Side-by-Side Summary of State Medical Home Programs

The "Patient-Centered Medical Home" – a model of practice that emphasizes readily accessible, comprehensive, coordinated care – is rapidly gaining traction as a way to reform health care. Many states have begun work to implement "medical home" models in their health programs. This chart describes and compares these state efforts, including the population covered, provider requirements, payment policies, performance measurement and public reporting, the status of the efforts, and additional relevant notes.

Please note that this chart is not exhaustive, and currently only includes public and public/private initiatives. While there are many private sector efforts underway, these efforts are not yet part of this document. We will continue to update this chart, but encourage you to contact us with any additions or comments that could make this chart more useful for the group. Please send additions to Lee Partridge, Senior Health Policy Advisor, at lpartridge@nationalpartnership.org.

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Last updated 9/26/08

State/ program	Population covered	Provider requirements	Payment policies	Performance measurement/ Public reporting	Status	Special notes
Alabama "Patient 1st" www.medicaid.al.us/programs/patient1st/index_patientlst.aspx?tab=4	All Medicaid beneficiaries except disabled and elderly	Providers must agree to act as primary care giver for patient. To earn "enhanced management fees," they must complete 3 training modules on health literacy, medical home, and Medicaid. Includes "In-Home Monitoring," a complementary program allowing Patient 1st enrollees with certain chronic conditions such as diabetes and hypertension to monitor their conditions at home by transmitting readings into a centralized database.	Multi-component case management fee, maximum of $2.60 PMPM. Elements of fee include use of health information technology, Providers also paid regular Medicaid fee for specific medical service given to patient Providers also share in savings realized by state from program.	Certain measures required. State issues provider report card.	Primary care case management program, in place since 2004.	Has very consumer oriented patient handbook with clear statement of rights, including access to family planning, and responsibilities
Colorado	Children enrolled in state Medicaid and Child Health Insurance programs	Legislative definition: "A practice that verifiably ensured continuous, accessible, and comprehensive access to and coordination of community based medical care, mental health care, oral health care, and related services for a child." Responsible for health maintenance and preventive care, anticipatory guidance, acute and chronic care, coordination of meds, specialists, and therapies, provider participation in hospital care, and 24 hour telephone care. More detailed standards require:	Pilot program will pay providers higher fee for comprehensive well child visits Additional payment to providers meeting medical home standards being considered	Will be required	Law (SB 07-130) enacted 2007. Implementation ongoing. State currently offering providers some assistance with care coordination and case management. Pilot program underway	State providing website for consumers to see provider credential and record of any complaints.

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		- same day appointments if needed - provider and staff encourage family participation in health care decision making - medical record sharing with other providers if family authorizes - practice has a continuous quality improvement plan			(2008) with 24 providers and 1000 children	
Illinois Health Connect Web address: www.illinoishealthconnect.com	All Medicaid beneficiaries except those In HMO	Provider signs addendum to standard Medicaid physician participation agreement and promises to: - serve as patient's primary care provider -have hospital privileges or arrangements for admission -makes referrals to specialists -24/7 coverage -maintain office hours of at least 24 hrs/week (solo practices) or 32 hours/wk (group practices) -follow recognized preventive care guidelines -manage chronic disease Enrollees will be assigned a PCP if they do not choose one. Complementary disease management program available for chronically ill	$2 PMPM per child, $3 for parent, $4 for elderly or disabled Plus regular FFS fees Bonus for meeting or exceeding national 50th HEDIS percentile in: -immunization -dev. Screen -asthma mgt. -HbAIC -mammograms -well child	Provider profiling, not publicly reported, using 20 HEDIS and HEDIS-like measures, viz: Child imm, lead testing, asthma/diabetes care, well child and adolescent well care, prenatal frequency/timeliness, depression, cervical cancer screen, adult access to preventive care, rate of ER visits and ambulatory	Primary care case management program, began in 2007.	State provides special secure web portal to support PCP and grant access to patient roster. Beginning 5/2008 will also give patient's Medicaid claim history and 7 years of immunization data Beneficiaries under 21 may obtain preventive

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		beneficiaries, currently targeting children with asthma and disabled adults		care sensitive hospital visits Calculates statewide benchmarks		health care from approved local health department, school-based clinics, and women's health care providers without referral from PCP.
Iowa	All state residents	Leads team of individuals at the practice level who collectively take responsibility for ongoing health care of patients. Provides or arranges for care by other professionals; care coordinated with community. Participates in NCQA voluntary recognition process or similar system to demonstrate practice has capacity to provide patient-centered services consistent with medical home model. Primary care provider can be: - MD who is family practitioner, GP, pediatrician, internist, OB-gyn - Advanced nurse practitioner - Physician assistant - Chiropractor	Reimbursement to be studied by state depts.. and recommended to insurers and state program administrators.. Assumes care management fee add on to FFS. Allows gain sharing, quality incentives. Recognizes value of IT.	Voluntary engagement in performance measurement and improvement. Measures to be specified by dept. For children, suggest immunization, ER use, well child and oral health utilization rates.	Section of an omnibus health reform bill (HF 2539) which became law May 2008	Legislation envisions statewide medical home system that offers care coordination, data collection and analysis, other assistance and monitors quality Medical home system would support both public and private

