



**STRENGTHENING PRIMARY AND CHRONIC CARE:
STATE INNOVATIONS TO TRANSFORM
AND LINK SMALL PRACTICES**

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ABSTRACT: Federal and state governments play a significant role in strengthening the delivery of primary care; current efforts, however, have disproportionately been focused on large or multispecialty practices. This report examines the roles states are playing to reorganize the delivery of primary and chronic care to produce more efficient and effective care for patients and providers, particularly in small practices. Through short case studies developed via interviews with state officials and physicians in Colorado, Michigan, North Carolina, Oklahoma, Pennsylvania, and Vermont, the authors highlight several state-based initiatives that seek to create high-performing health systems by targeting local and regional strengths. Additionally, the authors identify five themes critical to enacting strategic delivery system reforms: leadership and the convening of stakeholders, payment incentives, support for infrastructure, information feedback and monitoring, and certification and recognition.

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EXECUTIVE SUMMARY

Although most of the debate preceding the passage of the Affordable Care Act in March 2010 was focused on improving access to care, it is widely agreed that without equal attention to reforms that address cost and quality, the United States is destined to continue its path of uncontrolled, spiraling costs and poor overall performance. The issues are complex, and there is no silver bullet or panacea to solve the problems. This paper examines the roles states are playing to reorganize the delivery of primary and chronic care to produce more efficient and effective care for patients and providers, with an emphasis on small practices. The paper includes short case studies highlighting the diversity of work in Colorado, Michigan, North Carolina, Oklahoma, Pennsylvania, and Vermont, as evidence of effective policies and strategies being used to transform and link practices to improve primary and chronic care.

Federal and state governments have important roles to play in facilitating or establishing the primary care foundation, which is the backbone of an organized delivery system. There have been a number of recent initiatives to strengthen the delivery of primary care, but activity has disproportionately been focused on larger, multispecialty practices. Spreading change to smaller practices remains a challenge.

The state policy levers and actions highlighted in this study emphasize the following five strategic themes that will be crucial in affecting change. These are:

- *Leadership and convening*: bringing public and private payers and stakeholders together and brokering multipayer agreements;
- *Payment incentives*: using a variety of strategies to pay primary care providers for key elements infrequently reimbursed by other payers and to reward outcomes;
- *Support for infrastructure*: shared services to create a team-based approach, state-supported and organized learning, and information exchange;
- *Information feedback and monitoring*: data collection and reporting on process and outcomes; and
- *Certification and recognition*: meeting characteristics deemed necessary for optimal primary care using the certification of external organizations (such as the National Committee for Quality Assurance) or through state-conducted audits to ensure compliance.

Leaders in the case study states recognized that primary care practice behavior would not change unless payment changed. Findings also indicated that states pursued changes to emphasize more coordinated care across a range of chronic conditions rather than single conditions. The state-based initiatives highlighted in this report are evidence that states are working to create high-performing health systems using approaches and policy strategies that play to local and regional strengths and differences. The states vary greatly in their economic, social, and geographic environments. Highlights of the key features used by states include:

- Pennsylvania and Vermont had high-profile leadership support of the legislature and governor in directing efforts toward chronic care management and controlling costs.
- In Michigan and Oklahoma, state agencies asserted their influence to convene public and private entities in jointly planning for statewide primary care practice transformation.
- States utilize a variety of payment incentives to reimburse primary care providers for key elements infrequently reimbursed by other payers. One regional network in Pennsylvania uses a shared-savings model to pay providers for desired outcomes, while Michigan leverages managed care contracts to support elements of medical homes. Oklahoma learned that its former partial capitation payment did not directly support medical home principles and changed to a strategy using fee-for-service plus per-member per-month care coordination payments based on certification tiers, patient characteristics, and transition payments to help support practices during the first year.
- States provide support to practices to build the infrastructure for patient-centered care within the primary care setting and across the care continuum. Colorado funds community-based medical home navigators to help practices connect patients to community resources. Regional networks in North Carolina directly hire care coordinators to work within practices.
- States can help practices by setting targets for excellence and quality through process and outcomes measurement and reporting. All of the study states produce reports on a number of measures to enhance clinical processes and population management.
- States regulate or certify practices to ensure they meet the components for optimal primary care. In Oklahoma, providers self select an appropriate medical home level based on three predefined tiers. Pennsylvania ties payment to National Committee for Quality Assurance accreditation and other state-based criteria.

- States are supporting small practices by providing financial incentives and education. In North Carolina, each network organizes a quarterly meeting; care managers disseminate information from these meetings if providers are unable to attend.

Moving forward, both federal and state policies will play a significant role in strengthening the delivery of primary care. Several provisions in the Affordable Care Act create noteworthy opportunities for primary care in the development of workforce, payment, and practice innovation. Many states will have expanded opportunities to continue experimenting with alternative payment and delivery structures to strengthen primary care and develop the needed infrastructure and workforce. These efforts may benefit from the growing knowledge base developed by the innovative demonstrations and broad-based initiatives under way in the leading states. Finally, the promise of Medicare's participation looms as a potential significant accelerator in the next few years. For example, Medicare's participation in multipayer medical home payment schemes would greatly enhance states' ability to spread innovations, and its participation would also encourage private carriers to participate.

States can have a significant impact on strengthening primary and chronic care delivery through numerous actions to transform and link small practices. This report illustrates that states can lead the way in delivery system reform and share lessons among each other and with the rest of the nation.

Exhibit ES-1. Key State Strategies to Improve Primary and Chronic Care

	Colorado	Michigan	North Carolina	Oklahoma	Pennsylvania	Vermont
Overview of Approach	Medicaid and multipayer medical home initiatives focused on children and adults; patient-centered medical home (PCMH) certification of providers; payment changes	Created a consortium of public and private members that has led initiatives intended to: transform practices into PCMHs, address payment reform, engage consumers, and rebuild the primary care workforce	Statewide formation of geographically based provider networks to link primary care providers with safety net, specialty providers, local health departments, social services, and hospitals	Medicaid reform providing payment incentives based on a three-tiered, state-developed medical home recognition process	Multi-stakeholder collaborative tasked with establishing infrastructure change of chronic care delivery, resulting in a PCMH initiative based on payments for practice achievements	Establishment of communities organized around hospital systems to improve care through training, payment incentives, health IT use, evidence-based care, and community-based programs. Multipayer payment reform for chronic conditions across public and private payers
State policy levers and actions						
Leadership and Convening	Legislature passed bills requiring medical homes for children and Title V/Medicaid collaboration to create statewide medical home system Created broad stakeholder medical home advisory board	The Department of Community Health led efforts to establish the Michigan Primary Care Consortium (MPCC) and currently funds a portion of its operation State served as neutral convener to enable diverse stakeholders to discuss critical issues	Medicaid issued request for proposal to create Community Care of North Carolina (CCNC) and its networks CCNC oversees 14 local networks Created statewide physician advisory group	Medicaid-led transformation of delivery system from partial capitation to primary care case management Created Medical Advisory Task Force and led statewide town hall meetings	Governor created Chronic Care Commission tasked with creating and implementing a plan to roll out the chronic care model statewide Governor's office led meetings with stakeholders and payers establishing regional chronic care rollouts	Governor, with legislature support, enacted health care reform bill: Vermont Blueprint for Health Legislature passed bill requiring all commercial insurers to be payers in Blueprint pilots; appropriating funding to pay for Medicare's portion; establishing office for Blueprint leadership Blueprint led meetings with stakeholders and payers for pilots
Payment Incentives	Increase in Medicaid pediatric provider rates Pay-for-performance for certain preventive measures	Medicaid has requested that contracted managed care plans voluntarily provide incentive payments in at least two of the following areas: e-prescribing, expanded access, all-payer, or all-patient registry use	Fee-for-service and per member per month payments to CCNC providers and networks Pay-for-performance Shared savings (Medicare pilot)	Fee-for-service and per member per month care coordination fees adjusted for population and medical home tier Pay-for-performance for quality, screening, and immunizations Transition payments (Year 1)	Northwest Pennsylvania: Care management payments Practice support payments Value reimbursement payments Southeast Pennsylvania: Practice support payments	Fee-for-service and per member per month tiered based on NCQA level

Lump sum payments aligned with NCQA level						
Transition to pay-for-performance						
Infrastructure	Quality improvement practice coaches Medical home navigators	MPCC sponsored the Improving Performance in Practice program in Michigan PCMH toolkits Quality improvement coaches from industry MPCC has become a nonprofit corporation	Local networks Local quarterly meetings to support providers Provider toolkits	Health management program with care management for the top 5,000 high-needs patients; practice facilitators State-employed Medicaid nurse care managers for complex patients Quarterly meetings with large academic provider practice groups	On-site care-coordinators Registries or electronic medical records (EMRs) Learning collaboratives Practice coaches Registries or EMRs Learning collaboratives Patient self-management support	Community health teams On site care support On site support for NCQA certification Registries or EMRs Learning collaboratives Patient self-management support
Information Feedback and Monitoring	Cost and quality measures Provider and patient satisfaction	Data feedback to practices Quality measures Focus on adult diabetes and pediatric asthma	Data feedback to providers with technical assistance Costs and quality measures Health population management Gaps in care analysis reports	Data feedback to practices Cost and quality measures Provider and patient satisfaction Focus on diabetes, coronary artery disease, and asthma through health management program	Data feedback to providers with technical assistance Cost and quality measures Patient self-care Patient function and health status Engaged providers Focus on adult diabetes and pediatric asthma	Data feedback to providers with technical assistance Cost and quality measures Health status measures Focus on diabetes, hypertension, asthma; population health management and prevention
Certification and Recognition	For the children's initiative, Medicaid agency certifies practices that meet quality standards developed in eight domains NCQA standards recognized for both children and adult initiatives	Statewide definition of patient-centered medical home endorsed by Michigan payers, health plans, and providers Some pilots use NCQA recognition as the basis for incentive programs	Practices must sign an agreement certifying that they meet certain standards and show they have been accepted by a network	Providers complete forms that place them in one of the three tiers of medical home	Practices must achieve NCQA level 1 recognition, plus additional state-established criteria within a time limit Insurers whose market share exceeds 5 percent of Vermont business must participate in the multipayer medical home pilots (provision pending)	Practices paid additional payments based on NCQA recognition process score Insurers whose market share exceeds 5 percent of Vermont business must participate in the multipayer medical home pilots (provision pending)

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INTRODUCTION

Although most of the debate preceding the passage of the Affordable Care Act in March 2010 focused on improving access to health care, without equal attention to reforms that address cost and quality, the United States is destined to continue on its path of uncontrolled, spiraling costs and poor overall performance.

The Commonwealth Fund Commission on a High Performance Health System has identified six attributes of an ideal health delivery system and calls for policy reforms that promote greater organization of the delivery system.¹ Here are the six attributes needed at the local level to achieve an ideal health care delivery system:

1. Clinically relevant information available to all providers at the point of care through electronic medical records (EMRs).
2. Patient care coordinated across providers and transition settings.
3. Providers (and practice team members) collaborate across settings.
4. Patients have easy access to care that is culturally competent and responsive.
5. Clear accountability for the total care of patients.
6. Ongoing innovation and learning to improve quality, value, and patient experience.

Achieving these attributes will require not a single fix, but a diversity of approaches to account for regional and local differences. In all cases, policies must support and build a strong primary care foundation. Federal and state governments have important roles to play in establishing this foundation, which is the backbone of an organized delivery system. There have been recent initiatives to strengthen the delivery of primary care but they have disproportionately focused on larger, multispecialty practices. Spreading change to smaller practices remains a challenge.

This paper examines the leadership roles states are playing together with other payers to better organize the delivery of primary and chronic care to produce more efficient and effective care for patients and providers, with an emphasis on small practices. Semiformal telephone interviews were conducted with state officials and

physicians in Colorado, Michigan, North Carolina, Oklahoma, Pennsylvania, and Vermont. Input from an advisory group was used to select these states.²

To understand a variety of models that recognize the needs of smaller practices, we sought information from the perspective states, as well as practices. In this paper, we discuss the importance of primary care, small practices, and the policy levers and actions available to states. Using the case studies, we provide a snapshot of how policies are being used to build this delivery system, with a special focus on how these approaches affect small and rural practices. In addition to state officials, sources include family physicians in solo or two-physician practices (Vermont and Oklahoma), a medical director from an area health plan (Pennsylvania), a medical doctor from a physician–health organization (Michigan), and staff from key community agencies (Michigan, Colorado, and North Carolina). We conclude with an analysis of key roles for states, as well as a discussion of federal policies that are needed to encourage, support, and sustain these innovations and the opportunities afforded by the health reform bill to do so.

Highlights from the state profiles include:

- **Colorado** supports better primary care through its Medicaid medical home initiative, intended to maximize the number of children enrolled in Medicaid and the Children’s Health Insurance Program (CHIP) who have access to a “medical home system,” using payment incentives and a state-developed medical home certification process. Sixteen practices in the state are also participating in a multipayer medical home pilot convened by a nonprofit collaborative. The pilot provides enhanced per-member per-month (PMPM) payments and technical support for participating practices to achieve National Committee for Quality Assurance (NCQA) standards.
- **Michigan** advances its primary care goals through a consortium of public and private partners established to improve the delivery of preventive and chronic care, address workforce gaps, align quality improvement initiatives, advance the patient-centered medical home (PCMH), and engage consumers. Since its inception in 2006, the consortium has set definitions for Michigan’s PCMH standards and convened providers to construct payment incentives and was awarded grant funds to streamline primary care and improve treatment for chronic disease. The state has also launched practice transformation initiatives and Medicaid managed care contracts to drive providers toward PCMH adoption.

