Healthy Idaho"</li> <li>• Created Select Committee on Health Care by executive order</li> </ul>	The Health Quality Planning Commission will review quality standards and information technology and pilot the Idaho Health Data Exchange	Medicaid embedded the medical home requirement in the Idaho Medicaid State Plan
Louisiana	Legislation enacted	Signed legislation Funding was included in the Governor's Budget for the establishment of the Provider Service Networks.	The Louisiana Health Care Quality Forum was established to convene all public and private stakeholders to advance quality initiatives in the state including the medical home.	<ul style="list-style-type: none"> <li>• Department of Health and Hospitals prepared for implementation of the medical homes through the Provider Service Network development.</li> <li>• DHH provided \$3.21 million, 3-year contract to the Quality Forum</li> <li>• Quality Forum won a CMS EHR demonstration award</li> </ul>
Minnesota	Legislation enacted	Signed 2007 and 2008 legislation	Academy Health/ Commonwealth Fund Quality Improvement Institute	MCHB and state funded Medical Home Learning Collaborative for Children with Special health care needs

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New Hampshire	No legislation	Launched the New Hampshire Citizens Health Initiative (CHI)	The CHI Medical Home Workgroup includes senior leadership from major payors as well as the NH Medicaid program.	<ul style="list-style-type: none"> <li>In 2009, the Medicaid Medical Home will have dedicated Medicaid funding of \$1.3 million per year.</li> <li>Comprehensive Healthcare Information System, an all-payer claims database, will facilitate program evaluation.</li> <li>New fiscal agent required to launch program; July 2009 program start.</li> </ul>
Oklahoma	Legislation enacted	Signed legislation creating the Patient-Centered Medical Home Task Force	Medical Advisory Task Force (MAT) collaborates with the Oklahoma Health Care Authority and is scheduling town meetings for providers	<ul style="list-style-type: none"> <li>Legislation requires study of concept for both government-supported and non-government-supported health insurance with report due by Dec. 1, 2009.</li> </ul>
Oregon	Legislation enacted	Signed The Healthy Oregon Act in 2007	Oregon Health Fund Board (OHFB) created committees that have included over 100 key stakeholders and consumers	<ul style="list-style-type: none"> <li>Legislature approved two primary care home pilots in Feb 2008</li> <li>Large Medicaid managed care plan with 4 pilots ongoing for past year</li> <li>Efforts in the Public Employees Benefit Board.</li> </ul>
Washington	Legislation enacted HB 2549 (Establishing a primary care collaborative) SB 5930 Blue Ribbon Commission SB 5093 Child Health Care	Formed a Blue Ribbon Commission (BRC) to develop a five-year plan	<ul style="list-style-type: none"> <li>The Rethinking Care Initiative</li> <li>Washington State Collaborative to Improve Health</li> <li>AcademyHealth/ Commonwealth Fund Quality Improvement Institute formed a public-private work group that includes legislative, executive branch, carriers, and provider representatives</li> <li>Primary Care Coalition</li> <li>Puget Sound Health Alliance</li> </ul>	<ul style="list-style-type: none"> <li>The Children's Healthcare Improvement System (CHIS) which promotes medical homes for children</li> <li>Emergency Department Diversion grant from CMS.</li> <li>Patient Navigator pilot program</li> <li>Existing Chronic Care Management Program</li> <li>Health Information Technology Expansion</li> </ul>

