Making Connections:
Medicaid, CHIP, and Title V
Working Together on
State Medical Home Initiatives

By Jason Buxbaum

September 2010
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Finally, the author thanks the Maternal and Child Health Bureau of the Health Resources Services Administration; John Snow, Inc.; and the Association of Maternal & Child Health Programs for making this work possible.
Executive Summary

A medical home is an enhanced model of primary care that offers whole person, comprehensive, ongoing, and coordinated patient and family-centered care. Having originated in the pediatric community, a wide range of stakeholders are now looking to the medical home model to improve quality, increase access, and contain costs. States have led in promoting the medical home model, with 37 states undertaking activity to advance medical homes since 2006.

Several of the most promising state medical home initiatives are characterized by interagency collaboration among Medicaid, Children’s Health Insurance Program (CHIP), and Title V agencies. By including Medicaid and CHIP, initiatives draw on the programs’ considerable size. This scale and the ability to modify payment policies offer leverage that can encourage practice transformation. Medicaid and CHIP agencies also have experience offering health care providers other means of support and implementing broad, systems level changes. By including Title V agencies, medical home initiatives draw on their extensive experience developing and promoting the medical home model of care. Title V agencies also offer experience providing medical homes for children with special health care needs (CShCN).

In March 2010, the National Academy for State Health Policy (NASHP) convened a meeting to explore interagency partnerships among Medicaid, CHIP, and Title V agencies in state medical home initiatives. The Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA) and the Association of Maternal and Child Health Programs (AMCHP) provided support. Through facilitated discussion, officials from Colorado, Illinois, Iowa, Minnesota, Pennsylvania, and Texas discussed the value of interagency collaboration and how it has materialized in their states. There was consensus that collaborative medical home building makes for stronger initiatives. Agency leaders can lay the foundation for medical home building, and then work together to engage patients and families, engage health care providers and practices, and build systems of care.

Foundations for partnership. Medical home initiatives have found that a variety of formal and informal structures, relationships, and practices prepare agencies for further collaboration on medical home initiatives. Key policy considerations and actions include:

- Arriving at shared goals, visions, and definitions.
- Drawing on the actions of elected officials to set the stage for collaboration.
- Fostering cultures of collaboration.
- Institutionalizing collaboration through written agreements.
- Forming standing committees.
- Using state, federal, and private expertise and resources.
- Anticipating challenges, such as organizational inertia and transient staffing.
- Preparing to adjust plans on the basis of local and changing realities.

Patient and family engagement. Including patients and families in medical home initiative policymaking operationalizes the philosophy of patient and family-centeredness. Critical perspectives are obtained more easily when patients and families are deliberately and meaningfully included. Medicaid, CHIP, and Title V bring distinct capabilities to this area. Key policy considerations and actions include:

- Engaging patients and families in initiative planning, implementation, and evaluation.
- Adopting patient and family-friendly policies.
- Encouraging health care providers to engage patients and families in practice transformation and quality improvement.
• Providing patient/family education and training.
• Recognizing that certain vulnerable populations are harder to engage than others, and taking steps to find, value, and embrace hard-to-hear voices.
• Anticipating challenges in learning to view patients and families as policymaking partners – not just care recipients.

Health care provider and practice engagement. Medicaid, CHIP, and Title V agencies can partner with health care providers and their staffs to transform practices into medical homes. Key policy considerations and actions include:

• Encouraging practice change with enhanced payment.
• Tailoring approaches to meet health care providers’ practice transformation needs.
• Partnering with health care provider organizations.
• Providing feedback to practices.
• Promoting continuous quality improvement.
• Educating health care providers and practices.
• Anticipating challenges such as focusing on quality improvement – not just cost savings.

Building systems of care. Given the multi-dimensional nature of primary care, medical home initiatives tend to consist of many components. State medical home initiatives are working to integrate the capabilities of Medicaid, CHIP, Title V, and others to promote system cohesion. Key policy considerations and actions include:

• Focusing on system cohesion in the most critical areas.
• Aligning financial incentives with medical home initiative goals.
• Providing practices with enhanced information and supporting care coordination.
• Integrating public health activities.
• Pursuing practice-wide transformation.
• Collaborating to evaluate.
• Integrating health information technology (HIT) efforts.
• Integrating Federally Qualified Health Centers (FQHCs).
• Anticipating challenges in spreading change both wide and deep.

State medical home initiatives stand to gain when agencies partner with one another. Interagency collaboration may in turn serve as a strong foundation to take advantage of emerging opportunities for collaboration with private stakeholders and federal partners. By reaching beyond their agencies, officials in leader states report that their medical home initiatives are stronger – and better positioned to deliver medical homes that improve outcomes, bend the cost curve, and meet the challenge of strengthening the nation’s primary care system.
**Introduction**

The medical home model – an enhanced model of primary care – has a long tradition in the care of children with special health care needs (CSHCN) and pediatrics more broadly.1 The term “medical home” originated in the pediatric community in the 1960s, and in 1992 the American Academy of Pediatrics (AAP) formalized the concept as care that is accessible, family-centered, continuous, comprehensive, coordinated, and compassionate.2 In 2002 the AAP added “culturally effective” to these tenets, and reaffirmed that every child should have a medical home.3 Today, medical homes are widely seen as valuable for patients of all ages and their families.4 One family physician describes the model as “rocket fuel” for practices: when implemented, medical homes increase access to care, improve clinical quality and patient/family experience, enhance health care provider satisfaction, and may even boost practice efficiency.5 In addition to these benefits, payers, purchasers, and policymakers are intrigued by the model’s potential for significant savings.6

Given this promise, the medical home model has received considerable support. The Affordable Care Act (ACA) devotes substantial resources to testing and implementing medical homes across the country.7 And more than 700 stakeholders – including payers, large corporations, and professional societies – have united to advance medical homes under the Patient-Centered Primary Care Collaborative (PCPCC).8 Despite this considerable momentum, however, the implementation of medical homes remains limited.9

Most states – some in partnership with private payers – have worked to spread the medical home model. Since 2006, 37 state Medicaid programs and Children’s Health Insurance Programs (CHIP) have taken steps to promote medical homes.10 Collaboration between agencies, especially among Medicaid, CHIP, and Title V agencies, has been a hallmark of several promising medical home initiatives.

Medicaid and CHIP are pivotal payers in state medical home initiatives. Nationally, there are more than 64 million non-institutionalized Medicaid and CHIP enrollees.11 This provides Medicaid and CHIP officials with significant platforms from which to effect change. Medicaid and CHIP agencies can structure their programs to provide financial incentives to affect health care provider behavior.12 Medicaid and CHIP programs also have experience offering other types of support to practices (e.g., producing health care provider and patient/family education materials) and implementing broad, systems-level changes (e.g., transitioning from a fee-for-service system to managed care). These institutional assets make Medicaid and CHIP agencies important partners in promoting the medical home for safety-net populations.