- **North Carolina** has formed 14 regionally based nonprofit provider networks to link primary care providers with safety-net providers, specialty providers, local health departments, social services, and hospitals. Physicians may voluntarily enroll in a network and receive a PMPM payment for meeting state medical home requirements and network data collection and reporting standards. The networks provide shared services such as pharmacists, dieticians, and care coordinators to the practices. Each network is given a PMPM management fee based on its number of enrolled Medicaid recipients.
- **Oklahoma** is reforming its Medicaid program to support a medical home model, based on recommendations from a task force initiated by the state's Medicaid providers. PCMHs and payment reforms were listed as the top provider priorities for health reform and, as a result, a new payment model was created consisting of a fee-for-service reimbursement of office-based services and per-member per-month fees to reflect the ongoing cost to the practice of serving as a medical home, as well as payments to support practice transformation and performance-based measures.
- **Pennsylvania**, through an executive order, launched a multi-stakeholder collaborative to target chronic care delivery reform. The collaborative's work resulted in an initiative that uses a medical home framework to establish payment incentives for practice transformation and meeting performance measures. Pilots of the initiative have been gradually rolled out by geographical regions, with modifications made to account for regional flexibility, competing insurer interests, and lessons learned from established pilots.
- **Vermont**, backed by legislative support, initially selected six communities to participate in practice transformation pilots targeting improved diabetes care and prevention through provider trainings, payment incentives, use of health information technology (IT), community outreach, and evidence-based care. Later legislation expanded these pilots within three communities to test payment reform measures targeting multiple chronic diseases. Statewide expansion is planned. All payers are participating, including Medicaid and private insurers with provider incentives that include PMPM payments, payer-funded "community health teams," and subsidization for Medicare payments.

TRANSFORMING PRIMARY AND CHRONIC CARE

The contribution of primary care to a high-performing health system has been well documented.^{3,4} It has been demonstrated to improve population health, reduce health disparities, produce healthier patients, and lower total health care costs.⁵ Similarly, chronic care models emphasize the need for good primary care delivery systems to enhance disease management.⁶ Primary care must fulfill the following functions to be assessed as “good” primary care:

- Be the first point of contact for each new need.
- Provide continuous, ongoing care focused on patients’ health, well-being, and preventive care.
- Offer comprehensive care that addresses most common health needs, considers the patient’s health preferences, encourages self-management techniques, and develops health literacy.
- Provide a resource for patients when they must seek specialty care elsewhere to ensure care is well-coordinated, integrated, and timely.⁷

Primary care providers are in demand, and the workforce overloaded, due to an increase in the incidence of chronic disease, a high proportion of patients with mental illness, and an escalating shortage in providers.^{8,9,10} In the face of such demand, there has been a focus on building models of care that help strengthen practices’ ability to deliver good primary care and meet the six attributes of an ideal delivery system described previously. Without a strong foundation of high-performing primary care practices, we will be unable to build integrated, accountable delivery systems.¹¹ Two models that are currently being broadly tested throughout the United States are:

- *Patient-centered medical home model*: an approach fostered by four primary care physician organizations that focuses on providing comprehensive primary care for children, youth, and adults with an emphasis on quality and safety. It embraces seven principles: personal physician, physician-directed medical practice, whole-person orientation, coordinated and integrated care, enhanced access, quality and safety based, and payment that recognizes value.¹²
- *Chronic care model*: an approach that starts with a strong primary care or medical home base and builds additional skills for providers and the patient to effectively manage chronic illnesses. These skills include six critical elements: health care organization, community resources, self-management support, delivery system design, decision support, and clinical information systems.¹³

Both models show promise in helping to reform the delivery of primary care, but many of the initiatives that employ these and other models have focused on larger practices, leaving out smaller practices.¹⁴ Yet, 32 percent of U.S. physicians practice in solo or two-person practices and 75 percent of all primary care physicians practice in office-based settings with five or fewer physicians.^{15,16}

What Small Practices Need to Transform

Both the PCMH and chronic care models call for systems of care that incorporate evidence-based treatment protocols, patient tracking, and referral systems, as well as team-based care that includes behavioral health specialists, nutritionists, and designated care coordinators. Payment that recognizes and supports the day-to-day cost of functioning in these models is critical to practice improvements. However, especially for small practices, paying for just the day-to-day cost of providing care is unlikely to provide sufficient impetus and revenue at the outset to allow practices to implement the models. Further, even with startup funding, an individual small practice is likely to never have enough volume to support a team with all the necessary members. States can support small practices through multiple policy strategies, but to appropriately apply these strategies, states first must understand what practices need to transform the way they deliver care:

1. *Identifying what needs to change and how to make the changes.* A physician's primary concern is caring for patients, not systems redesign. In addition, because most current reimbursement systems pay on a fee-for-service basis, practices may not be able to take sufficient time away from providing visits to think about systematic care improvement. States have met this need by sending experts into individual offices to work with practices to identify and make changes. They have also funded ongoing learning collaboratives that bring teams from practices together to identify and make needed changes and provided short-term "transformation" payments to augment internal resources. In addition, they can assist by providing practices with performance information.
2. *Sharing resources to provide practices with access to a multidisciplinary care team.* Some states have provided practices with funding to support a care coordinator. However, even if able to afford them, very small practices may not need full-time care coordinators, nutritionists, or behavioral health specialists. States have met this need by providing state or contractor staff who fulfill those functions for multiple practices, facilitating (or requiring) practices to form networks that can pool resources to pay for these services, banding together with other payers to fund teams that support all of the practices in a community, and

- fostering colocation of separately funded behavioral health specialists with primary care practices.
3. *Means to purchase and use new tools.* There are many new tools available to help practices improve performance. Clearly, advances in health information technology (e.g., all-patient registries, e-prescribing, electronic medical records, and health information exchanges) have great potential to improve care. In addition, new tools are being developed that better support patient engagement and self-management of chronic conditions. Small practices, however, cannot always afford the latest tools, or, if they can, do not have the expertise or time needed to select and implement these new technologies. States have met this need by providing practices with funds (or loans) to purchase items, by offering direct access to systems maintained by the state, and by providing consultation to practices to enable them to select and implement new technology.
 4. *Payment methods that support new models of care.* To sustain new models over time, practices need financial incentives that reward the adoption and use of such models and tools. They need a payment mechanism that rewards ongoing transformation, as well as initial adoption.
 5. *Streamlined administrative requirements.* Practices' administrative functions are a common source of frustration and inefficiency. Simplifying administration by streamlining the varying requirements of multiple payers would allow practices to focus on caring for patients and improving care. For example, states can bring payers together to reach consensus on common performance goals, measures, or reimbursement models. All practices benefit from this, but small practices, which often have very limited administrative resources, may benefit more than large ones.

State Impetus for Action

States decide to implement strategies that support small practices for a variety of reasons. The states profiled in this report were driven to invest in these programs by a combination of the following four factors:

1. *Patients were not getting the primary care they needed.* For example, Colorado's efforts were spurred by research showing that 180,000 children in or eligible for Medicaid and CHIP were unable to find a medical home.¹⁷ Similarly, Oklahoma Medicaid found that its existing payment structure (capitation for primary care) was not motivating primary care providers to see patients for regular checkups until the state started rewarding practices explicitly.

2. *Chronic care was poorly delivered, wasting money and harming patients.* In 2003, a study found that nationally, people with chronic conditions received only 56 percent of recommended care.¹⁸ Complementing this national finding, Pennsylvania traced 78 percent of its total health care costs to 20 percent of patients with chronic diseases and found that the state's rate of hospitalizations that could have been avoided by better treatment of chronic conditions was among the highest in the country.¹⁹ Vermont found that "chronic conditions [were] the leading cause of illness, disability and death, and consumed more than three quarters of the \$3.3 billion Vermont spends on health care annually."²⁰
3. *A "system fix" was needed, including payment and delivery reform, across multiple sites and conditions.* Fee-for-service, especially when coupled with low reimbursement rates, often forced providers to spend less time than needed with patients. Alternatively, one state found that capitating primary care services alone resulted in perverse incentives. Because practices received the same payment amount whether their patients came to the office or not, some practices made insufficient effort to provide patients with regular checkups. Efforts that focused on a single condition were similarly flawed, because there was no incentive to improve care for all conditions.
4. *Public support by key stakeholders.* North Carolina, the longest operating program profiled, established its program when many other states were transitioning their Medicaid programs to commercial, capitated managed care organizations. Physicians worked with the state to develop the program and viewed it as a desirable alternative that allowed them more control and protected their reimbursement rates.²¹ Similarly, Colorado and Pennsylvania established stakeholder groups that included providers, payers, and patients. Finally, employers and other large payers in Michigan supported changes, in part because cost trends were perceived as unsustainable and because new data showing the potential for improvement were available.

State Policy Levers and Actions

States have many options for strengthening the ability of small, independent and rural practices to transform care. In this section we describe five strategies to organize the state policy levers and actions and include a few examples from the states that are using them.

Leadership and convening. High-profile leadership from the governor or legislature can draw attention to the need to improve and set a course for improvement that supports small practices. These leaders also have the power to commit resources to the effort and to mandate participation in payment change, either in pilots or by using

leverage (e.g., all insurers who do business with the state must participate as a condition of doing business in the state).

States are effective conveners for a variety of reasons. The governor and legislature have the power to establish commissions and convene study groups that bring public and private sector partners together. In the case of Pennsylvania, such efforts created ongoing partnerships that supported implementation. This can also occur at the agency level. Oklahoma Medicaid, for example, convened a physician advisory group to help plan efforts. Finally, antitrust issues can arise in multipayer projects, and the state's participation as convener (as happened in Michigan and Pennsylvania) can address some of those concerns.

Payment incentives. States are major payers in the health care system. They pay for services provided to Medicaid and CHIP participants, as well as to state employees. States can structure their payments to support primary care practices, including small practices. Of course the portion of any one practice's patients who are covered by state funding varies widely. As a result, practices with a greater proportion of state-funded patients will benefit more from payment strategies than those with a smaller portion; when states partner with private payers, the impact increases proportionally. States have developed many innovative payment strategies to support primary care practices, as described below.

- *Changing how, and how much, they pay for primary care services.* On the average, primary care providers earn less money than other specialists. Some states have raised the rates they pay to primary care providers to address this problem.²² Other states have changed their billing policies to allow providers to receive payment for some key primary care services that are infrequently reimbursed by other payers, such as care coordination, screening for substance abuse, or identification of children who may be at risk for developmental delay.²³
- *Paying primary care providers for the ongoing day-to-day cost of serving as a high-performing medical home.* In recent years, most states that have defined performance expectations for high-performing medical homes have also provided additional funding to primary care providers who demonstrate that they meet those expectations. Some states vary these payments based on the characteristics of the patients served or the qualifications of the medical home—paying more for patients with more complex needs or to practices that meet more stringent criteria. Most of these states pay qualified practices a separate per-person per-month

payment in addition to standard fee-for-service payments for medical services.

Additional payment methods under consideration include:

1. an additional lump sum payment, above fee-for-service;
 2. an enhanced fee-for-service payment made for specific visits, such as well child visits, when these visits are provided by a qualified provider to patients who recognize the practice as their medical home;
 3. creation of a separate billing code for additional medical home costs, and payment for that code when it is billed in conjunction with a qualified visit provided by a qualified provider to a patient who has chosen that provider as his or her medical home; and
 4. separate additional per-person per-month payments to networks of primary care practices and other providers; the networks use the funding to support shared resources, such as care coordinators, that work with multiple practices.
- *Paying primary care providers for achieving desired outcomes.* States are using a variety of pay-for-performance and shared savings (sometimes known as “gainsharing”) methods to reward desired care, foster efficiency, and achieve stated outcomes.
 - *Leveraging managed care.* Whether through Medicaid or through providing benefits for their employees, many states purchase health care through managed care. This provides some opportunities for supporting small practices by leveraging the purchasing process. For example, states could consider potential contractors’ plans for supporting small practices in plan selection or establish contract requirements that require plans to support primary care.
 - *Providing financial incentives for patients.* In their Medicaid or state employee programs, states can create financial incentives for patients to select a medical home, either in state-only or multipayer initiatives. None of the states profiled here are currently using this potentially powerful tool.

Support for infrastructure. States can, and do, provide other support to practices that enable them to build the infrastructure needed to foster patient-centered care within their practices and between the practice and other providers, settings, patients, families, and caregivers. Recognizing that many small practices cannot move to a team model without sharing some services, they can provide those shared services in a variety of ways. Some specific strategies states may use include:

- *Providing state-funded staff that supports practices.* Colorado, for example, funds community-based “medical home navigators” that will help practices, including small practices, connect patients to resources in the community. Similarly, Oklahoma Medicaid staff is available to help practices in that state coordinate the care of individuals with complex needs—those patients who need more support than can reasonably be provided by a small practice.
- *Fostering the development of community networks to provide nonphysician shared services that support a team-based model.* Although payment is important, several states, such as North Carolina, started their networks before they had approval from the Center for Medicare and Medicaid Services to pay the networks. Even without payment, they found the network infrastructure was effective.
- *Organizing and funding provider training opportunities, including learning collaboratives, continuing medical education, and on-site practice coaches.* The learning collaboratives and practice coaches are designed to assist practices in incorporating their new knowledge into their standard office practices. This assistance may be particularly valuable for small practices that have few administrative resources and are less likely than large practices to have internal staff dedicated to quality improvement.
- *Brokering expenses.* On a very practical level that goes beyond the antitrust protection afforded by states as conveners, states can collect use tax returns or practice expense reports, determine the ratio each payer needs to contribute, and bill the payers directly for their share of expenses for infrastructure, care management, practice coach payments, etc. Pennsylvania uses this approach.
- *Enabling small practices to obtain and use technology to improve patient care.* Some states are developing health information exchanges or offering providers access to Web portals to help providers obtain information about the services provided to their patients by other providers. Some are supporting practices in obtaining and implementing electronic health records or referral tracking systems that will allow providers to more efficiently and comprehensively track patients’ needs, utilization, and health status. They can also provide practices with training and access to materials that help practices empower patients to be more involved in selecting treatment options and managing their own conditions. Some states are also relying on technology in this area—providing patients with access to electronic health records or access to Web portals that help them make more informed decisions, see test results, or coach them in managing their conditions. Since small practices are often very busy and may not have the expertise to effectively implement these

new tools, some states, such as Oklahoma and Pennsylvania, are helping to integrate the tools into day-to-day office operations.