## State Definition for Medical Home

State	Definition	Source of Definition	Who in your state can serve as a medical home
Colorado	<p>"Medical Home" means an appropriately qualified medical specialty, developmental, therapeutic, or mental health care practice that verifiably ensures continuous, accessible, and comprehensive access to and coordination of community-based medical care, mental health care, oral health care, and related services for a child. A medical home may also be referred to as a health care home. If a child's medical home is not a primarily medical care provider, the child must have a primary medical care provider to ensure that a child's primary medical care needs are appropriately addressed. All medical homes shall ensure, at a minimum, the following:</p> <ul style="list-style-type: none"> <li>(a) health maintenance and preventative care;</li> <li>(b) anticipatory guidance and health education;</li> <li>(c) acute and chronic illness care;</li> <li>(d) coordination of medications, specialists, and therapies;</li> <li>(e) provider participation in hospital care; and</li> <li>(f) twenty-four hour telephone care.</li> </ul>	Patient Centered Primary Care Collaborative (PCPCC)	Certified providers and health plans
Idaho	Will be adopting the PCPCC definition	Patient Centered Primary Care Collaborative (PCPCC)	Any practice that meets the definition
Louisiana	The Joint Principles of the Patient-Centered Medical Home (PCMH Principles)	Patient Centered Primary Care Collaborative (PCPCC)	The standards for a medical home in Louisiana are the NCQA guidelines.

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

State	Definition	Source of Definition	Who in your state can serve as a medical home
New Hampshire	CMHI definition - The Center for Medical Home Improvement defines a medical home as a community-based primary care setting which provides and coordinates high quality, planned, family-centered health promotion, acute illness care, and chronic condition management. PCMH Principles, NCQA medical home standards for measurement and recognition.	PCPCC, NCQA	Any PCP providing medical services to the Medicaid disabled recipients can participate. PCP will be family practitioners, pediatricians or internists providing primary care
Oklahoma	PCMH Principles	PCPCC	In the SoonerCare Choice partially capitated program that will be transforming in January 2009 to a more enriched medical home model, we have individual physicians, physician assistants and advanced nurse practitioners as contractors, as well as groups of practitioners. Specialties include family medicine, pediatrics, and OB/GYN.
Oregon	Primary care medical home can generally be characterized as a primary care practice which provides the following to its patients: a continuous relationship with a physician; a multidisciplinary team that is collectively responsible for providing for a patient's longitudinal health needs and making appropriate referrals to other providers; coordination and integration with other providers, as well as public health and other community services, supported by health information technology; an expanded focus on quality and safety; and enhanced access through extended hours, open scheduling, and/or email or phone visits.	The Medical Home Model of Primary Care: Implications for the Healthy Oregon Act <a href="http://www.oregon.gov/OHPPR/docs/The_Medical_Home_Model_Final.pdf">http://www.oregon.gov/OHPPR/docs/The_Medical_Home_Model_Final.pdf</a>	Several different, grant-funded efforts going on currently and several more starting up, with the definition of the medical home varying in those pilots. One of the Oregon Health Fund Board's recommendations to the state is to develop a set of standards that all payers would use to incentivize a medical home, or as the Board discusses, an "integrated health home" which allows for multiple models as "the home" – medical-focused practices or clinics, behavioral health focused practices or clinics, with the appropriate collaboration with other disciplines. These standards would be set based on national and local efforts already going on, and reflect back to the state's similarly set of common quality standards.

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

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## Qualifying Practices and Measuring Performance