The Maternal and Child Health (MCH) Services Block Grant, authorized by Title V of the Social Security Act, provides a foundation for ensuring the health, safety, and well-being of the nation’s mothers, children, youth, and families. It provides comprehensive services, including direct health care services (gap filling), enabling services, population based services, and infrastructure building. Statute has specified that – among other purposes – Title V promotes the provision of preventive care for children and “family-centered, community-based, coordinated care” for CSHCN.13 When implemented successfully, medical homes advance these goals, and having a medical home is one of the national performance measures for the Title V population.14 Consistent with these aims, the federal MCH Bureau (MCHB), which administers Title V, has a long history of working with families, states, and public and private partners (especially the AAP) to promote the medical home model of care for families and children.15 Special projects grants administered by MCHB have helped test and spread medical home models, especially for CSHCN.16

The federal Title V agency and its state partners have particular experience fostering systems of patient/family-centered, culturally effective, comprehensive, and coordinated care for CSHCN, who frequently require the services of numerous agencies and health care providers. Title V agencies are likely to have experience
What are Medicaid, CHIP, and Title V?

**Medicaid**: Medicaid is a health and long-term care coverage program established in 1965 as Title XIX of the Social Security Act. The program operates as a state-federal partnership. In 2009, Medicaid offered coverage for nearly 60 million individuals with low incomes. Approximately half of these individuals are under 18 – representing more than one in four American children. With the enactment of the ACA, Medicaid is poised to provide coverage for an additional 16 million individuals by 2019.17

Each state administers its own Medicaid program, but programs must operate within federal parameters. States have considerable latitude, however, to shape their Medicaid programs. Programs set different eligibility criteria, design different benefit packages, and choose whether to contract with managed care organizations.

In 2008, Medicaid accounted for about 14.7 percent of national health expenditures.18 These costs are shared by the states and the federal government. In 2008, states spent more than $146 billion on their Medicaid programs. In addition, more than $192 billion in federal Medicaid matching funds were distributed to states through a formula accounting for population and state income.19


**CHIP**: The Children's Health Insurance Program (CHIP) was enacted in 1997 as Title XXI of the Social Security Act. CHIP is intended to provide health care coverage for children whose family incomes are too high to qualify for Medicaid, but who are not able to afford private coverage. State CHIP programs take three forms: Medicaid expansions, separate children's health programs, and combination approaches.20

CHIP is a state-federal partnership. As with Medicaid, states have flexibility to administer CHIP programs in their states within broad federal guidelines, with additional flexibility for separate CHIP programs. In fiscal year 2008, the federal government spent about $7 billion on CHIP. States matched these funds with about $3 billion. That year, more than 7 million individuals, primarily children, received health coverage through CHIP.21


**Title V**: Title V of the Social Security Act, the Maternal and Child Health (MCH) Services Block Grant, aims to improve the health and well-being of the nation's mothers and children – particularly those from vulnerable communities.22 Established in 1935, and converted to a block grant in 1981, the program operates as a state-federal partnership. With federal Title V funds, the MCH Bureau (MCHB) of the Health Resources and Services Administration (HRSA) provides funding by formula to state Title V agencies. Title V also includes discretionary funding that allows MCHB to directly support special projects, training, and research.

State Title V agencies are generally housed in state departments of health, and programs are typically organized into MCH and CSHCN components. Title V officials use federal MCH funds to administer a wide variety of activities and programs that serve four major functions:

- Infrastructure building (e.g., conducting needs assessments, educating health care providers);
- Offering population-based services (e.g., newborn screening, immunizations);
- Offering enabling services (e.g., care coordination, translation, transportation); and
- Directly providing health care services (e.g., gap-filling care for CSHCN).

Congress appropriated $662 million for the Title V MCH Block Grant for fiscal year 2010.23 Approximately 85 percent of funding was allocated to states, which must provide matching funds, and the remainder was allocated to special projects, research, and training.

engaging health care providers in practice transformation, and frequently are in close contact with families and advocacy groups concerned with the well-being of vulnerable populations. These contacts can be crucial in engaging important stakeholders.

Policymakers tend to report better outcomes when agencies collaborate, integrate their areas of expertise, and draw on the talents of a broad range of officials. By including a range of officials who cross agency lines, medical home initiatives also increase the likelihood of drawing on key talent. Programs developed jointly may be more likely to:

- Reach the implementation stage,
- Achieve desired penetration,
- Motivate health care providers to undertake meaningful and sustainable practice transformation, and ultimately
- Improve the care experience for patients and families.

In examining collaboration to advance state medical home initiatives, this report draws on the experiences of agencies in six leading states selected by national experts for their achievements in partnering across agency lines and their diversity of approaches. The six states are Colorado, Illinois, Iowa, Minnesota, Pennsylvania, and Texas. This report focuses on four aspects of collaboration in state medical home initiatives:

- **Foundation-laying** – setting the groundwork for further efforts through leadership and relationship development;
- **Patient and family engagement** – ensuring the patient and family perspectives are honored in medical home initiative planning, implementation, operation, and evaluation;
- **Health care provider and practice engagement** – working with health care providers and their staffs to promote practice transformation; and
- **Building systems of care** – ensuring the internal cohesion of a medical home initiative through systems planning and development, and measuring results.

The experiences of the six selected states in these areas offer many lessons for those seeking to work across agencies to increase the availability of medical homes in their states.24 Their experience may also be valuable in informing policy development in other complex policy areas.
In March 2010, the National Academy for State Health Policy (NASHP) convened a meeting in National Harbor, Maryland to discuss interagency collaboration on state medical home initiatives. Support was provided by John Snow, Inc. through a contract with the Health Resources and Services Administration’s (HRSA’s) MCHB and by the Association of Maternal & Child Health Programs (AMCHP). The AAP/MCHB National Center for Medical Home Implementation also participated in the organization of the meeting.

The March meeting focused specifically on collaboration between Medicaid, CHIP, and Title V agencies. Through expert consultation, meeting organizers identified six states with medical home programs and diverse, promising approaches to interagency collaboration: Colorado, Illinois, Iowa, Minnesota, Pennsylvania, and Texas. Organizers then invited three-person teams from each selected state. Teams were made up of one Medicaid/CHIP representative, one Title V representative, and one patient/family or health care provider representative. (The participant list is included as Appendix A.) Team members were asked to complete a short survey on collaborative activities in their state’s medical home initiatives prior to attending the March meeting. The meeting agenda covered topics ranging from funding to patient/family-centeredness to health care provider engagement. Each session featured short presentations from discussants followed by moderated discussion.

This report is informed primarily by the day’s discussions, as well as attendees’ survey responses and discussants’ slides.
When Title V, Medicaid, and CHIP agencies work together, they may be able to effect health systems change on a greater scale than would be possible alone. Formal structures, such as memoranda of understandings, legislative requirements, executive mandates, or regularly scheduled workgroup meetings, can serve as the basis for partnership. Informal contact can also be key in strengthening interagency relationships. Officials may find previous collaborative efforts offer useful foundations for building new ones.