Information feedback and monitoring. States can also support excellence in primary and chronic care through process and outcomes measurement and reporting. Measures may target test duplication, access to after-hours care, and percent of a practice's population receiving all age-appropriate preventive services. States can provide quality measurement feedback to individual practices on patient characteristics and utilization and help a practice compare its performance with other practices or against benchmarks. This information helps practices identify what they need to improve and provides them with information to do so.

Certification and recognition. States can recognize, regulate, or certify practices to ensure they meet characteristics deemed necessary for optimal primary care. They can either accept external organization's (e.g., NCQA) certification or conduct their own audits. Most states today tie certification to the payments they make to practices; other payers can use the states' processes in a coordinated effort for a larger impact.

CASE STUDIES

COLORADO

The strong culture of private and public stakeholder collaboration in Colorado has fueled initiatives that seek to better support family- and patient-centered primary care. Colorado is home to integrated health care systems like Kaiser Permanente and Denver Health, and cooperative communities like Grand Junction that deliver low-cost care and high-quality outcomes through a coordinated, team-based approach. The state is modeling some of these systems to better support all physicians and become a “medical home” state.

In addition to the efforts profiled here, there are other activities that serve to transform practice in Colorado. For example, the Colorado Association of Family Medicine Residencies, which is a part of the state’s medical safety net, experienced difficulty working with multiple competing residency training programs in the state. Their ongoing challenges led them to the idea that was eventually funded by the Colorado Health Foundation to integrate the primary care medical home model into the curriculum. These residency programs now collaboratively develop curriculum and share best practices to improve the care delivered to 75,000 patients, of which 58 percent are Medicaid, Medicare, or uninsured patients.²⁴ Likewise, commercial health plans are interested in attracting more physicians to primary care and supporting efforts to increase their ability to coordinate patient care but are finding a lack of sufficient data measuring the impact of patient-centered medical homes. To begin assessing the local impact, the Colorado Trust funded a two-year, \$1.4 million pilot program. The program involves five of the state’s largest private health plans and Medicaid and enhances compensation to 17 internal or family practices, serving more than 25,000 patients. These practices have agreed to follow the patient-centered medical home model and will receive additional incentive payments for meeting quality benchmarks and coordinated care metrics.

Developing a Medical Home System to Support Primary Care

Colorado launched the Colorado Medical Home Initiative in 2008. This initiative was in response to a survey conducted in 2006 that found Medicaid children had significantly poorer outcomes than children with private health insurance. These findings were likely related to other research that showed only 20 percent of private pediatric practices were accepting Medicaid or Child Health Plan Plus (CHP+), Colorado’s CHIP. About 140,000 children in or eligible for Medicaid and CHP+ were unable to find a medical home.²⁵ Although this initiative focuses on Medicaid and CHP+ beneficiaries, the goal is to develop a system to support medical homes for all families.

The legislation establishing the state’s initiative required the Colorado Department of Health Care Policy and Financing (HCPF), in conjunction with the Colorado Department of Public Health and Environment (CDPHE), to develop systems and standards to maximize the number of children enrolled in Medicaid and CHP+ who have a “quality” medical home.²⁶ The Colorado Medical Home Initiative (administered by the CDPHE) has led to the two agencies collaborating on the development of a medical home system, utilizing existing state and local infrastructure (e.g., personnel, processes, procedures, and materials) to meet two distinct purposes:

1. To support providers to become certified medical homes by ensuring the availability and accessibility of required health care resources.
2. To support Medicaid and CHP+ children and families to effectively use these resources.²⁷

Building a medical home system resulted in many public/private partnerships, including one with the nonprofit organization, Colorado Children’s Healthcare Access Program (CCHAP). With foundation support, CCHAP was tasked with increasing physician participation in Medicaid and CHP+ and ensuring that participating practices have access to needed resources to meet medical home standards.

Enhanced Payments Tied to Enhanced Expectations

State agencies and CCHAP have worked together to improve Medicaid payments to physicians and to build support services for practices and families. As a result, the number of private pediatric practices accepting Medicaid and CHP+ soared from 20 percent to 93 percent by October 2009.²⁸ Colorado Medicaid also increased evaluation and management codes for primary care visits to 90 percent of the Medicare rates. In addition, practices receive a significantly higher bump for Medicaid preventive visits (between 120 percent to 130 percent of the Medicare rate) if they complete a medical home index ²⁹ questionnaire and meet medical home standards developed by the state.³⁰

**Support Services Available for Colorado Primary Care Practices
to Provide Medical Homes for Medicaid and CHP+ Children**

Administrative Supports

Enhanced provider reimbursement

Enrollment and eligibility assistance (e.g., community outreach using school-based health centers to identify and enroll eligible children and a Spanish-language soap opera that includes information on applying and using public health insurance)

Review of office process (e.g., assistance with billing and claims forms and identifying items for which practices could be paid but are not currently paid)

Connections for practice administrators (e.g., provider network to support interactive learning opportunities)

Family Supports and Clinical Services

Social services support (e.g., access to care coordinators, medical home navigators and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) to assist families in accessing services and meetings to bring practices together with social services agencies)

Mental health services (e.g. primary care providers are provided access to on-call mental health experts for children)

Case management/care coordination services

Immunizations

Transportation to medical and social services

Cross-cultural communication training

Hotline for children with special health care needs

Developmental screening services, with explicit payment to providers

Becoming an Effective Medical Home (a program in which families complete the Colorado standards and medical home index; CCHAP reviews the scores and works with the practices to improve office processes)

Continuous quality improvement/best practices (technical assistance to improve efficiency or “medical homeness”)

Source: Colorado Children’s Healthcare Access Program, 14 Support Services for Colorado Primary Care Practices, Jan. 17, 2010.

Enhanced payments come with expectations. To receive the added payments, practices must fulfill the following steps to become certified as a Colorado medical home:

- Orientation on support services, organized by CCHAP, which often include in-person meetings with community resources such as Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program workers to understand the resources available to families and practices. EPSDT workers provide many of the core services to support families (and practices), including linking families to low- or no-cost services, educating families about preventive health services, and following up on referrals, as well as missed appointments.
- Practices conduct a self-assessment using an abbreviated medical home index. A navigator schedules an on-site group visit with the practice to assist with the assessment. Medicaid provides funding to the nonprofit Family Voices of Colorado to hire navigators to certify practices as medical homes.
- Families in the practices undergo an informal interview by the navigator to assess the practice's "medical homeness."
- CCHAP quality improvement coach (a masters-level professional) contacts the practice manager to discuss the medical home index results.
- Practices work with a coach to develop strategies for making quality improvement changes, as well as measures to evaluate the effectiveness of changes. Practices must conduct a quality improvement project to be recertified as a medical home.
- Practices also must meet Colorado medical home standards that include expanding access to care, using certain evidence-based guidelines, and participating in the immunization registry. Practices must be certified annually by navigators. (See [Appendix C](#) for standards.)

Although not a formal practice redesign, the quality improvement projects are often a door to help practices rethink policies and procedures and have included projects such as improving family involvement in practices and increasing use of developmental screening, referrals, and follow-up. In addition, CCHAP conducts bimonthly practice managers network meetings to provide support on a wide array of issues, including, for example, billing and claims processes that act as Medicaid barriers.

A CCHAP representative stated that small practices would greatly benefit from additional state intervention in the following areas:

- *Better data.* Practices are not getting high-level data feedback that would help improve performance.
- *Better payment to pediatricians.*
- *Support for electronic communication.* Currently, medical home standards do not require an electronic medical record, but communication among providers and families could be greatly enhanced through this tool.
- *Improved family education about medical homes.*

In addition, practices in the state are being transformed through a two-year, multipayer, multistate PCMH pilot convened by the nonprofit Health TeamWorks, which began in 2009. Public and private payers have agreed to provide enhanced payments between \$4 and \$8 per member per month to 16 family medicine and internal medicine practices. Most of the practices have four physicians or fewer. The payment system builds on fee-for-service with a per-member per-month care coordination fee and performance payments for practices that meet or exceed quality benchmarks. Practices are provided technical assistance to meet NCQA Physician Practice Connections–Patient Centered Medical Home (PPC–PCMH) standards through on-site quality improvement coaching, learning community webinars, and learning collaboratives. Practices are required to submit monthly progress reports and prevention, wellness, and chronic disease quality measures; have registry functionality for population management; and employ a care coordinator. Practices are provided with assistance in helping to connect patients to community services, many of which are provided through the state’s public health system.

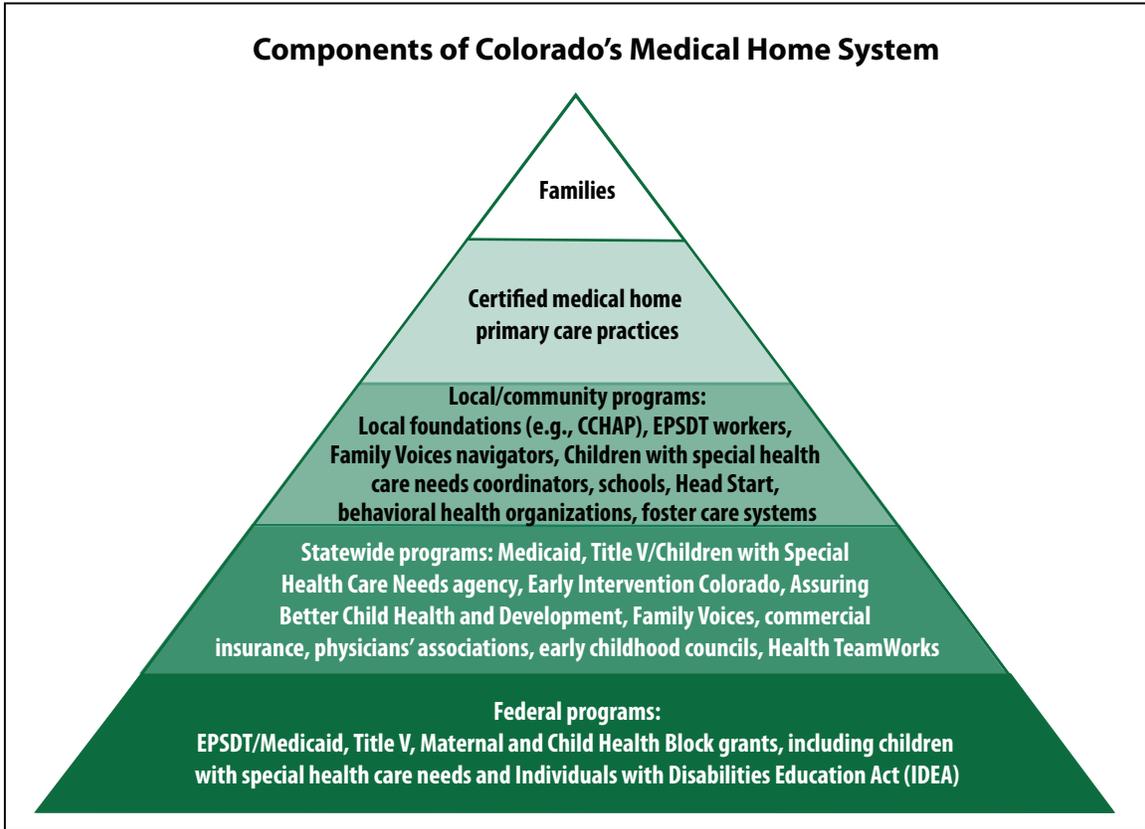


Exhibit 1. Strategies to Strengthen and Link Primary Care Practices, Colorado

Leadership	<p>Children's medical home initiative Legislature passed: Concerning Medical Homes for Children (SB-07-130)</p> <p>Directed Department of Public Health and Environment and Department of Health Care Policy and Financing to jointly implement integrated systems and standards</p> <p>Adult multipayer medical home initiative Multiple participants at both state and national level including the five largest commercial health plans, Medicaid, and Colorado Access; employer groups, including the state, IBM, and the Patient-Centered Primary Care Collaborative; and physicians' organizations such as the American Academy of Family Physicians, Colorado Academy of Family Physicians, and American College of Physicians</p>
Convener	<p>Children's medical home initiative Medical Home Advisory Board (MHAB): 125 members comprised of health plans, providers, payers, family leaders, and community advocates supported strategic plan for community level infrastructure and local implementation</p> <p>Board convened by Department of Public Health and Environment and Department of Health Care Policy and Financing</p> <p>Adult multipayer medical home initiative Health TeamWorks is convening organization and technical assistance to pilot practices</p>