State	Status of criteria development	Approach to qualifying practices	Practice- and System level measures under consideration
Colorado	SB07-211 mandated performance measures related to the medical home legislation, SB07-130 Medical Home Legislation (CO Appendix I) Adopted Colorado Medical Home Standards for use	<ul style="list-style-type: none"> <li>• Annual certification of each provider conducted by state Medicaid agency</li> <li>• Certification process includes:               <ul style="list-style-type: none"> <li>▪ An office visit with providers and their staff</li> <li>▪ A parent satisfaction survey</li> <li>▪ A review of and training on medical home regulations</li> </ul> </li> </ul>	
Idaho	Reviewing materials	Reviewing materials	
Louisiana	Agreed to use NCQA/PPC	NCQA's Physician Practice Connections® Patient-Centered Medical Home™ Recognition Program (NCQA/PPC) plus additional state criteria  Quality Forum offering technical assistance to providers  Local projects aimed at building capacity and facilitating implementation	NCQA/PPC HEDIS; APA Hospitalization for ACSC
Minnesota	DHS and MDH are working with provider and patient communities to develop proposed criteria for certifying providers	<ul style="list-style-type: none"> <li>• Criteria proposed include               <ul style="list-style-type: none"> <li>▪ participating in a learning collaborative,</li> <li>▪ using an internal registry for patient population management,</li> <li>▪ keeping updated care plans, and</li> <li>▪ including parent/patient representatives on care teams</li> </ul> </li> </ul>	
New Hampshire	Agreed to use NCQA/PPC	<ul style="list-style-type: none"> <li>• NCQA/PPC</li> <li>• CMHI is developing a gap analysis package designed to assist primary care sites to prepare themselves to both meet these requirements and improve performance</li> </ul>	NCQA definition will be used to identify a medical home. Practice level structure and process measures, consistent with Medicare's PRQI program will likely be selected
Oklahoma	Oklahoma has developed a tiered reimbursement system with requirements stratified to reflect the advancement of the practice as a medical home.	Providers will conduct a self-audit when recontracting to identify the applicable medical home tier for the practice. The established tiers are also attached.	Quarterly excellence calculations will be reported to contractors.
Oregon	Development has started, in anticipation Oregon Health Fund Board recommendations to Legislature to develop a common set across public and private sector of measures and standards, esp for payment reform efforts.	Coordination with quality measurement efforts ongoing in state and nationally, including NCQA but wanting to avoid burdening providers with "certification" but focus on obtaining outcomes	NCQA/PPC HEDIS; APA Hospitalization for ACSC And state's own work around Common Measures via Alligning Forces grants

State	Status of criteria development	Approach to qualifying practices	Practice- and System level measures under consideration
Washington	<ul style="list-style-type: none"> <li>• Under development, performance measures developed following decision re: reimbursement mechanism which may include performance based reimbursement.</li> <li>• Considering using Puget Sound Health Alliance's provider guidelines and quality of care measures.</li> <li>• As part of the 2009 Medical Home Collaborative, performance measures will be defined.</li> <li>• Structure, process, and outcome measures are defined in CHIS.</li> </ul>	<ul style="list-style-type: none"> <li>• Undetermined; examination of NCQA standards underway.</li> </ul>	<p>Combination of structure, process and outcome measures to include:</p> <ol style="list-style-type: none"> <li>1. The number and rate of clinics that: <ul style="list-style-type: none"> <li>○ Implement and maintain 24/7 access.</li> <li>○ Do any of the following with Electronic Medical Records (EMRs): <ol style="list-style-type: none"> <li>i. Receive state grants for EMR purchase</li> <li>ii. Successfully implement EMRs</li> <li>iii. Implement a care coordination function within the EMR.</li> <li>iv. Implement registries for chronically ill individuals.</li> </ol> </li> </ul> </li> <li>2. Rate of adherence to clinical practice guideline performance measures.</li> <li>3. Parent assessment of medical home through annual clinic-based patient surveys.</li> <li>4. Rate of emergency department (ED) utilization for non-emergent and emergent/primary care-treatable care.</li> <li>5. Rate of hospitalizations for ambulatory care sensitive conditions</li> <li>6. Parent perception of quality of care.</li> </ol>

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## Restructuring reimbursement