Collaboration to advance medical homes makes sense given the areas of expertise that Medicaid, CHIP, and Title V agencies possess. Many Title V officials have experience fostering patient/family-centered care for CSHCN – individuals who frequently require the services of numerous agencies and health care providers. These officials know what medical homes look like and why they are needed. Medicaid and CHIP officials have experience bringing pilots up to scale, administering broad programs, and serving more general populations. They can deploy a variety of payment and purchasing strategies to achieve their goals. In building medical home initiatives, Medicaid, CHIP, and Title V all bring key assets to the table. Medical home efforts – and the populations they serve – stand to gain by combining these assets.

Establishing Foundations in Select States
There is no single model for interagency collaboration to advance medical homes. States are pursuing a variety of promising strategies. For instance, Texas is undertaking multiple medical home projects, many housed in separate agencies. To coordinate efforts and ensure that state officials are kept abreast of relevant developments, stakeholders from more than a dozen organizations and state agencies – including Texas Medicaid and Title V – participate on the Texas Medical Home Workgroup. This workgroup, facilitated by the state’s Title V CSHCN Program, “primes the pump” for collaboration on specific initiatives. For instance, workgroup members have been asked to encourage practices to apply for participation in Medicaid’s $25 million Health Home Pilot Programs project.

Table 1 illustrates the diversity in collaboration strategies undertaken and underway in select states.

**Table 1: Interagency Collaboration on Medical Home Initiatives in Select States**

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<th>Written Agreement Addressing Medical Homes</th>
<th>State Legislative Requirement to Collaborate on Medical Homes</th>
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<tr>
<td><strong>Colorado</strong></td>
<td>• Dept. of Health Care Policy and Financing (Medicaid/CHIP) – Dept. of Public Health and Environment (Title V) (Colo. Rev. Stat. 25.5-1-123).26</td>
<td>• CHIP, Medicaid, and Title V participate on the Colorado Medical Home Initiative (CMHI) Advisory Committee. Increasing developmental screening rates was identified as a key goal. • Medicaid and CHIP have led in practice transformation efforts as part of the CMHI; Title V has provided support for systems evaluation. • Monthly Title V meetings include Medicaid representatives involved in the medical home initiative. • MCHB provided Title V funding for National Initiative for Children’s Healthcare Quality (NICHQ) medical home learning collaborative. Colorado has also received a State Implementation Grant from MCHB that includes funding for learning collaboratives.</td>
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| **Illinois** | • Interagency agreement: Medicaid/CHIP-Title V not specific to medical homes, but allows for better coordination on medical homes. | • Dept. of Human Services (Medicaid/CHIP) – Dept. of Public Health (Title V) (Iowa Code 135.159).27  | • Representatives from Title V and Title V-funded program staff participated in stakeholders meetings to assist in the development of the primary care case management (PCCM) program. They are partners in many initiatives designed to improve the content of care delivered in the medical home.  
• Department of Healthcare and Family Services (Medicaid) serves on many committees charged with building the MCH infrastructure in the state. These workgroups and committees, some of which are legislated, are managed by Title V.  
• Two interagency agreements are in place between Title V and Healthcare and Family Services for the purpose of sharing data and to assist Healthcare and Family Services with the administration of specific activities, such as management of the family case management program.  
• MCHB provided Title V funding for NICHQ medical home learning collaborative. Illinois has also received a State Implementation Grant from MCHB that includes funding for learning collaboratives. |
| **Iowa**   | • Interagency agreement: Medicaid/CHIP-Title V.                                                          | • Dept. of Human Services (Medicaid/CHIP) – Dept. of Public Health (Title V) (Iowa Code 135.159).27  | • Legislation established the Medical Home System Advisory Council under the Iowa Department of Public Health. The Director of Human Services or his/her designee is required to sit on the Council.  
• Iowa has received a State Implementation Grant from MCHB that includes funding for learning collaboratives. |
| **Minnesota** | • Dept. of Human Services (Medicaid/CHIP) – Dept. of Health (Title V) (Minn. Stat. 256B.0751).28            | • Dept. of Human Services (Medicaid/CHIP) – Dept. of Health (Title V) (Minn. Stat. 256B.0751).28       | • Medicaid, Title V, and others formed a leadership team that met monthly and guided the development and implementation of Minnesota’s Medical Home Learning Collaborative. MCHB provided funding. This shaped two key subsequent pieces of medical home legislation.  
• Title V staff sit on key Medicaid committees, and Medicaid staff sits on the Title V Advisory Task Force.  
• Medicaid and Title V staff drafted rules and regulations regarding certification of clinics as health care homes, and the two agencies worked together to devise a payment methodology.  
• The Health Care Home (HCH) Program Manager reports to both the Department of Health and the Department of Human Services.  
• MCHB provided Title V funding for NICHQ medical home learning collaborative. |
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<td>Pennsyl-vania</td>
<td>Memorandum of understanding: Medicaid-Title V-Department of Insurance</td>
<td>An executive order required the Department of Health (where Title V is housed) and the Department of Public Welfare (where Medicaid is housed) to provide support to the Chronic Care Commission that oversees the medical home multi-payer initiative.29</td>
<td>Data sharing agreements exist between Medicaid and the Pennsylvania chapter of the AAP. The Pennsylvania AAP’s work in this area is funded by Title V. State institutional review board (IRB) approval has been granted for the Educating Practices in Community Integrated Care (EPIC IC) medical homes project. MCHB provided Title V funding for NICHD medical home learning collaborative.</td>
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Policy Considerations and Challenges

How can officials build strong foundations for interagency collaboration? Several recommendations emerged from the March 10 meeting.

Shared goals, visions, and definitions are fundamental. In considering how best to fulfill an agency’s mission or program objectives, officials may realize that other agencies share related goals. By recognizing this and arriving at a common vision, officials can increase the momentum for collaboration. These visions may be articulated in written mission statements. For example, Colorado’s Department of Health Policy and Financing (Medicaid/CHIP) and Department of Public Health and Environment (Title V) agreed on the importance of increasing Early Periodic Screening, Diagnosis, and Treatment (EPSDT) screening rates for children. The agencies also agreed on a common definition of the medical home. These shared goals and conceptualizations were important foundations for moving the Colorado Medical Home Initiative forward.

Elected leaders can set the stage for collaboration. In many states, legislators and executives have directed agencies to collaborate, specified mechanisms for collaboration, and/or established fundamental policies.

- Minnesota statute charged the Commissioner of Health and the Commissioner of Human Services with jointly developing certification standards for health care homes. The statute specified basic
principles for the health care home standards. Consistent with the interagency partnership laid out in the legislation, the Health Care Home Program Manager reports both to an official in the Department of Health (where Title V is housed) and an official in the Department of Human Services (where Medicaid and CHIP are housed).