Payment Incentives	<p>Children’s medical home initiative Medicaid increased payments for all evaluation and management codes for primary care visits to about 90 percent of Medicare; enhanced EPSDT visit rates for practices that meet Colorado medical home standards; instituted separate payment for developmental screening by primary care providers</p> <p>Adult multipayer medical home initiative Three-tiered reimbursement methodology: fee-for-service; care management fee, which increases with higher levels of NCQA PPC–PCMH achievement; and pay-for-performance bonuses</p>
Infrastructure	<p>Children’s medical home initiative On-site quality improvement coaching, learning community webinars, and learning collaboratives</p> <p>Assistance in helping connect patients to community services, including access to state-funded care coordination staff, meetings with community agencies, and 800-line access</p> <p>Assistance in office redesign, including peer-to-peer learning opportunities for practice administrators</p> <p>Adult multipayer medical home initiative Health TeamWorks provides technical assistance in the following areas: office redesign, technology, integrating care, and patient-centered care delivery</p> <p>Quality improvement coach provides practice-level support to improve efficiency and care delivery</p> <p>Learning collaborative sessions</p>
Information Feedback and Monitoring	<p>Children’s medical home initiative Measures include: number of practices certified, number of children enrolled, cost, and utilization</p> <p>Adult multipayer medical home initiative Measures include: clinical quality, cost, patient experience and satisfaction, and provider experience and satisfaction</p>
Certification and Recognition	<p>Children’s medical home initiative Medicaid agency certifies practices that meet quality standards developed in consultation with MHAB in eight domains: accessible, family-centered, comprehensive, culturally competent, compassionate, coordinated, continuous, and community based</p> <p>Practices may instead choose to be NCQA recognized</p> <p>Adult multipayer medical home initiative NCQA PPC–PCMH standards</p>

MICHIGAN

Although many states are suffering from the financial recession, the economic climate in Michigan is dire. Over the past decade, the state, which has nearly 10 million residents, has watched its power and influence rapidly decline. The loss of manufacturing jobs and the decline in the automotive industry's tax base have left roughly one of six residents statewide without a job; in areas like Detroit, this number is as high as one in four. Roughly 17,000 people each month are being added to Medicaid; the uninsured population, including families and children, is growing. Additionally, approximately 1.47 million residents are enrolled in Medicare. There are not sufficient state funds to draw down all the federal dollars for which Michigan is eligible. Economists are projecting that an additional 20 percent of the jobs Michigan had in 2000 will dry up in 2011, and auto industry jobs will decrease by 75 percent.³¹

Although monetary support from the state is limited, there is a long history of supporting robust Medicaid enrollment and benefits. There is also a strong presence of nonprofit health care and managed care. Blue Cross Blue Shield of Michigan (BCBSM) has by far the largest market share of private patients (about 70 percent) and is a leader in efforts to transform care in the state, including small practices, but interaction with the state efforts is minimal, except through the Michigan Primary Care Consortium.³² Despite the economic situation and the ever-dwindling financial support for health and social services, there is a strong political will within the top-tier administration and belief at the practice level that transforming primary care will result in lower health care costs, which will attract new businesses to the state.

State as Convener

The Michigan Department of Community Health (MDCH) oversees the state's public health and public mental health systems, the licensing of health care professionals and health care facilities, and the administration of Medicaid and CHIP. Over the past decade, leaders within the MDCH realized that the faltering economy was exacerbating an already broken health care system. Without monetary or political support to address the declining primary care workforce and the many other broken aspects, the state had limited power to force change. Therefore, the strategy for driving improvement centered on convening stakeholders and promoting collaborative efforts to improve the practice of primary care.

In 2006, MDCH leaders used their authority to convene disparate providers and payers to examine key issues facing the health care system. With the state-granted immunity, they discussed ways to improve the delivery of primary care and how to

realign provider payment—issues that would have violated antitrust laws if they had attempted to discuss without the state’s participation. The neutral forum provided by the state made it possible for competitors to discuss divisive issues and allowed for a process that established collegial cooperation and problem-solving. Through the state’s role as convener and facilitator, providers, health plans, and other stakeholders came to consensus on making systematic changes to restructure primary care. Participants’ enthusiasm about the process and purpose led to the establishment of a formalized group.

The Michigan Primary Care Consortium

Created by the MDCH and chaired by the MDCH director, the Michigan Primary Care Consortium (MPCC) was established as a public–private partnership to improve the delivery of preventive and chronic care services within primary care settings throughout the state by aligning existing quality improvement initiatives, addressing workforce gaps, and engaging in problem-solving strategies to ensure the availability of PCMHs. Originally composed of 35 organizations, membership in the MPCC continues to grow and currently includes more than 100 organizations.

MPCC member organizations include physician organizations, professional associations, health plans and insurers, large and small employers, academia, quality improvement organizations, public health agencies, and consumer groups. Member organizations participate in strategic planning and group activities to produce change in four areas: transforming primary care practices into PCMHs, convincing payers to address payment reform, engaging consumers in their own health care, and rebuilding the primary care workforce.

Since the organization’s inception, the MDCH has used funds generated from the tobacco tax to cover operating costs. However, due to budget constraints, the state’s modest annual support of \$400,000 is slowly disappearing, and by the end of 2010, no state funding will be available. Therefore the MPCC officially incorporated as a nonprofit corporation in December 2009 to pursue a broader funding base. Despite the financial setbacks, the state plans to maintain its partnership with the MPCC, and the MDCH director continues to lead the organization.

In 2008, the MPCC convened physician organizations, professional associations, and payers for the purpose of agreeing on a common approach to developing PCMHs in Michigan. The group adopted a definition of PCMH, agreeing to use the seven joint principles of the PCMH as developed by the American Academy for Pediatrics, with four Michigan-specific footnotes to further define patient-centered, personal physician, quality

and safety, and payment ([Appendix D](#)).³³ An MPCC work group also identified a set of metrics to distinguish medical homes from traditional primary care practices.

In 2009, the MPCC convened a group of Michigan-based payers concerned about the marginal financial status of many primary care practices. The group met to determine if they could agree on a common approach to financially stimulate practices striving to become medical homes. For 2010, the payers agreed to add three PCMH components to their pay-for-performance programs: use of an all-payer, all-patient registry, e-prescribing, and enhanced access to care (i.e., before 8 a.m. and after 5 p.m.). Additional measures are under consideration for 2011.

Through several statewide practice transformation initiatives and its Medicaid managed care contracts, the Department of Community Health is helping to drive practices to incrementally adopt all PCMH domains. Multipayer PCMH programs are being implemented in both the private and public markets, including grassroots countywide efforts, statewide public performance programs, and statewide private initiatives. A variety of practice-level mechanisms have been introduced to support practice redesign, add personnel to provide case management, provide resources to develop electronic health records and exchanges, and offer training and education to support providers' transitions. In partnership with the MPCC, the state is communicating with health care professionals through forums and presentations to help spread implementation of PCMHs statewide.

There are roughly 3,500 primary care practices in Michigan, 85 percent of which are solo or small practices with fewer than three physicians.³⁴ The decline in the supply of primary care providers is a major concern. About one-third of Michigan's physicians are primary care providers, slightly below the national average.³⁵ A slim majority of nurse practitioners work in primary care settings, and only 36 percent of physician assistants work in primary care. In addition, the primary care workforce is aging. A 2006 survey reported that 34 percent of current physicians planned to leave their practices within 10 years. Within three years, the same survey reported that this rate had increased to an alarming 47 percent.^{36,37} The MPCC is currently drafting a state plan to better define workforce concerns and propose solutions.

IPIP: A Practice Transformation Program

In 2008, MPCC applied for and was awarded an Improving Performance in Practice (IPIP) program grant from the American Board of Medical Specialties, with funding from the Robert Wood Johnson Foundation. The original intent of this program was to improve

the treatment of pediatric asthma and adult diabetes while streamlining primary care practice processes to remove waste and improve efficiency. In Michigan, the IPIP program is the product of collaboration between the automotive industry, primary health care, and government stakeholders. The MPCC was the program's sponsor, and the Automotive Industry Action Group (AIAG) operated as the program's fiduciary agent, which provided the space for meetings and other in-kind services to assist with enrolling and communicating with IPIP practices. AIAG also coordinated the planning of learning collaboratives and educational conference calls and recruited and prepared industry-trained quality improvement engineers to teach primary care practices quality improvement techniques.

Thirty-three primary care practices across the state were selected to participate in the IPIP learning collaborative and to receive on-site coaching from volunteer quality improvement experts. Each practice identified a practice improvement team that included a lead physician, clinical professional, and practice manager. Teams were charged with implementing key drivers of improved care. These included: using a patient or disease registry to track evidence-based care and to reach out to patients needing care, establishing team-based care through use of protocols and standing orders, and creating processes to support patients' self-management of health and chronic illness regimens. Practices used adult diabetes or pediatric asthma as their initial focus for learning purposes. They then were encouraged to use the improved processes for all chronic disease and preventive care. Each practice participated in three two-day learning sessions, monthly educational teleconferences, and on-site activities with their quality improvement coach. Each practice and coach submitted monthly progress reports including data on a set of quality indicators. Most of the IPIP practices are also engaged in PCMH initiatives sponsored by private payers, especially Blue Cross Blue Shield of Michigan.

Medicaid Managed Care

Michigan Medicaid serves roughly 1.5 million beneficiaries, 60 percent of whom are enrolled in managed care provided by 14 health plans. In this market, the state is advancing the PCMH concept by encouraging plans to voluntarily provide incentives to physicians in the following three areas: e-prescribing, developing patient registries, and expanding primary care access. To support the transition of primary care to PCMH, beginning in 2010, plans are encouraged to support practice transformation in two of the three focus areas. This gradual integration and promotion of PCMH was initially a component of the Medicaid contract, but the health plans were not supportive, and, as a result, the legislature did not approve the payment increase. The Medicaid program

intended to pool a certain percentage of health plans' payments to fund the PCMH initiatives. By limiting the withhold amount, there were insufficient funds in the bonus pool to push the PCMH incentive. Medicaid is currently encouraging the health plans to voluntarily integrate PCMH into their provider incentive programs.

The Medicaid program has undertaken a variety of measures that require managed care organizations to analyze Health Plan Employer Data and Information Set (HEDIS) data to identify and address disparities within the system. A recent initiative, funded by the Robert Wood Johnson Foundation, is assisting six small primary care practices in the Detroit area with a high volume of racially and ethnically diverse Medicaid beneficiaries to improve quality outcomes and to achieve NCQA certification as a PCMH.³⁸ Stakeholders are providing practice sites with data, technology, care management services, quality improvement training, and financial capital. The program supports interventions that identify and track the care of diabetes patients through electronic registries and electronic health records, adopt evidence-based practices aimed at chronic conditions, incorporate team-based care, and provide a financial incentive of \$1 per member per month for participation and performance.

Private Payer Activity

In the commercial market, private payer activities are driving PCMH transformation. Although several payers have PCMH initiatives, the Blue Cross Blue Shield of Michigan (BCBSM) initiative, Physician Group Incentive Program (PGIP), is the most comprehensive. The program reaches more than two-thirds of primary care physicians in Michigan and covers roughly 1.8 million beneficiaries. Thirty-eight physician organizations, representing approximately 5,000 primary care physicians and select specialists, participate. The program works through physician organizations to improve systems of care especially for chronic illnesses, to reduce the costs of care, and to support physician practices in their provision of patient-centered care.

BCBSM provides incentive dollars to physician organizations for participating in the PCMH program and for performance improvements of their affiliated practices. The physician organizations nominate primary care practices to participate in the program and help them implement PCMH components. The incentive dollars are intended to give providers support and funding to develop the practice-level infrastructure needed to deploy patient registries, enhance care coordination, and enable extended access for patients. In 2009, 300 primary care practices (and their 1,200 physicians) were designated by BCBSM as PCMHs on the basis of their strong quality and utilization performance. Practices that meet the criteria for PCMH designation receive differential reimbursement,

funded by provider payment withholds. In 2009, PCMH-designated practices received a 10 percent increase in office visit evaluation and management codes. BCBSM also routinely pays for care coordination and self-management education delivered by allied health professionals.