State	Status of reimbursement structure
Colorado	<ul style="list-style-type: none"> <li>• Pilot program will offer enhanced reimbursement for EPSDT/well-child visits.</li> <li>• Has funding to provide enhanced reimbursement to Medicaid and CHP <i>Plus</i> providers meeting medical home standards, but exact structure is still in development, considering               <ul style="list-style-type: none"> <li>▪ Using a "pay for performance" mechanism for enhanced reimbursement.</li> <li>▪ A per member per month (PMPM) payment structure for health plans and primary care case</li> <li>▪ Supportive payment to health plans for CHP <i>Plus</i>.</li> </ul> </li> </ul>
Idaho	<ul style="list-style-type: none"> <li>• Medicaid currently pays medical home providers for identifying their diabetic patients on a registry and enhanced payments for evidenced-based procedures.</li> <li>• Medicaid pays medical home providers an administrative fee of \$3.50 PMPM in addition to reimbursing on a fee-for-service basis for face-to-face services.</li> <li>• Sub committee working with major payors and Medicaid to design structure.</li> </ul>
Louisiana	<ul style="list-style-type: none"> <li>• Multiple structures are currently under consideration including pay for performance, incentives to both providers and beneficiaries, potentially capitation or a shared savings model.</li> </ul>
Minnesota	<ul style="list-style-type: none"> <li>• Payment per enrollee will vary according to the severity of the enrollee's condition.</li> </ul>
New Hampshire	<ul style="list-style-type: none"> <li>• Overall medical home reimbursement structure under consideration will likely include a prospective monthly payment (PMPM) and Pay-for-Performance payments.</li> <li>• The Medicaid Medical Information System, set to begin in the summer of 2009, will be capable of creating a medical home designation, patient assignment, and prospective and incentive payments.</li> </ul>
Oklahoma	<ul style="list-style-type: none"> <li>• Will combine traditional fee-for-service office visits with:               <ul style="list-style-type: none"> <li>▪ a monthly care coordination payment for the practitioner or provider work that falls outside of a face-to-face visit and for the health information technologies needed to achieve better outcomes;</li> <li>▪ a visit based fee-for-service component that maintains an incentive for the practitioner or provider to see the patient in an office-visit when appropriate.</li> <li>▪ A performance-based component that recognizes achievement of quality and efficiency goals.</li> </ul> </li> <li>• Considering transition payments to assist some primary care providers with the shift from partial capitation payments to traditional fee-for-service.</li> </ul>
Oregon	<ul style="list-style-type: none"> <li>• Overall medical home reimbursement structure under consideration, especially in Medicaid.</li> <li>• The Oregon Health Fund Board recommends that payment reform should be designed to incentivize desired outcomes: quality, efficiency, health outcomes, and care coordination.</li> </ul>
Washington	<ul style="list-style-type: none"> <li>• Multiple methods under consideration; may test several through pilots. Methods include:               <ul style="list-style-type: none"> <li>▪ Pay for primary care through capitation or global fee.</li> <li>▪ Pay for performance and other incentive-based mechanisms.</li> <li>▪ DRGs and case management fees</li> <li>▪ APGs and risk factor adjustments</li> <li>▪ Base payment and incentives for quality</li> <li>▪ Capitation and risk factor adjustment</li> </ul> </li> <li>• Meeting slated September 15<sup>th</sup> with Michael Bailit and Enrique Gomez-Vidal to review national models, Wa models; compare and contrast models. Follow-up meetings planned to score models using agreed-upon evaluation criteria and develop recommendations for legislative report and action (September – December)</li> </ul>

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## Relevant Private Sector Activity, including Multi-Payor