- In Iowa, legislation established the Medical Home System Advisory Council under the Iowa Department of Public Health (Title V). A Council seat is reserved for the Director of Human Services (under which Medicaid and CHIP are housed) or his/her designee.
- In Pennsylvania, an executive order issued by Governor Ed Rendell requires the Department of Health (where Title V is housed) and the Department of Public Welfare (where Medicaid is housed) to provide support to the Chronic Care Commission. The Chronic Care Commission has overseen Pennsylvania’s medical home multi-payer initiative.

**Foster a culture of collaboration.** Collaboration may extend beyond a project-specific basis. Establishing long-term relationships with individuals in peer agencies is of great value. Officials agreed that it is important for agency leaders to make clear that cultivating relationships with counterparts in other agencies is an important staff responsibility. In some cases, it may be helpful to designate individuals to serve as liaisons. Policymakers recommended avoiding the tendency to wait for an invitation to collaborate – officials can “invite themselves.” In doing so, officials may wish to explicitly note how they can assist. In Texas, for example, the Title V CSHCN Director has been actively involved in planning the Texas Medicaid Health Homes pilot – even though the initiative will not focus specifically on CSHCN. Previous work with Medicaid leaders precipitated this involvement.

### Federal Law and Medicaid-Title V Coordination

The Social Security Act requires that state Medicaid and Title V agencies coordinate, with the goals of providing better services and avoiding duplication of effort. Federal law further requires interagency agreements (IAAs) between Medicaid and Title V agencies. IAAs offer the advantages of (1) ensuring policy continuity over time, (2) building expectations of communication and accountability across programs, and (3) providing a formal plan for sharing responsibilities. IAAs tend to enumerate responsibilities of the Title V agency, responsibilities of the Medicaid agency, responsibilities of other agencies, and responsibilities that are shared.

### Institutionalize collaboration through written agreements.

Relationships and culture are important, but key individuals leave and cultures can change. Agencies may find it worthwhile to adopt arrangements that help perpetuate collaboration. Written agreements may take the form of memoranda of agreement (MOAs), or may build on the interagency agreements (IAAs) required by federal law (see text box). The Centers for Medicare & Medicaid Services (CMS) offers guidance pertaining to successful interagency relationships. It states in part: “Successful relationships are based upon detailed planning, clearly identified roles and responsibilities, program monitoring, periodic evaluation and revision, and constant communication.”

Several of the selected states have developed written agreements to support their medical home initiatives.

- Since 2004, the IAA between Colorado’s Department of Public Health and Environment (Title V) and Department of Health Care Policy and Financing (Medicaid/CHIP) has referred to medical homes.
- Pennsylvania’s Departments of Public Welfare, Health, and Insurance have a memorandum of understanding (MOU) defining their agencies’ participation in the state’s Chronic Care Initiative (CCI).

**Form standing committees.** Like written agreements, standing committees can help state agencies perpetuate cooperation on medical home activities. Committees may take many forms. They may develop informally or
originate through legislation or executive order. They may be charged with advisory, oversight, and/or management functions.

- Texas’s large medical home workgroup meets quarterly. A Texas official wrote: “The medical home workgroup has been an effective vehicle for sharing information on medical home activities around Texas, obtaining health care provider and family perspectives for policy issues, and providing updates on medical home projects.”
- In Iowa, legislation established the Medical Home System Advisory Council within the Iowa Department of Public Health. The Department of Human Services and the Insurance Division are represented on the Council, as are a broad range of private stakeholders.33

**Use state, federal, and private expertise and resources.** Once there is commitment to collaboration, agencies can divide the workload. As one Title V official said, there is frequently “too much work to do for one agency or program.” In dividing the workload, agencies may look to draw on existing areas of expertise and resources. In the Colorado Medical Home Initiative, Medicaid and CHIP have taken the lead in promoting and enabling practice transformation. Title V has led the evaluation.

As mentioned above, federal agencies (especially the MCHB) have histories of supporting state medical home initiatives, and several provisions of the ACA offer potential for additional federal support going forward. State agencies can draw on these federal opportunities, as well as other state and private resources.

- Colorado’s Department of Health Care Policy and Financing retrained EPSDT outreach workers to serve as medical home navigators. The state also repurposed an existing task force to develop recognition standards grounded in the state’s pediatric medical home definition.
- Minnesota’s Health Care Home project engaged a number of contracted community partners, such as the primary care physician organizations, the Institute for Clinical Systems Improvement (ICSI), and the University of Minnesota School of Public Health, to plan and implement its program. State agencies had a history of collaborating with these organizations on other projects.
- All six selected states have drawn on federal Title V/MCHB support to fund state medical home learning collaboratives, directly and/or through the National Initiative for Children’s Healthcare Quality (NICHQ).34

Relationships with grantors can also be key in allowing agencies to think strategically. State funding may not be available for long-term planning, and foundation support may help fill the void. A Colorado official noted that foundations funded facilitators, which allowed stakeholders “to meet and strategically think for the future.”

**Challenges**

Collaboration may not come easily. State officials frequently feel over-tasked and under-resourced. Adding steps to project processes can seem unnecessary and burdensome. Furthermore, in some states, interagency collaboration is simply not routine – and change can be perceived as difficult, uncomfortable, or even threatening. One family representative wrote, “Collaboration always takes longer than either doing it yourself or demanding someone do it.” A Title V official wrote, “Commitment to collaboration means a commitment to moving away from traditional ways of doing things (silos) which means a commitment to change [and]…accepting more fluid or changing influence/power equilibriums.”

Transient staffing may be an additional challenge to interagency collaboration. As discussed, establishing cultures of collaboration and structures that promote collaboration (e.g., IAAs, standing committees) can counteract this barrier.

Over-specialization of partnering agencies can also have drawbacks. As one meeting attendee put it, the medical home is like an elephant that everyone can feel part of. Partnering officials can lose sight of the overall picture without strong strategic vision from leadership.
Finally, collaborating officials must avoid the tendency to assume that what works well for one population (e.g., CSHCN) will work for all populations at all times. There is rarely one universally correct model. Plans may need customization on the basis of local realities and changing situations.
There is a clear consensus that patient and family-centered medical homes must be patient and family-centered in more than just name. In a pediatric context, the MCHB-supported National Center for Medical Home Implementation of the AAP declares that a medical home should offer “patient- and family-centered care through a trusting, collaborative, working partnership with families, respecting their diversity, and recognizing that they are the constant in a child’s life.” The Patient Centered Primary Care Collaborative notes that “Even the most capable and caring of clinicians cannot unilaterally improve a patients’ health.” The Joint Principles of the Patient Centered Medical Home emphasize the significance of patient and family engagement in medical homes. Engagement efforts are likely to achieve greater success by honoring the roles of patients and families at both the macro (policy) and micro (practice) levels. This means viewing patients and families as partners, equipping them to manage their own care, and ensuring they can advocate for their needs.