Exhibit 2. Strategies to Strengthen and Link Primary Care Practices, Michigan

Leadership	Michigan’s Department of Community Health (MDCH) led efforts that established the Michigan Primary Care Consortium (MPCC), which published papers discussing the crisis in primary care and offering potential solutions MPCC members created strategic plans that support the implementation of PCMH throughout the state
Convener	MDCH/MPCC convened a series of meetings among competing payers and providers to discuss alternative payment and delivery models, come to consensus on a medical home definition, and consider options for metrics MDCH/MPCC convened payers to identify a common set of PCMH metrics for inclusion in pay-for-performance programs
Payment Incentives	Medicaid is asking Medicaid-contracted health plans to voluntarily provide incentive payments for performance in two of the following three areas: e-prescribing, expanded access, and all-payer, all-patient registry use Michigan payers agreed to provide performance incentive payments in 2010 for three agreed-upon PCMH components, with each payer using its own payment scheme
Infrastructure	Through grant initiatives, selected primary care practices implement patient care registries and learn methods to improve clinical and administrative processes with coaching and learning collaboratives
Information Feedback and Monitoring	Medicaid Registry for tracking chronic diseases HEDIS data IPIP Practices report monthly clinical measures on diabetes and asthma Coaches report monthly on degree to which key interventions have been implemented Michigan Payers Group Providing incentives to practices for: all-payer, all-patient registry for tracking, monitoring, and outreach BCBSM–PGIP Uses practice self-reports and site visits to evaluate degree of implementation of PCMH Cost containment metrics are determined from claims data
Certification and Recognition	MPCC adopted a statewide definition of patient-centered medical home endorsed by Michigan payers, health plans, and providers Other pilot programs in Michigan use NCQA PPC–PCMH recognition as the basis for their incentive programs

NORTH CAROLINA

North Carolina, a state characterized by rural settings, small practices, and loosely organized medical systems, has built a primary care delivery system that links practices to resources, including care coordination, disease and care management, and quality improvement initiatives. In 1998, Medicaid began a pilot project in nine communities, building off its Medicaid primary care case management (PCCM) program called Carolina Access. The pilot program, which later became known as Community Care of North Carolina (CCNC), required providers to form networks to link primary care, safety net, and specialty providers in collaboration with hospitals and local departments of health and social services. During a time when many other states were transitioning their Medicaid programs to commercial capitated managed care organizations, physicians viewed CCNC as a desirable alternative that allowed them more control and protected their reimbursement rates. The medical association worked closely with the state to design the program, and practices complied with the changes in great part to keep organized managed care out and keep the program locally owned.³⁹

CCNC's program office is based in the North Carolina Office of Rural Health and Community Care and is supported by the Office of Rural Health, the Division of Medical Assistance (Medicaid), and the North Carolina Foundation for Advanced Health Programs. This support allows CCNC to administer a statewide program and oversee 14 private, nonprofit Community Care networks. CCNC convenes quarterly statewide meetings with key staff from each network to receive feedback about priority areas for quality improvement such as diabetes, congestive heart failure, and pharmacy utilization. The specifics of these quality improvement programs are left to each network to craft locally. CCNC collects data from the network, posts statewide results on its Web site, and convenes the medical directors. CCNC is working on a new system that will allow collected data to be disseminated across the networks to inform practices about their performances in comparison to others.

The Community Care networks contract with the state to cover two-thirds of the Medicaid population—over 900,000 Medicaid enrollees. There are more than 3,200 physicians voluntarily enrolled in CCNC. Those who enroll receive a \$2.50 per-member per-month payment and must agree to certain medical home requirements, including data collection and reporting. The network in which the provider is enrolled receives a \$3 per-member per-month management fee based on the number of Medicaid recipients enrolled. The network proposes how to spend the funds locally, but the state must approve the spending plans. Before implementation, the state established several population health issues. The networks decide to use their allotted funding to meet these objectives, dividing their funding between supporting individual patient care and

addressing population health. The per-member per-month fee is increased to \$5 for practices and networks to care for patients who are eligible for Medicaid through the aged/blind/disabled category.

A Mercer analysis showed that CCNC operations in 2004 saved \$244 million in overall health care costs for the state while improving overall health outcomes for select illnesses. Similar results were found in 2005 and 2006.⁴⁰

The state has recently signed a contract with the Centers for Medicare and Medicaid Services for a Medicare 646 waiver that is getting under way in 26 counties and more than 100 practices. This program will begin by targeting high-cost dual-eligibles (i.e., individuals who qualify for both Medicaid and Medicare) and rolling them into the existing infrastructure created by the networks. Eventually complex Medicare-only patients will be added into the demonstration. Enhanced services will be provided to assist with transitional care, behavioral health care, pharmacy support, and other services. Reimbursement will be supported through a regional physician pay-for-performance program using a common set of quality measures.⁴¹

Community Care of North Carolina (CCNC) providers must meet the following criteria:

- Perform primary care, including certain preventive services;
- Create and maintain a patient–doctor relationship for the purpose of providing continuity of care;
- Establish hours of operation for treating patients of at least 30 hours per week;
- Provide access to medical advice and services 24/7;
- Maintain hospital admitting privileges or have a formal agreement with another doctor based on ages of the members accepted;
- Refer or authorize services to other providers when the service cannot be provided by the primary care provider;
- Use reports provided by the Department of Medical Assistance managed care section to maintain the level of care that meets the goals of CCNC and patient needs. Reports are available in print and on the Internet; and
- Implement evidence-based best practices for core quality and disease initiatives.^a

^a “Participation Requirements of Primary Care Providers” (North Carolina Division of Medical Assistance, <http://www.dhhs.state.nc.us/dma/ca/overviewhistory.htm#part>, accessed on May 21, 2010).

Networks Match Local Community Needs and Resources

The 14 Community Care networks are largely supported by the Medicaid monthly payments per enrollee. Varying amounts of grant funding from the Office of Rural Health (to support care of the uninsured) and from private sources also support the networks. The networks provide shared services to all practices, including care coordination, but also provide direct care that supports a team approach to primary care. Each network has a common infrastructure that includes:

- *Medical director*: Oversees quality efforts, meets with practices and serves on State Clinical Directors Committee;
- *Executive director/Clinical coordinator*: Oversees network operations;
- *Care managers*: Provide care coordination and patient education for complex patients; small practices share a care manager; large practices may be assigned their own; and
- *Doctor of pharmacy*: Assists with medication management of high-cost patients.

Beyond this shared infrastructure, the network characteristics vary, largely shaped by provider input, geography, resources, and patient needs. The medical director and executive director of Access II Care, a Community Care network in Asheville, North Carolina, were interviewed to describe the way one network has evolved to meet the needs of small practices and patients.

Access II Care represents eight counties that span rural areas and small cities. It includes 60 practices—solo to large practices, community health centers, public health departments, and residency programs. The medical director at Access II Care is a practicing physician who works three-quarters time. The population is comprised of primarily women and children, but it also serves approximately 8,000 aged, blind, and disabled patients and is in the process of identifying dual-eligibles for the Medicare 646 demonstration.

While other regional networks utilize case managers who are under contract with local county health departments, Access II Care hires care coordinators who work with multiple projects. They have hired 22 coordinators, mostly registered nurses, to work with primary care practices and patients to improve quality of care and decrease costs. The rule of thumb across the networks is that each care manager is responsible for a caseload of roughly 4,000 patients, of which no more than 500 are in the aged/blind/disabled population. In Access II Care, these care managers are imbedded

directly in the practices. Larger practices may have a dedicated care manager on site, and smaller practices will share a care manager. Some care managers may cover as many as eight small practices.

Care managers connect small practices and their patients with needed resources. Over the course of a week, they will drop into practices to make face-to-face contact. Using the data provided by the state, the care managers can monitor patients' Medicaid and pharmacy claims and run customized queries to work with high-cost/high-utilization patients and share pertinent data in face-to-face meetings with primary care providers. In addition to the claims data feedback, all Community Care networks have annual independent audits as well as more "real-time" data feedback by Area Health Education Centers (AHEC)—community partnerships that work to address health care workforce issues through recruiting efforts. With foundation grant funding, Access II Care is providing additional support to practices. It has hired a nutritionist to work on a child obesity initiative and is working on other projects to better integrate behavioral health services and improve the care of certain chronic conditions.

AccessCare is another local network, operating in 24 counties and maintaining five network sites in other counties. It has become the largest of the 14 local networks with over 300 primary care practices and 1,000 providers serving more than 200,000 Medicaid enrollees statewide, as of January 2009. AccessCare operates within an enhanced case management fee. One of its initiatives successfully implemented a Web-based information technology system throughout its network. This Web portal provides feedback on quality measures to practices. This was funded by a Medicaid \$3 per-member per-month fee paid to the network and a small foundation grant. AccessCare care managers, in collaboration with care managers from other networks, designed the case management system with a software development organization. The case management system has become the statewide system for all of the networks. Practices are not required to have electronic health records, but for those that do, AHEC provides support to use this tool to improve practice performance. With funding from private sources, AHEC also works with practices to streamline office processes, such as same-day scheduling and patient flow.

Each of the 14 Community Care networks organizes quarterly medical management meetings as a part of its educational outreach to providers. Access II Care has divided its eight counties into three regions and hosts regional meetings. These meetings are usually attended by a team member from each practice, hospital, local health and social services department, and often the mental health agency. Each region

elects four representatives—half of whom are physicians—to serve on the board. In addition, there are lunch meetings, dinners, toolkits, electronic bulletins, and, of course, the care manager to provide practices with pertinent information.

Provider satisfaction has not been measured recently, but nearly all practicing physicians are participating. The minority of physicians who do not participate say they do not have a high enough Medicaid panel for CCNC to be of any benefit. With the addition of the Medicare 646 demonstration, which will include additional payments for Medicare patients, the CCNC benefit may be more appealing to these practices.

Exhibit 3. Strategies to Strengthen and Link Primary Care Practices, North Carolina

Leadership	<p>The Office of Rural Health, the Division of Medical Assistance (Medicaid), and the North Carolina Foundation for Advanced Health Programs formed Community Care of North Carolina to support the networks</p> <p>The Medicaid agency required providers to form networks around primary care practices that include hospitals and specialty physicians as well as local social services agencies and public health departments</p> <p>To expand the reach of the program across more practices, the state signed a contract with the Centers for Medicare and Medicaid for a Medicare 646 waiver</p>
Convener	<p>CCNC serves as convener for the networks, at various times bringing together physician and administrative leaders to plan for care management and quality improvement</p>
Payment Incentives	<p>Medicaid pays participating practices a PMPM fee to cover the day-to-day costs of serving as a medical home, plus fee-for-service for the services the practices provide; the networks receive a PMPM payment to pay for resources that are shared among practices, such as care coordinators and quality improvement infrastructure; Medicaid pays higher PMPM fees for patients who are eligible for Medicaid due to age or disability</p> <p>CCNC is seeking to establish a pay-for-performance program developed in conjunction with the networks; measures and metrics have been selected but the program has not yet been implemented</p>
Infrastructure	<p>CCNC supports the networks, convening clinical and administrative staff to plan for quality improvement and program administration; also provides performance data, patient educational material, care coordinator support material, and other resources</p> <p>The networks support primary care providers by, for example, hiring care managers who may work at a single practice or with several smaller practices or a pharmacist to assist with medication management of high-cost patients</p> <p>CCNC and the individual networks have worked with practices to integrate the resources offered by the network and CCNC into their delivery of services</p> <p>Each of the 14 CCNC networks organizes quarterly medical management meetings as part of its educational outreach to providers; each region selects representatives to serve on the board; there are meetings, toolkits, and electronic bulletins; the care manager provides practices with information, including information from these meetings if providers are unable to attend</p>

Information Feedback and Monitoring	<p>CCNC tracks a variety of cost and utilization measures that are selected in conjunction with the networks; this is driven by the quality improvement projects selected by the networks and includes measures that address diabetes, asthma, and preventive services</p> <p>CCNC commissioned a study of the effect of the program on diabetes and asthma care</p> <p>CCNC has commissioned several studies to calculate the savings produced by the program</p>
Certification and Recognition	<p>To participate in the program, practices must sign a PCCM provider agreement certifying that they meet certain standards and show that they have been accepted by a network</p>

OKLAHOMA

The Oklahoma Health Care Authority, the state agency in charge of purchasing decisions and controlling costs in state-purchased health care, reformed its SoonerCare Choice (Medicaid) program in response to provider dissatisfaction and a desire to improve quality and cost outcomes. The reforms were accomplished with input from the Medical Advisory Task Force (MAT), formed in 2007. This task force, comprised primarily of SoonerCare physicians representing state physician associations, collaborated with the state on ways to improve the quality of SoonerCare Choice. Over time, attendance at the meetings began to wane, with only representatives from the primary care physician organizations, including the Oklahoma Chapter of the American Academy of Family Physicians (OAFP), remaining. The physician representative from the OAFP found the Oklahoma Health Care Authority open and responsive to suggestions. The MAT also participated in town meetings across the state to receive input from providers. The consensus among Oklahoman physicians put medical homes and payment reform at the top of the list of priorities, beginning with state-sponsored programs but with plans to transform primary and chronic care across the state.⁴²

A Multifaceted Payment Model

The Oklahoma Health Care Authority designed a new payment model for Medicaid that provided much stronger incentives for linking practices. It started with unbundling its former partial capitation payment to better align with medical home principles. The new payment system consists of:

- fee-for-service reimbursement payment for office-based services;
- transition payments to help support practices during year one;
- per-member per-month care coordination payments based on certification tiers and patient characteristics; and
- expanded performance-based payments.

Implemented January 2009, this new payment model was linked to a three-tiered, state-developed medical home recognition process, created with the input of the MAT. The transition from partial capitation payment to one that supports medical home principles presented opportunities as well as challenges for Oklahoma physicians, particularly for those in smaller practices.

Fee-for-Service Reimbursement Payment for Office-Based Services

Many physicians on the MAT felt that the former capitation payment program created a “Medicaid mill” that perversely rewarded practices for enrolling as many Medicaid patients as possible, collecting the monthly capitation fee, neglecting patient outreach, and referring to emergency rooms for acute care treatment. Many thought that changing to a fee-for-service payment system would encourage more face-to-face office visits, providing a better foundation to build a medical home. Although Oklahoma pays Medicaid fee-for-service at 100 percent of Medicare rates, the transition from capitation to fee-for-service still posed some initial financial challenges for practices.⁴³

Transition Payments

Many MAT members feared that the initial adjustment from capitation to fee-for-service would cause significant strain on practice revenues. Instead of receiving a check to cover the per-member per-month costs for a practice’s Medicaid panel, practices would have to adjust their business operations to account for fee-for-service payments that come in after a patient’s visit. Although aimed at larger practices, the Oklahoma Health Care Authority provided practices with a one-time transition payment based on their percentage of Medicaid patients to help adjust to this initial payment gap. The transition payment pool was \$9 million for the first year. To receive a payment, at least 20 percent of a practice’s patients had to be Medicaid recipients and meet additional quality-based requirements.⁴⁴

Stratified PMPM Care Coordination Payments

Oklahoma developed its own recognition tool modeled after three-payment tiers that are stratified according to the population served (children, children and adults, adults) and aligned with increasing medical home expectations.⁴⁵ According to one family physician who serves on the MAT, requiring physicians to become NCQA PPC–PCMH certified would have been “too painful” and resulted in leaving out too many practices, particularly small, rural practices, that do not have the personnel or resources to become certified.