State	Activity
Colorado	<p>Colorado Patient Centered Medical Home Multi-Payor Pilot is discussing medical homes for adult populations. This initiative is under development in Denver and the Front Range. The Steering Committee includes local and national Business Group/Employer representation, local and national health plans, local and national physician organization representation. Committed health plan participants include Anthem-WellPoint, Aetna, CIGNA, Humana, Rocky Mountain Health Plan, United and possibly Medicaid. The guiding principles for the pilot are the "Joint Principles for Patient Centered Medical Home" specifically including the 3-tier reimbursement model of FFS, Enhanced Care Management Fee and a P4P Model. The NCQA PPC-PCMH tool will be utilized for measurement. The Pilot Evaluation will include analysis on cost, quality and provider/provider office and patient satisfaction. Colorado Clinical Guidelines Collaborative is serving as the convening organization and providing technical assistance in practice transformation. Practice Transformation is based on the national Improving Performance in Practice program.</p> <p>Through HRSA grant, CDPHE is contacting other Colorado communities interested in implementation.</p>
Idaho	Two major commercial health plans rolling out pilot medical home models have agreed to work collaboratively with the committee on a statewide model.
Louisiana	The Quality Forum is working towards the development of a private insurance benefit package to support the principles of a medical home.
Minnesota	Current legislation requires medical homes be offered as part of private health plan coverage in Minnesota beginning in 2010. Health plan, provider and patient support for this unified effort
New Hampshire	The private sector portion of the NH Multi-Payer Medical Home Project pilot will begin on January 1, 2009, and run for two years. It will likely focus on 4-5 health care delivery systems in the state. NH Medicaid program will harmonize with the NH Multi-Payer pilot with respect to attribution, medical home definition, performance measures to the extent possible.
Oklahoma	
Oregon	<ul style="list-style-type: none"> <li>• The Oregon Health Care Quality Corporation has received a three-year grant from Aligning Forces for Quality, a Robert Wood Johnson Foundation. This grant is allowing the Quality Corp to use statewide and Willamette Valley market forces to help the chronically ill receive high quality health care.</li> <li>• The Oregon Better Health Initiative is reaching out to providers in Oregon and nationwide to change the culture of the delivery system, to embrace the medical home, and work with policy makers to adopt policies that promote change.</li> <li>• CareOregon and The Oregon Primary Care Association are working together in assisting CHCs to implement the primary care home, developing criteria for what a primary care home is, and aligning financial incentives to support that criteria.</li> <li>• The Oregon Business Association supports a pilot program of the robust medical home model of delivering healthcare</li> </ul>
Washington	<ul style="list-style-type: none"> <li>• Endeavors by privately sponsored groups have identified potential options for reimbursement approaches that support and promote medical homes. (follow-up meeting planned for September 15th.)</li> <li>• The Puget Sound Health Alliance has worked on provider guidelines and quality of care measures</li> <li>• Primary Care Coalition</li> <li>• Collaboration with the Washington Health Care Authority on reimbursement models and program change</li> </ul>

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## Infrastructure Plans to Provide Information to Providers and Patients

### Plans to Provide Information to Providers

State	Best practices	Individual Provider/Practice performance	Individual patient's health history and health status
Colorado	Colorado Medical Home Initiative (MHI) task forces with specific focus from the Provider Task Force and the Family Task Force.	Provider Hotline supported by Family Voices Colorado, CCHAP and HCPF. EPSDT Outreach and Case Management will support providers with information. HCP Regional offices will also provide training and outreach on the Colorado Medical Home Standards.	MHI is reviewing the options of parent controlled electronic health records. Colorado Immunization Registry. Develop comprehensive website for providers <a href="http://www.MedicalHomeColorado.org">www.MedicalHomeColorado.org</a> Specific training for parents
Idaho	In discussion		
Louisiana	Quality Forum	Quality Forum Quality Measurement Committee initiatives; Louisiana Right to Know Act	EHR Demonstrations; DHH disease management initiative; PSASG; PSN
Minnesota	Criteria proposed include participating in a learning collaborative		
New Hampshire		<ul style="list-style-type: none"> <li>Providers will be asked for voluntary participation, with direct outreach to high volume providers</li> <li>Plans to develop a statewide HIE system are under discussion with the Citizens Health Initiative</li> </ul>	<ul style="list-style-type: none"> <li>Pharmacy and fiscal agent claims level data will be directly available to providers from Medicaid program vendors.</li> <li>Plans to develop a statewide HIE system are under discussion with the Citizens Health Initiative. Provider access to pharmacy history is currently available through e prescribing program. Patient access to pharmacy history will be available with the next pharmacy benefits administrator program, Oct 09.</li> </ul>
Oklahoma			
Oregon	Learning collaborative in place via CareOregon, one of Oregon's Medicaid managed care plans. Want to expand	Quality Corp's Common Measures being implemented, and individual plans are providing feedback	Public Employees Board has discussed how to best work with its commercial plans to improve this, in progress Public Health role in development as well via the Oregon Health Fund Board