Many of the most promising medical home initiatives have heavily engaged patients and families in planning and policymaking by including them in working groups and regularly soliciting their input and feedback. Several medical home initiatives have also worked to ensure patients and families are engaged in practice-level organizational transformation. Initiative leaders have found that including these individuals is worthwhile because it operationalizes the philosophy of patient and family-centeredness at the system and policy levels. Patient and family perspectives critical to implementation are then more easily incorporated into initiative design, implementation, and evaluation. Meaningful patient and family engagement offers several related advantages:

- Engagement can help develop a constituency that may advocate for additional resources.
- Engaged patients and families are unlikely to have professional “turf” to defend and tend to be perceived as neutral. One meeting participant noted that “bitter pills” are more easily accepted by other stakeholders when they are put forward by patients and families.
- Engagement enlists communities that have been previously left out of health care system planning.
- Engaged patients and families understand that the enhanced attention offered by medical homes is designed to improve patient/family experience and health outcomes. With these tenets in the forefront, patients and families can also participate in the efficiency and value aspects of the medical home.
- Engaged patients and families have a unique role to act as ambassadors for the system redesign offered by medical homes.

Title V, Medicaid, and CHIP agencies all have roles to play in promoting patient and family involvement in medical home initiatives. Title V officials have experience working with families, especially those with CSHCN. These officials frequently have strong working relationships with consumer and family advocacy organization leaders, and may be able to draw on those relationships to identify individuals well-suited to help guide the medical home initiative. As large payers and purchasers, Medicaid and CHIP agencies have significant platforms from which to influence health care providers through incentives and policy. Used appropriately, their “bully pulpits” can encourage health care providers to engage patients and families in their practices through shared decision-making, education, and practice redesign.

**Patient and Family Engagement Efforts in Select States**

There is considerable diversity in the patient/family engagement strategies being pursued by the selected states. Among the six selected states, Title V agencies have generally been most active in this area.
In Minnesota, both the Department of Health and the Department of Human Services are leaders in patient and family engagement. To implement the state’s 2008 health care reform legislation, the state formed a Consumer/Family Advisory Council. The Council was charged with assisting in the development, implementation, and evaluation of health care homes throughout the state. To date, the Council has helped set standards for practice certification, payment approaches, and evaluation measures. The practice certification standards require health homes to have internal quality improvement (QI) teams that include patients/families. To assist in forming these teams, the state has offered health home providers materials on engaging families, including suggestions on how to select individuals to serve on practice advisory groups. Key state leaders believe this investment in patient/family engagement has paid valuable dividends. The state Medicaid Medical Director has declared: “I am convinced that in our experience, patients drive change faster and more appropriately than anything else.”

Table 2 illustrates the considerable diversity in patient and family engagement strategies undertaken in select states.

**Table 2: Patient and Family Engagement in Policymaking**

<table>
<thead>
<tr>
<th>Initiative Planning and Implementation</th>
<th>Practice</th>
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<tbody>
<tr>
<td><strong>COLORADO</strong></td>
<td><strong>PRACTICE</strong></td>
</tr>
<tr>
<td>• Parents and advocates participate in monthly stakeholder group meetings.</td>
<td>• With funding from the Department of Health Care Policy and Finance (Medicaid), Family Voices Colorado hires and trains medical home navigators to administer a family survey and work with practices to become certified as medical homes.</td>
</tr>
<tr>
<td>• Outreach to providers and families is being undertaken by EPSDT Outreach and Case Management program in conjunction with Family Voices Colorado and Health Care Program for Children with Special Needs staff.</td>
<td>• Family Voices Colorado has been working to include parent partners in practice level improvements, and has been working with family leaders through the F2F program. Family Voices has also been working with providers to better understand how they can improve care for all patients.</td>
</tr>
<tr>
<td>• Outreach for families has been through a task force of family leaders in the CMHI. Family Voices Colorado has been working with leaders as navigators through the family-to-family (F2F) grant.</td>
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| **ILLINOIS**                           | |
| • Department of Healthcare and Family Services and Title V collaborate on outreach to pregnant women, infants, and some high-risk children. | |

| **IOWA**                              | |
| • Statewide outreach to patients and families through centralized Information and Referral Services. Toll free line is a partnership between Title V and Medicaid/EPSDT. | |

| **MINNESOTA**                         | |
| • As part of the HCH implementation activities during 2009, a Consumer/Family Advisory Council was formed to assist in the development, implementation, and evaluation of patient-centered, family-centered health care homes. Workgroups comprised of various council members have reviewed standards and certification, payment methodology, and outcome measures. The current Chair of the Council was a parent partner in the pediatric medical home collaborative. | • As a condition of certification, practices are required to have patients and families directly involved in their QI activities. |
| • HCH practices may apply for minigrants from the Department of Health. Many practices have used these minigrants to reimburse participants sitting on practice advisory committees for their time. | • HCH practices may apply for minigrants from the Department of Health. Many practices have used these minigrants to reimburse participants sitting on practice advisory committees for their time. |
| • Practices have been given materials developed by the state chapter of the AAP (with input from a stakeholder Resources and Education Committee) to assist in engaging patients and families. | • Practices have been given materials developed by the state chapter of the AAP (with input from a stakeholder Resources and Education Committee) to assist in engaging patients and families. |
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<td><strong>Pennsylvania</strong></td>
<td><strong>Texas</strong></td>
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<tr>
<td>• Title V has launched the Parent Youth Professional Forums with State Implementation Grant funding to provide a means for families and providers to communicate directly with the Pennsylvania Department of Health.</td>
<td>• The Texas medical home workgroup includes representation from Medicaid, Title V, and families.</td>
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<td></td>
<td>• A family representative participates in Title V block grant reviews and served on the Steering Committee of the Texas Medical Home Initiative.</td>
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<td></td>
<td>• CSHCN Services Program (Title V) community-based services contractors who provide case management and family and clinical supports to CSHCN and their families are required to complete the Texas Health Steps (EPSDT) medical home, transition, and cultural competency online training modules.</td>
</tr>
<tr>
<td></td>
<td>• Families and child advocates were represented in the Texas Health Steps Process Improvement Project workgroup, along with Medicaid/CHIP, Texas Health Steps, and Title V staff.</td>
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<td></td>
<td>• Title V and the Pennsylvania AAP have provided leadership training to parent partners, who are working with practices as part of the EPIC IC medical homes program. Practices are also trained in how to engage and maintain parent partners. EPIC IC reimburses parent partners for travel and child care expenses.</td>
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<tr>
<td></td>
<td>• With Title V funding, EPIC IC is conducting family satisfaction surveys regarding medical home providers, care coordination, unmet needs, and family experiences.</td>
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<tr>
<td></td>
<td>• Medicaid is exploring the use of consumer incentives to encourage participation in practice transformation.</td>
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<tr>
<td></td>
<td>• Title V is conducting family satisfaction surveys regarding medical home services.</td>
</tr>
<tr>
<td></td>
<td>• Title V is providing seed grants to practices for medical home improvements. Some practices have used this funding to enhance family involvement and assess family satisfaction.</td>
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<tr>
<td></td>
<td>• A Family Voices representative in Texas is piloting a parent liaison role in practices to assist practices with care coordination.</td>
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<td></td>
<td>• Texas Parent to Parent, the F2F Health Information Center, conducts training on the medical home for audiences throughout Texas, including parents, community-based organizations, and provider groups.</td>
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Policy Considerations and Challenges

As discussed, patient and family engagement in medical home initiatives can take place on multiple levels. At the macro level, patients and families need to be engaged and educated to not only be consumers but contributors to policy development. At the micro level, practices need to engage patients and families to be active participants in their own care, partners in clinical decision-making, and collaborators in transforming practices into medical homes. Meeting participants identified a variety of key policy considerations for appropriately engaging patients and families in medical home initiatives.