Practices can opt to work with Oklahoma Health Care Authority practice facilitators, who work on site with practices to redesign office systems and processes to improve the delivery of care to chronically ill patients. Practices that opt for this support also have access to a free Web-based health information registry tool that helps identify unmet patient needs and a data measurement component for ongoing evaluation and performance tracking. Incentives are offered to practices that participate in these initiatives.⁴⁶

For the one family physician interviewed for this report, being recognized as a tier II medical home was not difficult. He opted not to use a practice facilitator. His practice already had an electronic medical record and patient access to a Web portal. The two-physician practice's greatest obstacle toward tier III medical home recognition is being able to provide access to expanded hours—a concern frequently voiced by other solo and small practices. This obstacle may be temporary, as the modest added revenue from meeting medical home requirements, mostly due to performance payments, has generated some of the funding needed to hire a nurse practitioner who may enable the practice to meet tier III expectations.

Expanded Performance-Based Payments

The recently expanded pay-for-performance program, known as SoonerExcel, has been an essential tool to spur providers to focus on quality improvement initiatives. SoonerExcel makes quarterly payments to PCPs who meet or exceed expectations in the following areas: inpatient admitting and visits, breast and cervical cancer screenings, emergency department utilization, and EPSDT and immunization targets.

The payment bonuses have changed primary care provider behavior, resulting in providers running more frequent population-based reports and conducting outreach to patients to schedule needed visits. If a practice has a complex patient with poor quality outcome measures, nurse case managers from the Oklahoma Health Care Authority can be called to provide help with care coordination such as referrals, self-help activities, and links to community services.

One Year Checkup

Pledged to be budget neutral, SoonerCare Choice has early data showing reduced per capita member costs. In addition, the new program has enrolled 64 primary care providers over the past year.⁴⁷ According to one family physician, new providers are attracted to this program because of medical home philosophy, with payment incentives and other practice support.

Exhibit 4. Strategies to Strengthen and Link Primary Care Practices, Oklahoma

Leadership	<p>The Oklahoma Health Care Authority, the state’s Medicaid agency, formed the 11-member Medical Advisory Task Force to advise it on ways to improve the delivery of primary care</p> <p>Legislation created a PCMH Task Force within the Insurance Department to study quality, safety, value, and effectiveness of the medical home concept</p>
Convener	<p>Oklahoma Medicaid convened and staffed the task force</p> <p>Medicaid, in conjunction with the task force, convened town hall meetings across the state in fall 2008 to get broader input on proposed changes</p>
Payment Incentives	<p>Medicaid pays practices that meet medical home criteria:</p> <ul style="list-style-type: none"> • Fee-for-service for office visits; additional payment for behavioral health screening and after-hours care • Per-member per-month payment to recognize day-to-day cost of serving as a medical home; payment varies based on practice and patient characteristics • \$5 million in “excellence” payments distributed to practices in first year; amount varies based on individual performance in key areas, including EPSDT screening, breast and cervical cancer screenings, and emergency department utilization <p>Medicaid gave practices transition payments during first year</p>
Infrastructure	<p>Medicaid staff assists practices in coordinating the care of complex patients</p> <p>Medicaid offers practices access to a Web-based information registry with a data measurement component</p> <p>Providers may participate in an office practice design program, in which facilitators assist providers in improving delivery of care and other processes</p>
Information Feedback and Monitoring	<p>Biannual provider profiles include emergency room utilization and preventive care services</p>
Certification and Recognition	<p>Providers complete assessments that place them in one of the three medical home tiers; Medicaid performs a follow-up audit to verify accuracy of assessment</p>

PENNSYLVANIA

The origins of Pennsylvania's multi-stakeholder collaborative began with an executive order from Governor Edward Rendell creating the Chronic Care Commission. The commission is charged with establishing an infrastructure to change the way chronic care is delivered. The 37-member commission represents a broad cross section of health care-related fields and all geographic areas of the state. In addition, the secretaries of health, public welfare, and insurance, as well as the director of the governor's Office of Health Care Reform serve as ex officio members.

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

The first rollout of the Chronic Care Initiative began in southeast Pennsylvania in May 2008. The state has followed with six other subsequent rollouts, with variations to allow for regional flexibility and lessons learned. In these rollouts, payers and primary care practices signed a three-year commitment to participate. Payers agreed to provide up-front and ongoing payments to practices to help them implement the chronic care model and transform their practices. After three years, if there are not sufficient outcomes to support continuing participation, the payers could opt out. A different funding model was established in northeast Pennsylvania, where payers provided practice support payments starting in month one and funding for case management starting in month four. Additional incentives are available to practices based on savings generated by care that creates savings for the participating payers. Although practices in northeast Pennsylvania are still required to receive recognition by NCQA PPC-PCMH by month 18, like the other regions, these practices will not receive increased incentive payments based on that requirement.⁴⁸

Using Innovation Leaders to Design Local Pilots

Geisinger Health Plan, a nonprofit health management organization, began its involvement with the Chronic Care Initiative by serving as a stakeholder on the governor's Chronic Care Commission. Geisinger's main role was to share its expertise, particularly around the area of metrics. The northeast Pennsylvania rollout had the benefit

of learning from the lessons of previous regional rollouts, as well as Geisinger’s experience developing a medical home pilot.

In the southeast Pennsylvania rollout, payers agreed to pay practices a lump sum after achieving level 1 NCQA accreditation. Payments would be based on level of certification. This change was made after many practices rushed toward NCQA recognition without undergoing significant practice change. This lesson helped drive Geisinger and Blue Cross of Northeast Pennsylvania—the other payer in northeast Pennsylvania—to a consensus about creating a model that provided key infrastructure support to practices and introduced financial gain sharing. According to Duane Davis, Geisinger chief medical officer and member of the governor’s Chronic Care Commission, the missing piece in the southeast rollout payment model was that the practices had no ownership of the outcomes if they succeeded or failed.

Geisinger’s “Personal Health Navigator” Pilot

Components from Geisinger’s “Personal Health Navigator” pilot included in the northeast Pennsylvania model include:

- care coordination provided through an on-site nurse care coordinator and a personal care navigator;
- feedback to practices through quality and efficiency reports that are shared during monthly interactions with practices;
- EMR access for providers, team members, and patients;^a
- payments that include a monthly payment to each physician, additional pay for expanded access, and performance pay for meeting quality metrics; and
- participation in quarterly learning sessions, monthly conference calls, and coaching support.^b

After one year, preliminary findings showed the Geisinger pilot dramatically decreased hospital admission and readmission rates, resulting in a 7 percent reduction in overall medical expenditures.^c

^a Geisinger offers EHR access; the NEPA pilot instead offers a registry for practices to use.

^b Geisinger includes expanded access in its payments for practices not part of the NEPA pilot.

^c R. A. Paulus, K. Davis, and G. D. Steele, “[Continuous Innovation in Health Care: Implications of the Geisinger Experience](#),” *Health Affairs*, Sept./Oct. 2008 27(5):1235–45.

New Payment Model

The state's role as a convener with payers allowed the two competitors to develop trust and produce an aligned, sustainable payment model. The northeast Pennsylvania payment model differs from the southeast in several key areas:

- *Practice support payments:* Quarterly lump sum payments are made over three years that can be used for practice transformation including additional staff, time allocation for effective care management and planning, and equipment and office space.
- *Care management payments:* Quarterly lump sum payments are made over three years beginning with month four. Payments are made directly to a practice to support care management either by hiring new staff, transitioning current staff, or contracting with an independent entity for the services. Payments must be used to fund a care manager.
- *Practice support payments:* Quarterly lump sum payments are made over three years and can be used for additional staff, time for effective care management and planning, and equipment and office space.
- *Value reimbursement payments:* Beginning in year two and continuing through year three, practices that have met a certain number of performance threshold criteria will be qualified to share in any savings generated by the practices, if savings exceed the annual value of the care management and practice support payments. At 18 months, practices that do not meet the performance threshold will no longer be eligible for care management or practice support payments.

The northeast Pennsylvania rollout got under way in late 2009. Geisinger enrolled practices that were not involved in its Personal Health Navigator model and included several practices with fewer than 10 doctors. The payers were able to convince the state that if the pilot was to be sustainable, payment needed to be made to practices early (month four) to hire an on-site care coordinator to focus on post-discharge transitions and medication reconciliation. Geisinger's previous experience indicated that medication reconciliation alone could pay for the costs of the care coordinator. For smaller practices, the challenge has been to connect practices to shared care coordinator resources.

Unlike the southeast Pennsylvania rollout, the northeast Pennsylvania rollout has no Medicaid managed care organization payer participation. Geisinger has Medicaid patients in its plan, but without Medicare and Medicaid fee-for-service support, the practices receive no additional financial support for the additional services for

approximately 50 percent of its panel. Federal and state participation as payers would lend this initiative a great deal more traction. According to Dr. Davis, “Advice to payers: Don’t be afraid. It is not worse than what you have now. Design the program so that all are accountable and all incentives are aligned. Sustain what you started. It takes a while to transform. It takes a while to grow roots. Be patient. It will not happen overnight.”

Exhibit 5. Strategies to Strengthen and Link Primary Care Practices, Pennsylvania

Leadership	<p>Governor Edward Rendell established the Chronic Care Commission through an executive order</p> <p>The commission developed a strategic plan to implement a chronic care and patient-centered medical home delivery system statewide</p>
Convener	<p>The commission brought together key stakeholders, including private payers, and enabled them to develop a common approach to improving primary care</p> <p>The governor’s office convened regional steering committees to plan for rollout of the common model</p>
Payment Incentives	<p>The governor’s office is administering medical home payments—paying practices as determined in each region and collecting the funding from participating payers</p> <p>The exact payment model differs by region; payers across all regions use a combination of up-front and quarterly lump sum payments</p> <p>In addition:</p> <ul style="list-style-type: none"> • Northeast region: Practices that do not meet specified performance standards within 18 months will cease receiving the quarterly payments; these payers will also share any savings achieved with practices
Infrastructure	<p>State is creating common reporting structure for practices and conducting data analysis, marketing, and promotion</p> <p>Payers partially funding practice coaches to assist individual practices</p> <p>State provides practices with a Web-based patient registry</p> <p>State providing leadership, coordination, and partial funding for collaborative learning sessions and an “outcomes congress” for practices in each region</p>
Information Feedback and Monitoring	<p>Practices agree to regularly report performance indicators</p> <p>At 18 and 36 months, formal evaluations assess progress toward quality and cost containment goals</p>
Certification and Recognition	<p>Practices must achieve NCQA PPC–PCMH level 1 recognition plus additional state-established criteria within prespecified time to continue receiving payments</p>

VERMONT

In 2006, with the backing of the governor and the legislature, Vermont embarked on a mission to reform the state's health care delivery system to reduce the economic impact of the most common chronic conditions and focus on their treatment and prevention. The Vermont Blueprint for Health guided this process by selecting six "Blueprint" communities organized around hospital service areas. The process included improving diabetes care and prevention through provider training and incentives, expanded use of information technology, evidence-based process improvement through clinical microsystems training, self-management workshops, and support for community activation and prevention programs.⁴⁹

In 2007, additional legislation called for a small number of pilots to test the efficacy and sustainability of payment reform across all public and private payers, as well as for several chronic conditions (diabetes, hypertension, and asthma).⁵⁰ Given statutory authority and legislative funding, the Blueprint for Health has been able to convene payers and reach consensus around a central vision while building the health information infrastructure needed to support this vision. This protected venue has been important for allaying concerns about antitrust in this multipayer initiative, similar to the experience in Pennsylvania. All payers are participating in the pilot communities, including the top three commercial carriers, Medicaid, and the Blueprint (subsidizing Medicare). Payers agreed to common payments, evaluation measures, and clinical-based guidelines. This represents 98 percent of covered lives in Vermont (excluding Medicare).

Three of the six original Blueprint communities were selected for the Blueprint Integrated Pilot Program. The 12 practices and 40 physicians are supported by the following financial and infrastructure incentives:

- enhanced provider payment based on how practices score against the NCQA-PCMH; range is up to \$2.39 per member per month;
- shared payer support for local multidisciplinary care teams per pilot community;
- Blueprint subsidizes Medicare's share of payment;
- local multidisciplinary community health teams ;
- Web-based registry (DocSite⁵¹) supported by the Blueprint and Vermont Program for Quality in Health Care (VPQ), which produces reports on measures to enhance clinical operations, population management, and program evaluation. Providers without an EMR can use the registry for electronic prescribing, clinical microsystems training and VPQ coordinated training;⁵²

- statewide health information exchange network developed with Vermont Information Technology Leaders, Blueprint, and technology teams that enable data transmission from available sources (such as EMRs and hospital data warehouses) to DocSite;
- practice coaching and chronic care model training through the VPQ Learning Community that can accommodate practices off-site and on-site: centralized, statewide learning forums; multiple, community-based mini learning sessions; and a virtual learning community;⁵³ and
- evaluation and feedback on care.