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						programs, although implementation would begin w/ Medicaid program.
Massachusetts	Medicaid beneficiaries who enroll in planned pilot project	Practice must provide care using a medical home model that coordinates care across health care system and the patient's community. Detailed standards to be developed by state agency.	To be developed by state Medicaid agency. Payment should reward quality and improved patient outcomes.	Annual project evaluation, to be submitted to legislature, should include cost savings, health care screen rates, outcomes and hospitalization rates for patients with chronic illnesses.	Requirement included in omnibus health care quality improvement law (Senate 2863) enacted August 2008. Implementation turns on availability of funds and federal approval of payment structure.	New law also creates state quality and cost council which would determine what performance measures and cost information all providers would be required to submit to the state. Data would be reported on consumer web site.
Minnesota	Medicaid, SCHIP and state funded program for uninsured	All health care homes must: - Offer patient ongoing long term relationship with clinician, including advanced practice nurses and PAs - Provide care coordination	Per person pmts for care coordination, adjusted for patient care complexity. Providers might also quality for separate, add'l	Measures of quality, resource use, cost of care, and patient experience will be required;	New law, May 2008. Medical home standards and new payment system to be	Care coordination fees would be funded from savings in other

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		- Enhance patient/family participation in decision making - . - Ensure use of HIT - Must participate in health care home collaborative re QI More detailed standards under development (2008-09)	quality incentive payments	which ones to be specified by state executive branch agencies.	developed by state DHS and DH. .	segments of medical programs, including HMO capitation fees if necessary
North Carolina *Community Care of North Carolina*	All Medicaid beneficiaries except elderly and disabled	Practice that agrees to participate in state's primary care patient coordination system (Carolina Access) and provide, direct, and coordinate the health care and utilization of health care services of practice enrollees. All necessary medical services must be provided directly or authorized and arranged through the practice. Practice is supported by regional CCNC entity which assists in care management, identifies resources, collects performance data, and provides feedback to practice.	PMPM fee paid in addition to regular FFS payments. Currently $2.50 CNCN networks also receive PMPM fee for each beneficiary.	Measures .	In place since.1998; statewide beginning 2002	Piloting expansion to disabled and elderly populations
Oklahoma Health Management program	Selected Medicaid enrollees w/ chronic conditions	Direct care management support (RNs) for identified Medicaid beneficiaries with high risk chronic conditions, plus assistance to providers in practice redesign to improve quality and efficiency.	No additional payment to providers Nurses hired by state.		Began in January 2008	

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Oregon	Beneficiaries of public programs but available to others	Program should incorporate a health benefit model that promotes primary care medical home. Draft report (9/08) of Oregon Health Fund Board recommends Medicaid and SCHIP recipients be enrolled in an "integrated health home" (IHH) which reflect the patient-centered medical home model of team-based care, care coordination, and stress wellness, prevention and disease management.	Board recommends diverse IHH payment strategies be tested, including mix of fees for direct services and risk-adjusted bundled payment for care integration. Payment should also be tied to quality of performance.	Board recommends establishing comprehensive structure for collecting data on quality, cost, and outcomes from all providers and making publicly available.	Health Oregon Act of 2007 required Oregon Health Fund Board to develop comprehensive health reform plan for Oregon with specific action steps and timelines. Final Board report due 11/08.	Board report envisions IHH model adoption by other publicly funded program, including employee benefits, and private insurers
Pennsylvania Chronic Care Initiative	All beneficiaries enrolled in practices participating in regional medical home pilots.	Patient-centered medical home practice redesign initiative focusing on patients with chronic conditions. Initial focus: diabetics and pediatric asthma. Model based on the four professional society Joint Principles for Medical Home. .	Practices will receive increased reimbursement for attaining PCC-PCMH recognition, and also P4P. Funding supplied by participating insurers, including state Medicaid program.	Required.	First pilot located in SE Pennsylvania region in May 2008. Plan is to replicate in other regions of state.	Initiative lead by Governor's Office of Health Care Reform Practice redesign work being funded by foundation grant
Rhode Island *Connect Care Choice*	Adults enrolled in Medicaid program but not also eligible for	Primary care practices who agree to help coordinate care	Multi-component PMPM based on enhanced services offered Special additional PMPM for case managers for		In operation in some parts of state since 2007	

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	Medicare and not enrolled in a Medicaid HMO		identified high risk patients Both payments in addition to regular FFS reimbursement			
Vermont Blueprint for Health http://healthvermont.gov	Patients with chronic conditions enrolled in public programs; private providers encouraged to participate.	Primary care provider (board certified, if applicable) who provides ongoing support, oversight and guidance to implement an integrated patient care plan, uses HIT and clinical decision support tools, and encourages patient self-management. Providers supported by community-based care coordination teams (CCTs) to assist with care coordination and patient education, including workshops to enhance patient self-management abilities.	Participating providers to be paid care management fees plus incentive payments for demonstrated compliance with established clinical protocols. Recommended fee structure under development.	Data analysis and reporting structure to evaluate pilots under development	Implementation of two pilots underway in 2008	Vermont has also launched Healthier Living Workshops across state to help residents with chronic illness learn techniques for managing their condition and working with providers in partnership.
Washington *Chronic Care Management Program*	Medicaid beneficiaries Identified as high-risk and not enrolled in HMO	State contracts with King County Care Partners, a provider network in King County to provide medical home; network determines provider participation State also contracts with AmeriChoice to provide care management services for clients outside KingCounty and help client find medical home	Fee structure negotiated with state under contract		Program started 2/07	
Washington	Children enrolled in	Practice where patient receives medically appropriate medical, dental	Various methods under discussion; likely to	Measures identified that will	Multistakeholder workgroup	

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www.medicalhome.org	public programs	and behavioral services and community support services, using team approach. Qualifying primary care practices must be willing to adopt medical home models as defined by the dept. of social and health services in its nov 2007 report to the legislature.	include specific incentives tied to quality improvement	reflect impact of medical home, such as childhood immunization rates, well-child visits	mandated by Child Health Act of 2007; 2009?	