Engage patients and families in planning, implementation, and evaluation. Many state medical home initiatives include patients and families on stakeholder advisory councils, planning committees, or other formal or informal policy workgroups. In Colorado and Texas, for instance, patients and families participate in regularly scheduled stakeholder meetings, alongside Title V and Medicaid. State Family Voices organizations – which aim to “achieve family-centered care for all children and youth with special health care needs and/or disabilities” – have played key roles in medical homes activities in both states. Family Voices Colorado, for instance, employs medical home navigators to administer practice-level surveys and help practices become certified as medical homes.
**Adopt patient/family-friendly policies.** Patient and family engagement is more likely if state agencies adopt practices and policies that make it easier for laypeople to actively contribute in workgroups.

- The Minnesota Department of Health, which houses the state’s Title V agency, ensures that more than one patient/family representative serves on all working groups.
- Pennsylvania Title V covers travel and child care expenses for patient and family representatives serving on workgroups. Also, Pennsylvania Title V uses an interactive website to facilitate communication between patients, families, health care providers, and the Department of Health.42

When meeting, workgroup members can minimize the use of jargon and acronyms, so as to ensure meeting proceedings are as accessible as possible.

**Encourage health care providers to engage patients and families in practice transformation and quality improvement.** State officials report that while some health care providers may be initially reluctant to receive feedback from their patients and families, they often come to value the contributions they offer. Officials report that in some practices, patients and families have become the drivers of practice transformation.

Practice advisory committees can serve as spaces to routinely engage patients and families and harness their energies. Medical home initiatives can support the formation of these bodies though practice-level policy—for instance, by disseminating relevant educational materials to health care providers, providing minigrants to practices to compensate patients and families, or requiring patient and family inclusion in quality improvement work as a condition of practice recognition. The Minnesota Departments of Health and Human Services have pursued all three of these approaches. Initiatives might also support engagement work at the patient/family-level: Pennsylvania Medicaid, for example, has discussed using consumer incentives to recognize beneficiaries who work with health care providers on practice redesign.

In addition to encouraging the formation of advisory committees, state medical home initiatives can assist health care providers in measuring the extent to which they are engaging patients and families and delivering patient and family-centered care. To this end, Family Voices Colorado hires and trains medical home navigators to administer family surveys. Funding is provided by the Colorado Department of Health Care Policy and Finance. The Pennsylvania Department of Health has also worked with practices to develop surveys that assess patient and family experience.

**Provide patient/family education and training.** Educated patients and families are more likely to offer input during working group meetings and in practice advisory groups. With a better understanding of health policy, their contributions are more likely to be helpful. There is a need to “grow” patients and families to not only advocate for themselves, but to be community leaders and representatives. To this end, some medical home initiatives have established patient and family education programs. In Pennsylvania, the state Title V agency works via the Educating Practices in Community Integrated Care (EPIC IC) medical homes program to train practice-based parent partners. Parent partners assist practices with transformation as integral members of the medical home practice teams.43

Family-to-Family Health Information Centers (F2FHICs) may also be helpful in educating and training families. Authorized by the Family Opportunity Act as a part of the Deficit Reduction Act of 2006, MCHB provides the primary funding support for the F2FHICs. Located in all states and the District of Columbia, they provide assistance and training to families of CSHCN, enabling families to become more informed health care consumers.44

**Challenges**

While there is wide consensus that engaging patients and families is worthwhile, meeting participants noted a variety of challenges they face in working to include them in medical home initiatives.
First, policymakers and health care providers may view patients and families solely as consumers of services. Promoting increased compliance may be easier than promoting patient/family leadership in policy formation, program implementation, and practice transformation. Policymakers and health care providers may need to adjust perspectives in order to fully embrace the concept of patients and families as partners.

Second, “patients and families” are not a monolithic group. Choosing patients and families from different walks of life and valuing and embracing their diversity brings a variety of perspectives to the table. However, taking such an inclusive approach can be challenging. Meeting participants reported that they often found it easier to engage some populations (e.g., families of CSHCN, who are frequently well-organized) than others (e.g., low-income families, ethnic minorities). Recruiting members of different groups may require different strategies.

Third, meeting participants stressed the need for better approaches to data collection and measurement. How does an initiative know when it has a high level of patient/family engagement? How can an initiative measure the impact of patient and family voices on systems to make the case for their continued involvement? Participants noted the lack of clear answers and tools to address these questions.
Researchers describe the “exceptional individualized caring” of health care providers as a “pivotal feature” of the medical home model. Title V, Medicaid, and CHIP agencies can pool their internal assets to help health care providers deliver this type of care. Agencies’ existing assets in this area are considerable. Title V staff have experience working closely with health care providers to treat select populations. In many states, staff have developed and implemented programs that promote comprehensive, effective care for CSHCN. Medicaid and CHIP agencies — through their roles as large payers — can assist in bringing these programs to scale and reaching broader populations. These payers and purchasers can implement payment policies that recognize the added value of medical homes. They can also align medical home efforts with existing EPSDT outreach efforts.

**Health Care Provider and Practice Engagement in Select States**

States are engaging health care providers and practices in medical home programs in a variety of ways. Among the most common are: including health care providers on initiative advisory committees, pursuing quality improvement efforts such as learning collaboratives, increasing payment, and offering practice transformation assistance.

Colorado has made health care provider engagement a high priority in the state’s pediatric Medical Home Initiative. Legislation enacted in 2007 calls for the state to maximize the number of Medicaid/CHIP children served by a medical home; the Department of Health Care Policy and Financing (Medicaid/CHIP) and the Department of Public Health and Environment (Title V) are working together to this end. In Colorado, health care provider engagement has several components:

- The 75-member Colorado Medical Home Initiative Advisory Committee includes numerous health care providers alongside agency representatives.
- Practices receive help with state medical home certification from medical home navigators employed by Family Voices Colorado through a contract with the Department of Health Care Policy and Financing. There are currently three full-time medical home navigators.
- Certified medical home practices receive enhanced EPSDT screening rates from Medicaid and Child Health Plan Plus (CHP+), the state’s CHIP program.
- With funding from the Department of Public Health and Environment, local public health agencies offer technical assistance to practices in a variety of areas, including vaccinations and smoking cessation.