Minimizing Barriers to Maximize Transformation

The sum effect of these supports has been transformational. One solo physician practice described his practice “pre-Blueprint” as seeing patients all day long, with very little time to examine processes. With the on-site practice support provided by Blueprint, the physician is now focusing on “how to do things better.” Practices interviewed said they would have found the certification process too overwhelming and laborious to attempt independently. One physician reported that the process has provided incentives to improve patient management, for instance, by better test tracking and follow-up, something he was not doing before becoming NCQA level 1 certified. A year and a half later, this physician has applied for level 3 certification and has employed additional processes to better manage his panel through DocSite. Through the Blueprint pilot, he has received funding for a half-time position for data entry, tracking, and subsequent follow-up. He is now tracking who is due for preventive visits and following up with mailed reminders.

A key aspect of practice support is provided by the multidisciplinary community health teams (CHTs). The costs of these teams are shared by all payers. The teams are intended to be flexible and scalable, offering small practices an array of expertise to help them deal with common social, economic, and behavioral problems found in a general population.⁵⁴ The five team members have been hired by the local hospital in each community and may differ from community to community in terms of staff mix, hours, and site of operation.

Teams help patients with transitions across settings, such as discharge from the hospital to home and handling follow-up appointments. They meet regularly with each practice to coordinate individual patient care, organize clinical operations, review reports, and plan ongoing quality improvement. Each team is intended to support approximately

20,000 community members regardless of insurance status at a cost of approximately \$1.46 per person per month shared across all payers.⁵⁵

One small practice described the support provided by the CHT as “fantastic,” saying that it minimizes barriers and enhances care by providing access to nutritionists and social workers, among others. Another practice said the CHT has made addressing difficult patient problems like “hitting the easy button.”⁵⁶ For larger practices, the CHT members may be embedded on-site. For the solo physician interviewed for this report, team members are shared.

The added per-member per-month income on top of the fee-for-service payments to practices has not resulted in an appreciable change in income to one of the practices interviewed. As a solo doctor, he has not been able to expand his hours beyond working “all the time, including house calls” but is now considering adopting a new EMR that will allow patients access to their records as well as possibly allowing them access to scheduling and e-mail. Although it is too early for the objective reports the state is developing to measure costs and quality, this physician reports that his and his patients’ satisfaction has improved.

Exhibit 6. Strategies to Strengthen and Link Primary Care Practices, Vermont

Leadership	<p>Governor introduced the Blueprint for Health</p> <p>The legislature endorsed the Blueprint as part of the state’s larger health reform package, including payment reform, and a tax to establish health information technology</p> <p>Legislature passed additional legislation to initiate pilots to test payment reform across all public and private payers</p> <p>A legislative mandate is under consideration to require insurers that do business with the state to participate in the transformed payment and delivery system</p>
Convener	<p>State convened payers and reached consensus around vision and practice supports needed to improve chronic disease management</p> <p>All payers are participating in the pilots, including commercial carriers and Medicaid</p>
Payment Incentives	<p>All payers, including Medicaid, continue to pay fee-for-service for office visit plus a per-member per-month fee to recognize the day-to-day costs of serving as a medical home; the per-member per-month payment is triggered by achieving NCQA–PPC level 1 recognition and is increased based on the provider’s NCQA score</p>

Infrastructure	<p>All payers share the cost of community health teams that assist with care coordination and support practice improvement; the state funds a locally based public health prevention specialist to support practice improvement</p> <p>A statewide health information exchange network was developed to transmit data from EMRs and hospital warehouses to a Web-based registry; providers without EMRs may use registry tools to support individual patient care and panel management for chronic diseases</p> <p>State funds assistance with NCQA recognition process, including identifying needed practice changes, making those changes, and completing application</p> <p>All payers fund and state arranges for training in office process improvement, evidence-based treatment, patient self-management workshops, and community activation and prevention programs</p>
Information Feedback and Monitoring	<p>All payers have agreed on a set of uniform evaluation measures and clinical-based guidelines</p> <p>Practices receive evaluation and feedback on care, performance, and quality indicators</p>
Certification and Recognition	<p>Practices paid additional payments based on NCQA–PPC recognition process score</p> <p>Insurers whose market share exceeds 5 percent of Vermont business must participate in the multipayer medical home pilots (provision pending)</p>

FEDERAL POLICIES AND STATE ROLES

States can play multiple roles to strengthen primary and chronic care and work to link and transform small practices for better outcomes. In researching this report, we asked where federal action could better support these efforts. There was a clear and shared sense that because health care delivery is local, the federal government is neither designed nor equipped to devise and administer the specific actions states and private sector partners are undertaking. However, there are some key changes that would likely speed the pace of reform. In addition, with the passage of the Affordable Care Act in March 2010, there are some important new opportunities and funding for states to leverage.

Key federal policies and actions that would strengthen state actions include:

- **Medicare's participation in multipayer medical home payment schemes would greatly enhance states' ability to spread innovations.** Medicare's share of any practice's revenues varies, based in part on the structure of the state's market and whether the Medicaid delivery system is separate from or integrated into the private delivery system in the state. But all observers noted that Medicare picking up its share of expenses would strengthen the financial incentives for practice transformation. In Vermont, for example, the Blueprint program subsidizes Medicare's share of the community care team and data infrastructure investments. Even a state that has the ability to make a significant investment up front like Vermont or Pennsylvania can only go so far without Medicare dollars. Medicare's participation would also encourage private carriers to participate because they would no longer see Medicare reaping the benefit of private carrier innovation.
- **The health information technology provisions of the American Recovery and Reinvestment Act present an opportunity for states to strengthen primary care.** Funding for electronic medical record adoption and health information exchange will greatly aid states' efforts. Even more important, say observers, are the financial incentives through Medicaid and Medicare for meaningful use of electronic information. All programs profiled contain elements of meaningful use as being critical to success.
- **Federal demonstration programs generally seen as useful, but too slow for lessons to be adopted into policy and business standards.** For example, the Medicare medical home demonstration has not become operational. There are other examples, and there is a strong sense that states can move more quickly,

albeit not always with the same level of resources. Therefore, it was recommended that the federal agencies join the states in this area.

- **Shifting payments under Medicare’s relative value scale from specialty care to primary care would assist states in strengthening primary and chronic care.** Observers noted that the federally qualified health center (FQHC) payments, many of which are on a cost reimbursement basis that exceeds what Medicaid pays primary care physicians, provide a conundrum for state officials wishing to design a transformed system that includes private practices and FQHCs. Others noted that while more money for primary care is important, money alone does not transform practices.
- **Although federal goals for quality are important, they are unlikely to lead to the kinds of results sought by states to transform and link small practices.** Observers emphasized the critical role of nonfinancial support provided by the states, including the learning collaborative and other infrastructure support.

Opportunities Under Health Reform

The Affordable Care Act creates significant opportunities for primary care to reestablish itself as the centerpiece of American medicine. The legislation as it pertains to primary care addresses three key areas: workforce, payment, and practice innovation. While many components of the legislation will not go into effect until 2014, many critical aspects concerning primary care go into effect immediately.

- **The legislation authorized provisions to mitigate payment inequities between specialists and primary care physicians and to evaluate new models for payment.** The legislation approved an immediate 10 percent increase to primary care physician payment for the next five years and funds Medicaid payments to Medicare levels for two years (Sec. 5501, 1202). The resource-based relative value scale (RBRVS), a commonly accepted method for provider payment, is undervalued, and the legislation permits adjusting rates and bundling of individual services (Sec. 3134). The legislation acknowledges that current payment methodologies contribute to payment disparities between generalists and specialists and supports innovative payment models such as expanded bundling, capitation, shared decision-making, and gain sharing.
- **Reauthorizes Title VII, section 747, primary care training and workforce education and provides funding to expand the dwindling primary care capacity.** These programs authorize funding for five years to establish accredited programs or participate in existing programs for physician training in family,

general internal, pediatric, or geriatric programs including community-based settings. Other provisions support student loan repayment programs for physicians who practice in primary care, including residency training in primary health care. The National Health Care Workforce Commission to be established may also be integral in identifying barriers to coordination among federal, state, and local entities; determining potential demand for particular health care workers; and recommending innovations.

- **Delivery reform elements to evaluate and promote practice innovation and evaluation of new models of care.** There are several new governing bodies and pilot programs created by Congress that have potential to reshape the current delivery system. The value-based purchasing and pilot programs will test and expand programs that meet quality thresholds and decrease costs. One such model, effective in January 2012, will enable providers to organize as accountable care organizations. Congress established and funded a new entity, the Center for Medicare and Medicaid Innovation, to operate within the Centers for Medicare and Medicaid Services, to determine payment and delivery models to be tested, such as patient-centered medical homes. The community-based collaborative care network establishes grant opportunities for states, local government, health centers, and many other organizations to provide primary care services and outreach to medically underserved community settings (Sec. 2534).

CONCLUDING COMMENTS

States can have a significant impact on strengthening primary and chronic care delivery through numerous actions to transform and link small practices. Perhaps the most critical role is leadership, which is at the core of all the policy levers and actions of the states profiled in this report. In some cases, the leadership of the governor or the legislature led to dedicated funding to invest in a new system. But even where no funding was possible, leadership led to measurable action. Public funding for infrastructure, technical assistance, and new payment models is extremely helpful but not essential; leadership is essential.

States as payers alone can have an important impact on the delivery system, but their ability to bring multiple payers to the table and join with them in initiatives can have perhaps the greatest impact on the system. The state as convener serves to provide antitrust protection to discussions among multiple payers seeking to develop a common payment structure that rewards good primary care. The multipayer examples in this paper provide excellent models for other states to follow. The promise of Medicare's participation looms as a potential significant accelerator in the next few years.

States can also play a role in providing technical assistance to small practices through a variety of methods and can foster learning exchange through collaboration. State officials note that technical assistance is essential to spread new models quickly. Practices may also need funding to free up time to participate in various trainings.

State leaders differ in their opinions of the importance of practices using electronic health records or being linked through health information exchange. One observer noted that automating inefficient or ineffective systems does not result in transformed care delivery. So, although information must be exchanged in coordinating patients' care, there are practice changes that matter more than the presence of electronic medical records or electronic information exchange. Other informants note that information exchange functions that measure and reward quality could not happen manually.

Small practices need support, which can be provided in a variety of ways. States may entice small practices to participate in transformation by providing them with direct resources or by building support structures to help them better manage patient care. This will vary according to the states' landscape. In states with more managed care plans and integrated delivery systems, there is less need to build the support than in states with less existing structure. Finally, in small states and in states with a large number of smaller carriers, it is particularly critical to have all payers at the table, because Medicaid is not large or concentrated enough in practices to make a difference.

This report illustrates that states can lead the way in delivery system reform. While there is a distance to go, leaders are blazing the trail and sharing lessons learned along the way.

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APPENDIX C. THE COLORADO MEDICAL HOME STANDARDS

Standards of care that Medicaid and Child Health Plan Plus (CHP+) children should receive from a medical home in Colorado were developed under the leadership of the Colorado Department of Health Care Policy and Financing and the Colorado Department of Public Health and Environment, with considerable input from the Colorado chapter of the American Academy of Pediatrics (AAP), Colorado Children's Healthcare Access Program, the Colorado Academy of Family Practice, parent groups, and community-based organizations.

The medical home standards drew heavily from the AAP's work, with many pediatricians and practice managers contributing to their development. The standards are as follows:

- 24/7 access to a provider or telephone nurse triage service;
- family has a personal provider or team of providers;
- appointments are based on the child's condition (acute, chronic, and well) and provider can accommodate same-day scheduling when appropriate;
- information is made available about insurance, community resources, nonmedical services, and transition to adult providers;
- provider and office staff are culturally competent;
- medical home takes the primary responsibility for care coordination;
- age-appropriate preventive care and screening are provided through structured templates and anticipatory guidance, with counseling and referrals as appropriate;
- practice adopts and implements evidence-based diagnosis and treatment guidelines;
- medical records are up-to-date and comprehensive; and
- continuous quality improvement plan that references medical home standards and elements.

APPENDIX D. MICHIGAN PRIMARY CARE CONSORTIUM'S FOOTNOTES TO THE JOINT PRINCIPLES

- The patient-centered model of care recognizes the central role of patients and, when appropriate, their families as stewards of their own health. In the patient-centered medical home, the team of health professionals guides and supports patients and their families to help them achieve their health and wellness goals.
- A personal physician may be of any specialty but, to be considered a patient-centered medical home, the practice must meet all patient-centered medical home requirements. There may be situations in which a physician is not on site and the patient's relationship is with a certified nurse practitioner or physician assistant who provides the principal or predominant source of care for a patient. In those instances, the nurse practitioner or physician assistant, in collaboration with a physician, may perform the responsibilities of first contact and continuous and comprehensive care if he or she is otherwise qualified by education, training, or experience to perform the selected acts, tasks, or functions necessary where the acts, tasks, or functions fall within the certified nurse practitioner's or the physician assistant's scope of practice.
- Clinical outcomes, safety, resource utilization, and clinical and administrative efficiency are consistent with best practices.
- Transformational change in health care financial incentives should occur simultaneously with, proportionally to, and in alignment with patient-centered medical home adoption.

NOTES

¹ A. Shih, K. Davis, S. C. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, *Organizing the U.S. Health Care Delivery System for High Performance* (New York: The Commonwealth Fund, Aug. 2008).

² An advisory group was established to provide insights and feedback on case study selections and review draft interview guides. The group met twice by phone, once at the outset of the project and again to review preliminary findings. This work group includes several state officials who are thinking about state and national roles as well as national experts. See Appendix A for members.