State	Best practices	Individual Provider/Practice performance	Individual patient's health history and health status
Washington	<p>One MCO (Community Health Plan) provides performance data (immunizations, well child care visits and ED utilization) to contracted RHCs and FQHCs.</p> <p>WA Medicaid FFS identifies clients over-using narcotics and provides data to all prescribing providers.</p>	<p>Combination of structure, process, and outcome measures as described in CHIS.</p> <p><i>Rethinking Care Initiative</i> provides historical utilization data on chronically ill individuals used by contractors to ensure clients have a Medical Home and if appropriate, care management services.</p>	<ul style="list-style-type: none"> <li>• Whatcom County WHInet allows providers to check results of patients' hospitalization and lab work, receive alerts to medication conflicts, duplicate therapies and allergies, send legible scripts to the pharmacy, track diabetic patients and review medical references, all online.</li> <li>• Large provider network is building on electronic medical record by building a common, care management internet tool.</li> </ul>

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## Plans to Support Patients

State	Providing patients with information on provider performance	Providing patients with information they can use to manage their own care.	Initiatives to support consumer activation in their medical homes
Colorado	Website for consumers to review provider credentials and complaints. Strong efforts within network of family advocacy groups to support anecdotal reporting. Access to the MHI	Redesigning the EPSDT Outreach and Administrative Case to better support the Colorado Medical Home Standards HCP Regional offices offer clinic systems and support for families, including a website. Linkages with other state agencies and community based organizations such as Family Voices and Family Resource Center. Messaging Task Force is currently developing orientation materials.	Under consideration. No formal plan developed.
Idaho	In discussion		The Governor's Select Committee on Health Care is taking a global approach. A sub-committee of this group is discussing the details, bringing together other groups, and working on a pilot with the two major private payors and Medicaid.
Louisiana	Louisiana Right to Know Act;	Louisiana Right to Know Act; Quality Forum Outreach and Education Committee's health literacy and patient empowerment initiatives	Incentives such as these will be incorporated into the development of the Provider Service Networks. Additionally, the Quality Forum has a focus of consumer education and empowerment of consumers to understand what they should expect from a medical home.
Minnesota			We are required to measure patient engagement. We have some general consensus in the state that patients should be involved in medical home team quality improvement.
New Hampshire	Plans to develop a statewide HIE system are under discussion with the Citizens Health Initiative	<ul style="list-style-type: none"> <li>• Pharmacy and fiscal agent claims level data will be directly available to providers from Medicaid program vendors.</li> <li>• Plans to develop a statewide HIE system are under discussion with the Citizens Health Initiative. Provider access to pharmacy history is currently available through e-prescribing program. Patient access to pharmacy history will be available with the next</li> </ul>	Support coordinators (I'm not sure what this means; here's my stab.) The current disease management program manger will run the program internally. At the PCP office, the expectation will be that offices will hire or otherwise dedicate a care manager to coordinate patient needs via a team approach.

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		pharmacy benefits administrator program, Oct 09	
Oklahoma			A pilot was approved in the legislature. We will furnish more information as this develops.
Oregon	Quality Corp's Aligning Forces Work and the State's working on provider performance. Already have hospital data up and available Oregon Health Fund Board will recommend increasing efforts, including HIT efforts.	Will develop and evaluate strategies to empower consumers to become more involved in their own health and health care by partnering and engaging with integrated health homes.	Our Public Employees' Benefit Board and our one Medicaid managed care plan are both starting to look at this, but primarily more from an education perspective not with incentives. Have been discussions on the use of incentives, but still very early in those.
Washington	<ul style="list-style-type: none"> <li>• The Puget Sound Health Alliance (PSHA) published a Report titled Community Checkup, a report to the community on health care performance across the region. It was developed with the cooperation and participation of Puget Sound physicians, clinic leaders, and others, including patients and employers. The report establishes a baseline for understanding health care in the local area.</li> <li>• Consumer survey data is provided to MCO enrollees to aid in plan selection.</li> </ul>	<ul style="list-style-type: none"> <li>• Self-management educational materials supplied by CCM Contractors.</li> <li>• Health information technology work by Health Care Authority to help patients maintain their own medical record.</li> <li>• The PSHA offers health literacy information called "Health in Plain Terms" to patients to help guide health care decision-making for patients as they work with their doctors to prevent and manage illness and better manage their own care. The initiative includes information to patients on how to access health information in local libraries.</li> <li>• The Patient Activation Measure is a survey tool used in both the Intensive Care Management Program and the Chronic Care Management Program to assess client readiness for changing behavior.</li> </ul>	In both the Chronic Care Management and Rethinking Care program/initiative, patient activation coaching and educational materials are provided to clients enrolled in these programs.