Table 3 offers information on the select states’ approaches to health care provider and practice engagement in medical home initiatives.
### Table 3: Health Care Provider and Practice Engagement

<table>
<thead>
<tr>
<th>State</th>
<th>Providers on Medical Home Initiative Committee?</th>
<th>Financial Incentives</th>
<th>Other Incentives and Activities</th>
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</thead>
<tbody>
<tr>
<td><strong>Colorado</strong></td>
<td>• CMHI Workgroup.</td>
<td>• Medicaid and CHIP pay enhanced rates for developmental screenings when performed by medical home-recognized providers.</td>
<td>• Colorado Department of Health Care Policy and Financing has received funding from the Governor's office for provider recruitment and retention.</td>
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<td></td>
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<td></td>
<td>• Medical home navigators assist Colorado practices in completing recognition processes. Family Voices Colorado employs the navigators; funding is provided by the Department of Health Care Policy and Finance (Medicaid/CHIP).</td>
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<td></td>
<td></td>
<td></td>
<td>• Linkage to private funding sources is made for practices wishing to achieve National Committee for Quality Assurance (NCQA) recognition.</td>
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<td>• With private grant funding, Colorado Children’s Healthcare Access Program (CCHAP) and Family Voices Colorado offer a provider helpline.</td>
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<td></td>
<td></td>
<td>• CCHAP employs two full-time equivalent (FTE) practice coaches to assist with practice QI.</td>
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<tr>
<td><strong>Illinois</strong></td>
<td>• Illinois Health Connect (IHC, the public PCCM program) Steering Committee and the five IHC advisory subcommittees that provide policy input.</td>
<td>• IHC offers an enhanced fee schedule and pays monthly case management fees to providers. IHC offers providers pay-for-performance incentives for adopting select recommended clinical practices. Bonuses have been paid for achieving benchmarks in five clinical areas including developmental screenings, immunization rates, mammography rates, use of controller medications in asthma, and rates of annual HbA1c testing in diabetes.</td>
<td>• IHC’s clinical data feedback program gives providers information on numerous measures such as vision screenings and developmental screenings.</td>
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<td>• IHC is working to share information with practices using data from Title V data system.</td>
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<td>• IHC academic detailing program offers providers and staff information on appropriate screening tools and billing procedures.</td>
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<td></td>
<td>• IHC has worked to learn more about barriers in the practice that the Department of Healthcare and Family Services can address.</td>
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<td><strong>Iowa</strong></td>
<td>• Medical Home System Advisory Council.</td>
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<td>• Community-based contractors will serve as community utilities, providing care coordination for clients served by select primary care providers (PCPs).</td>
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<td>• Medicaid-Title V agreement provides for basic care coordination for all Medicaid-enrolled children. Title V also coordinates oral health services for CHIP-enrolled children.</td>
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<td></td>
<td>• Effort underway to inform providers about existing ability to bill for providing certain developmental screenings.</td>
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<td>• Department of Public Health’s 1st Five Healthy Mental Development Initiative provides a wide range of services, including care coordination and training on developmental screenings.</td>
</tr>
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<td><strong>Table 3: Health Care Provider and Practice Engagement</strong></td>
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<td><strong>Financial Incentives</strong></td>
<td><strong>Other Incentives and Activities</strong></td>
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</tr>
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</table>
| **Minnesota** | • HCH Payment Methodology Steering Committee.  
• HCH Standards and Criteria Work Group. | • The Primary Care Coordination (PCC) program offers PCPs up to $917.04 annually for providing care coordination services for Medicaid fee-for-service patients with at least five chronic conditions.  
• The Department of Health (Title V) and the Department of Human Services (Medicaid) collaborated with stakeholders to create a payment methodology for certified health care homes that includes all patients with one or more major chronic condition. Payment will include Medicaid and privately-insured populations, and proposed Medicaid rates (which will replace the PCC rates listed above) range from $10-$60 per member per month. | • Provider associations helped develop the standards for HCH certification.  
• The Department of Health has a contract with the Department of Human Services to provide EPSDT training to PCPs.  
• The Department of Health and the Department of Human Services contracted with ICSI to select patient outcomes to be tracked. ICSI included numerous providers on its Outcomes Development Work Group.  
• The Department of Health and the Department of Human Services work together on topic-specific provider learning collaboratives.  
• Under the HCH program, information on quality, patient experience, and service utilization will be regularly provided to clinic sites. |
| **Pennsylvania** | • CCI: Governor’s Chronic Care Management, Reimbursement and Cost Reduction Commission. | • CCI has used different payment methods across its four regional rollouts. These methods include per member per month, lump sum, and performance payments. | • EPIC IC is funded by Pennsylvania Title V and administered by the Pennsylvania AAP. In partnership with Medicaid, the program educates and provides coaching for practices on how to provide medical homes for all children, including CSHCN. EPIC IC works on PDSA (plan-do-study-act) QI cycles with practices and Medicaid partners.  
• EPIC IC provides mini-grants to practices to support care coordination.  
• EPIC IC developed a DVD to educate practices on the medical home.  
• Title V launched Parent Youth Professional Forums that enable providers and parents to communicate directly with Title V staff.  
• CCI and EPIC IC explicitly reference specific performance benchmarks for medical homes. |
| **Texas** | • Texas Health Home Pilot Project Expert Panel.  
• Texas Medical Home Workgroup.49 | • The $25 million pediatric-focused Medicaid Health Home Project will provide grants to practices to become medical homes. | • A common contractor provides provider outreach and recruitment for both Medicaid and the CSHCN Services Program.  
• Texas Health Steps, the state’s EPSDT program, has produced free online continuing education modules. There are modules on the medical home and case management.  
• The Texas Council for Developmental Disabilities funds a medical residency educational program administered by Texas Parent to Parent. The program allows residents to learn how medicine translates into the personal lives of CSHCN and their families. Also, other Family Voices representatives in Texas conduct “Project DoCC (Delivery of Chronic Care)” resident training programs. |
Encourage practice change through enhanced payment. The Joint Principles of the Patient-Centered Medical Home state that the medical home approach provides for payment that "recognizes the added value provided to patients who have a patient-centered medical home." To this end, the Joint Principles recommend a multi-pronged approach that includes: (1) traditional fee-for-service visit rates, (2) ongoing payment for services and supports provided outside of office visits, (3) pay-for-performance incentives, and (4) sharing the savings that accrue to payers when excellent primary care averts costly acute care utilization. In addition to supporting infrastructure investment and increased operating costs, enhanced payment sends broader signals about priorities. This symbolic value is significant.

- Minnesota Medicaid, the state employee health plan, and state-regulated private payers will adopt "consistent" payment methodologies for the Health Care Home program. Rates will vary with patient complexity. Primary care providers will receive a $10-$60 per member per month payment for Medicaid patients with one or more major chronic conditions. Private payers will negotiate rates outside of Medicaid with individual health care providers, using a common patient tiering structure and administrative billing process.
- In addition to paying monthly case management fees for all beneficiaries, Illinois Health Connect offers health care providers pay-for-performance incentives.
- Pennsylvania’s Chronic Care Initiative has deployed numerous innovative payment methods across its four regional rollouts. Strategies have included:
  - Per member per month payments dedicated to funding a care manager,
  - Lump sum payments that include reimbursement for time spent out of the office attending learning collaboratives, and
  - A shared savings model that varies the percentage of savings shared with performance on 14 quality metrics.