³ D. McCarthy and K. Mueller, *Organizing for Higher Performance: Case Studies of Organized Delivery Systems* (New York: The Commonwealth Fund, June 2009).

⁴ J. Buxbaum and M. Takach, *State Multi-Payer Medical Home Initiatives and Medicare's Advanced Primary Care Demonstration* (Portland, Maine: National Academy for State Health Policy, Feb. 2010).

⁵ B. Starfield, "Contribution of Primary Care to Health Systems and Health," *Milbank Quarterly*, 2005 83(3):457–502.

⁶ E. H. Wagner, "Chronic Disease Management: What Will It Take to Improve Care for Chronic Illness?" *Effective Clinical Practice*, Aug.–Sept. 1998 1(1):2–4.

⁷ These four components are based on Barbara Starfield's core domains of primary care: "first-contact" care, continuous care, coordinated care, and comprehensive care.

⁸ Institute of Medicine, *Crossing the Quality Chasm* (Washington, D.C.: National Academies Press, 2001), <http://www.nap.org>.

⁹ National Institute of Mental Health, "The Numbers Count: Mental Disorders in America" (Washington, D.C.: NIMH, 2008), <http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml>, accessed April 26, 2010. More than one of four adults suffer from a diagnosable mental illness in a given year; 46% of these adults suffer from more than one mental disorder.

¹⁰ T. Bodenheimer, "Primary Care—Will It Survive?" *New England Journal of Medicine*, Aug. 31, 2006 355(9):861–64.

¹¹ D. Rittenhouse, S. M. Shortell, and E. S. Fisher, "[Primary Care and Accountable Care—Two Essential Elements of Delivery System Reform](#)," *New England Journal of Medicine*, Dec. 10, 2009 361(24):2301–03.

¹² *Joint Principles of the Patient-Centered Medical Home* (Washington, D.C.: Patient-Centered Primary Care Collaborative, 2005), <http://www.pcpcc.net>, accessed April 26, 2010.

¹³ E. H. Wagner, B. T. Austin, C. Davis et al., "Improving Chronic Illness Care: Translating Evidence into Action," *Health Affairs*, Nov./Dec. 2001 20(6):64–78.

¹⁴ D. Rittenhouse, L. P. Casalino, R. R. Gillies et al., "[Measuring the Medical Home Infrastructure in Large Medical Groups](#)," *Health Affairs*, Sept./Oct. 2008 27(5):1246–58.

¹⁵ A. Liebhaber and J. Grossman, *Physicians Moving to Mid-Sized, Single-Specialty Practices*, Track Report No. 18 (Washington, D.C.: Center for Studying Health System Change, 2007). The percentage of physicians practicing in solo or two-person practices has declined from 40.7% in 1997 to 32% in 2005. Although this is a drastic decline over the last decade, this type of practice setting is still the most commonplace in the United States.

¹⁶ E. Hing and C. W. Burt, “Office-Based Medical Practices: Methods and Estimates from the National Ambulatory Medical Care Survey,” *Advanced Data*, No. 383 (Washington, D.C.: Vital and Health Statistics, National Center for Health Statistics, March 12, 2007).

¹⁷ “Background Information” (Aurora, Colo.: Colorado Children’s Healthcare Access Program, Jan. 17, 2010), <http://www.cchap.org/cchap/>, accessed April 27, 2010.

¹⁸ E. A. McGlynn, S. M. Asch, J. Adams et al., “The Quality of Health Care Delivered to Adults in the United States,” *New England Journal of Medicine*, June 26, 2003 348(26):2635–45.

¹⁹ E. Rendell, “Prescription for Pennsylvania” (Harrisburg, Pa.: Commonwealth of Pennsylvania, Office of the Governor, 2007), <http://www.gohcr.state.pa.us/prescription-for-pennsylvania/Prescription-for-Pennsylvania.pdf>, accessed April 26, 2010.

²⁰ S. Besio, “Overview of Vermont’s Health Care Reform” (Burlington, Vt.: Vermont Agency of Administration, 2008), http://hcr.vermont.gov/sites/hcr/files/Revised_Vermont_HCR_Overview_October_08_0.pdf, accessed April 26, 2010.

²¹ Kaiser Commission on Medicaid and the Uninsured, “Community Care of North Carolina: Putting Health Reform Ideas into Practice in Medicaid,” Policy Brief (Washington, D.C.: Henry J. Kaiser Family Foundation, May 2009).

²² T. Bodenheimer, R. A. Berenson, and P. Rudolf, “The Primary Care-Specialty Income Gap: Why It Matters,” *Annals of Internal Medicine*, Feb. 20, 2007 146(4):301–6. According to surveys done by the Medical Group Management Association, median physician income for family practice physicians increased by 7.5% from 2000–2004 to \$156,000, compared with a 15.8% increase to \$297,000 for all non-primary care specialists.

²³ Examples of CPT codes used, include: 1) 96110: Developmental Testing; limited; 2) 99339: Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (e.g., assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, and 3) 99408: Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes.

²⁴ A. Prado-Gubierez, “Framing the Medical Home” (Commission on Family Medicine and Colorado Association of Family Medicine Residencies, July 20, 2005).

²⁵ “About Colorado Children’s Healthcare Access Program” (Aurora, Colo.: Colorado Children’s Healthcare Access Program, Jan. 17, 2010), <http://www.cchap.org/cchap>, accessed April 27, 2010.

²⁶ Colorado Medical Homes for Children is based on SB07-130, which mandates that every child eligible for Medicaid and CHP+ have access to a medical home by 2010. SB07-211 was signed into law to support the creation and adoption of performance measures and metrics related to medical homes.

²⁷ J. Henneberry, “Colorado’s Medical Home Initiative” (Denver: National Academy for State Health Policy Annual Conference, Oct. 2008).

²⁸ “Colorado Children’s Healthcare Access Program,” (Aurora, Colo.: Colorado Children’s Healthcare Access Program, Jan. 17, 2010), <http://www.cchap.org/cchap>, accessed April 27, 2010.

²⁹ “The Medical Home Index: Pediatric” (Concord, N.H., Center for Medical Home Improvement, 2006), http://www.medicalhomeimprovement.org/pdf/CMHI-MHI-Pediatric_Full-Version.pdf, accessed May 21, 2010.

³⁰ Standards of care that Medicaid and CHP+ children should receive from a medical home in Colorado were developed by HCPF and CDPHE, with considerable input from the Colorado

Chapter of the American Academy of Pediatrics, Colorado Children’s Healthcare Access Program, the Colorado Academy of Family Practice, parent groups, and many, many community-based organizations, and a statewide provider survey. For a complete list of medical home standards, please refer to [Appendix C](#).

³¹ N. Borney, “Michigan’s Unemployment Rate Will Top 15% Through 2011, U-M Economic Forecast Says,” *Ann Arbor.com*, Nov. 20, 2009, <http://www.annarbor.com/business-review/michigans-unemployment-rate-will-top-15-through-2011-economic-forecast-says/>, accessed April 27, 2010.

³² According to state officials, the BCBSM participates in the MPCC as described here, but there is no formal interaction between Medicaid and BCBSM’s program as described or data sharing or reporting measures. About 20,000 of Medicaid’s 1.2 million enrollees participate in a BCBSM managed care product and may indirectly get the benefits of the BSBCM program.

³³ “Seven Joint Principles of the Patient-Centered Medical Home” (Lansing, Mich.: Michigan Primary Care Consortium, Feb. 2007), <http://www.mipcc.org/sites/mipcc.org/files/u4/022107medicalhome.pdf>, accessed April 27, 2010.

³⁴ “Transform Primary Care Practice and Payment” White Paper Series Part 2 (Lansing, Mich.: Michigan Primary Care Consortium, 2009), http://www.mipcc.org/sites/mipcc.org/files/u4/combined%20white%20papers_new%20page%20numbersindd.pdf, accessed April 27, 2010.

³⁵ “MDCH Survey of Physicians 2009” (Lansing, Mich.: Michigan Department of Community Health, 2009), http://www.mhc.org/file_archive/physiciansurvey2009FINAL.pdf, accessed April 27, 2010.

³⁶ “MDCH Survey of Physicians 2006” (Lansing, Mich.: Michigan Department of Community Health, 2006), http://www.mhc.org/file_archive/physiciansurvey2006.pdf, accessed April 27, 2010.

³⁷ “MDCH Survey of Physicians 2009” (Lansing, Mich.: Michigan Department of Community Health, 2009), http://www.mhc.org/file_archive/physiciansurvey2009FINAL.pdf, accessed April 27, 2010.

³⁸ The Reducing Disparities at the Practice Site (RDPS) initiative was developed by the Center for Health Care Strategies. The RDPS initiative is testing the leverage that Medicaid agencies, health plans, primary care case management (PCCM) programs, and other community-based organizations have for improving chronic care at small practices serving racially and ethnically diverse beneficiaries. State-led teams in Michigan, North Carolina, Oklahoma, and Pennsylvania are working to build the quality infrastructure and care management capacity of “high-opportunity” primary care practices. At the end of the initiative, lessons will be broadly disseminated to help additional states and health plans support quality improvement in small-practice settings.

³⁹ Kaiser Commission on Medicaid and the Uninsured, “Community Care of North Carolina: Putting Health Reform Ideas into Practice in Medicaid” Policy Brief (Washington, D.C.: Henry J. Kaiser Family Foundation, May 2009).

⁴⁰ “Program Overview of Community Care of North Carolina” (Raleigh, N.C.: North Carolina Foundation for Advanced Health Programs), <http://www.communitycarenc.com>, accessed Jan. 28, 2010. See also <http://www.commonwealthfund.org/Content/Publications/Case-Studies/2009/Jul/Organizing-for-Higher-Performance-Case-Studies-of-Organized-Delivery-Systems.aspx>.

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⁴² “Fall 2008 Provider Training” (Oklahoma City, Okla.: Oklahoma Health Care Authority, October 8, 2008).

⁴³ Payment reform became a topic of high priority after the ruling of a 2001 lawsuit claiming that the state of Oklahoma violated the equal access provision of the federal Medicaid law and deprived Medicaid recipients of their civil rights. The final ruling, in 2005, required that Medicaid reimbursement rates increase to 100% of the Medicare rates. The decision was overturned in 2007, but the Oklahoma Legislature had already increased Medicaid funding levels. “Oklahoma Chapter of the American Academy of Pediatrics vs. Michael Fogerty of the Oklahoma Health Care Authority,” United States District Court for the Northern District of Oklahoma, http://www.pilcop.org/Courts_Order.pdf, accessed Jan. 28, 2010.

⁴⁴ Average office visit per member must be within one standard deviation of the average utilization for their specialty. “SoonerCare Choice Patient Centered Medical Home Transitional Payment Methodology” (Oklahoma City, Okla.: Oklahoma Health Care Authority, 2009).

⁴⁵ See <http://www.ohca.state.ok.us/providers.aspx?id=8470&menu=74&parts=8482> for specifics.

⁴⁶ “2009 Annual Report” (Oklahoma City, Okla.: Oklahoma Department of Human Services, 2009), <http://www.oucpm.org/okdhsannualreport/archive/2009/index.html>.

⁴⁷ L. Mitchell, “The Patient-Centered Medical Home Voyage” (Tampa, Fla.: National Academy for State Health Policy Annual Conference, Oct. 2009).

⁴⁸ Our case study and interviews focused on the Northeast region. We include limited information about the southeast region for comparison, but did not study in depth that pilot in this paper.

⁴⁹ A microsystem in health care delivery can be defined as a small group of people who work together regularly to provide care to discrete subpopulations, including the patients. It has clinical and business aims, linked processes, shared information environment, and produces performance outcomes. Developed by Dartmouth-Hitchcock Medical Center, Clinical Microsystems provides practices with free tools to become high-performing clinical microsystems. See <http://www.clinicalmicrosystem.org/>.

⁵⁰ Vermont. Gen. Laws ch. 204, § 7. An Act Relating to Managed Care Organization, the Blueprint for Health, and Immunizations of Children Prior to Attending School and Child Care Facilities, and the Immunizations Registry.

⁵¹ DocSite is a company specializing in the creation of clinical support tools. For more information see <http://www.docsite.com/>.

⁵² Vermont Program for Quality in Health Care (VPQ) developed the VPQ Learning Community, which coincided with the initiation of the Blueprint for Health and funding for provider training in six Blueprint communities. This enabled VPQ to accommodate small practices unable to attend the learning sessions but that wanted to incorporate and spread the quality improvement methods into their daily work. VPQ Learning Community consists of three components: centralized, statewide learning forums; multiple, community based mini-learning sessions (the Collaborative on Wheels); and a virtual Learning Community dimension. <http://www.vpqhc.org/uploads/1255977762.pdf>, accessed May 21, 2010.

⁵³ For more information about the VPQ Learning Communities, please see: <http://www.vpqhc.org/interior.php/pid/17/sid/106/tid/171>, accessed Nov. 10, 2010.

⁵⁴ Board of Directors, “2008 Annual and Quality Report” (Montpelier, Vt.: Vermont Program for Quality in Health Care, 2008), <http://www.vpqhc.org/uploads/1255977762.pdf>, accessed May 21, 2010.

⁵⁵ Ibid.

⁵⁶ M. Takach, *The Role of Federally Qualified Health Centers in State-Led Medical Home Collaboratives* (Portland, Maine: National Academy for State Health Policy, June 2009), <http://www.nashp.org/node/1099>, accessed May 21, 2010.