## Plans to support care coordination

State	Technology	Other
Colorado	<ul style="list-style-type: none"> <li>* State building infrastructure to support the increased use of health information technology (HIT) through enhancements and changes to the Medicaid Management Information System (MMIS).</li> <li>* Developing the Colorado Regional Health Information Organization (CORHIO).</li> <li>* CHP <i>Plus</i> managed care organization system upgrades to support medical home.</li> <li>* Medical Home Website for both providers and patients to support the entire community.</li> <li>* Reviewing models of patient-controlled electronic health records.</li> </ul>	<p>Redesigning the EPSDT Outreach and Administrative Case Management program to a "medical home navigators" model (implementation due July 1, 2009). SB211 requires development of care coordination and case management measures.</p> <p>Universal Care Plan developed for providers. Training is provided by MHLC.</p> <p>Linking and Aligning mental health care coordination within local communities</p> <p>CDPHE is finalizing a paper on overall care coordination.</p> <p>Project Bloom is finalizing a paper on care coordination for the early childhood system</p>
Idaho	<p>Will pilot the Idaho Health Data Exchange (IHDE) beginning this fall. The IHDE provides the capacity to electronically move health care information between different healthcare information systems.</p>	<p>Medicaid will implement its new MMIS (Medicaid Management Information System) in January 2010 which will provide greater flexibility for tracking data on medical home performance.</p>
Louisiana	<p>DHH has provided funding to support HIT, promote EHR adoption, health information exchange, and disease management programs. The Quality Forum won a CMS EHR demonstration awards to promote adoption of EHRs and quality reporting by primary care practices statewide.</p>	<p>Other care coordination includes comprehensive disease management; an integrated approach with the PSNs and primary care clinics (including PSASG); and a Behavioral Pharmacy Management Program.</p>
Minnesota	<p>Each PCC Practice will create and maintain an electronic, searchable Registry and a care plan for each PCC patient.</p>	<p>-The state is working with the provider and patient communities to develop specific criteria and certifying providers to provide comprehensive care coordination and care plan development.</p> <p>-2007 legislation gave DHS the authority to pay for provider directed care coordination</p> <p>-Each PCC Practice designates a Care Coordinator</p>

State	Technology	Other
New Hampshire	Will launch Medicaid Medical Information System in the summer of 2009. Both providers and patients will have access to claims history through new agent. New Hampshire providers have been early adopters of electronic health records (EHR), with fully functional systems at both the DHC and all of NH's community health centers.	The State's Comprehensive Healthcare Information System (CHIS) will facilitate program evaluation and benchmarking to the private sector and other state Medicaid programs.
Oklahoma		
Oregon	Governor has appointed a Health Information Infrastructure Advisory Committee to develop recommendations for widespread HIT adoption and interconnectivity, building on previous efforts under federal HISPC activities, and current Medicaid Transformation Grant to Oregon for a Health Record Bank Also recent FCC money to lay cable to rural portions of the state to assist HIT adoption with rural providers.	Oregon Health Fund Board will be recommend increased funding to support HIT adoption and interconnectivity.
Washington	Promote use of the Chronic Disease Electronic Management System (CDEMS), a Registry for patients and providers to help in care planning and patient management.  Promote use of HIT in medical clinics in WA by awarding grants to clinics participating in the WA Department of Health Collaborative.	<ul style="list-style-type: none"> <li>• The 2008 Collaborative focused on improving systems of care for patients with chronic diseases and for children with special health care needs (via medical homes)</li> <li>• Legislation mandates that the state improves coordination of primary, acute, and long-term care for clients with multiple chronic conditions and is key to the Medical Home expansion pilots.</li> <li>• Care coordination is supported in the CHIS.</li> <li>• <i>Rethinking Care</i> initiative has a Care Coordination activity or focus.</li> </ul>