State officials may choose to adjust payment approaches as programs develop. For instance, the Colorado Medical Home Initiative is considering replacing the enhanced fee-for-service developmental screening rates that certified medical home providers currently receive with monthly care coordination fees.

Meeting participants referred to enhanced payment as the “green enzyme”: while increased funding is important, it is not sufficient to ensure practice transformation.

Tailor approaches to meet health care providers’ practice transformation needs. To this end, the best resources and materials are easy to access and absorb. Prioritizing information is also important. Some officials found, for instance, that health care providers were more open to quality improvement assistance after medical home-related billing questions were resolved.

- As discussed above, in collaboration with Family Voices Colorado, the Colorado Department of Health Care Policy and Financing funds three full-time medical home navigators. In addition to other duties, these individuals assist practices with the paperwork involved in obtaining medical home recognition.
- In Iowa, some health care providers inaccurately believed that developmental screenings were not eligible for reimbursement. Officials have worked to correct these misperceptions, thereby boosting reported screening rates.
- Pennsylvania Title V and the EPIC IC medical homes program developed a DVD to educate practices on the medical home concept.

Meeting practice needs may mean accommodating the diversity among practices. For instance, practices vary greatly in the extent to which they have adopted health information technology (HIT) and health information exchange (HIE) systems. Initiatives can ensure that policies and programs work for advanced users of HIT and HIE, paper-based practices, and practices in between.
Partner with health care provider organizations. Primary care provider associations may make for valuable allies. Several states have reported positive results working with local pediatric, family medicine, internal medicine, osteopathic medicine, and nursing associations. States can also draw on the resources of national health care provider associations, such as those offered by the AAP/MCHB National Center for Medical Home Implementation.53

- Pennsylvania’s EPIC IC medical homes program is funded by the state’s Title V agency and administered through the Pennsylvania chapter of the AAP.
- Representatives of the Texas Pediatric Society participate in the Texas Medical Home Workgroup.

Provide feedback to practices. Patient rosters, health care provider report cards, and other routine forms of performance feedback tend to be well-received by providers if they are designed well. Such reports can leverage health care providers’ professional pride and promote healthy competition.

- Illinois Health Connect offers health care providers information on which patients have and have not received required developmental screenings. Illinois Health Connect also offers health care providers semi-annual profiles that show aggregated screening rates and how a given health care provider compares with his/her peers. EPSDT screening rates have dramatically increased, as have other services such as objective developmental screenings.
- Under the Minnesota Health Care Home program, information on quality, patient experience, and service utilization will be provided to clinic sites on a regular basis.

Promote continuous quality improvement. Medical professional and accreditation societies are increasingly emphasizing commitment to quality improvement as a core competency for health care providers and institutions.54 Medical home initiatives can help develop this culture of continuous quality improvement by: (1) working to improve practices’ understanding of how to measure performance, (2) improving practices’ understanding of how to use that information to improve care for patients, and (3) framing program goals in terms of improved quality. In fact, many initiative leaders report that health care providers tend to be more enthusiastic about medical home transformation when program goals are framed primarily in terms of quality rather than cost savings.

- The Pennsylvania Chronic Care Initiative practice agreement and the Pennsylvania EPIC IC medical homes program reference specific performance benchmarks for medical homes.
- The Minnesota Department of Health and the Minnesota Department of Human Services engaged the Institute for Clinical Systems Improvement to select patient outcomes to be tracked under the Health Care Home project. Four physician representatives from the primary care field were included on the workgroup.55

In addition to focusing on clinical (e.g., diabetics’ HbA1c levels) and patient/family-centered measures of quality (e.g., patient and family satisfaction surveys), officials can highlight the potential of the medical home model to improve health care provider work life satisfaction.56 For example, materials prepared by the Pennsylvania Title V/AAP EPIC IC medical homes project explicitly reference “increased professional satisfaction” as a benefit of the medical home model.57

Educate health care providers and practices. As discussed earlier, all of the select states have drawn on federal Title V resources to support learning collaboratives. There are many additional ways initiative leaders can increase health care provider knowledge about the medical home model and relevant resources in their communities. Offering practice coaching, partnering with professional organizations, working with medical schools and training institutions, and developing continuing education programs are four such options.

- Illinois’s Enhancing Developmentally-Oriented Primary Care (EDOPC) program is a joint initiative of the Illinois Department of Healthcare and Family Services (Medicaid), a health system, and two primary care provider associations (the state chapters of the AAP and the American Academy of Family Physicians
Making Connections: Medicaid, CHIP, and Title V Working Together on State Medical Home Initiatives

National Academy for State Health Policy

EDOPC “work[s] to improve the delivery and financing of preventive health and developmental services for children birth to age three.” EDOPC offers online and office training on topics including developmental screening, perinatal depression, and autism. (Office trainings are eligible for continuing medical education credit.) Trainings include discussion of cultural and linguistic competency.

- The Texas Council for Developmental Disabilities funds a medical residency educational program administered by Texas Parent to Parent. Under this program, “trained volunteer parents invite residents into their lives to experience first-hand how they meet the challenge of raising a child with special healthcare needs.” The program also organizes talks for health care professionals on topics of interest, including the medical home model. Texas Parent to Parent has collaborated with several medical school residency programs.

- Minnesota’s Health Care Home practice recognition standards emphasize patient and family-centeredness. Accordingly, the state maintains an online toolbox to educate health care providers about culturally competent, patient/family-centered care.

Numerous meeting participants stressed the crucial role that office support staff (e.g., office managers, receptionists) play in the daily running of a practice. The team approach to care is a hallmark of the medical home, and initiatives can engage practice staff in transformation efforts.

- The Iowa Healthcare Collaborative – “a provider-led and patient-focused nonprofit organization dedicated to promoting a culture of continuous improvement in healthcare” – has hosted learning collaboratives for office managers. Going forward, the Iowa Healthcare Collaborative will be focusing on assisting practices in obtaining National Committee for Quality Assurance (NCQA) recognition.

- Illinois Health Connect has educated office managers on proper billing procedures. Illinois Health Connect has also worked to learn more about barriers in practices that the Department of Healthcare and Family Services can address.

Challenges

Supporting health care providers in medical home efforts can raise a variety of challenges. It can be difficult to focus on enhanced quality and access – rather than just cost savings – as rationales for building medical homes. Savings may be more easily achieved when implementing the medical home for older, chronically ill adults. Expecting the same level of savings for children may be unreasonable. In this case, the case for medical homes may rest on improved quality, improved access, and public health accountability (i.e., achieving Healthy People 2010/2020 goals).

Several other challenges related to health care provider engagement were noted:

- Moving beyond claims data for quality measurement can be difficult, especially in the absence of widespread electronic health record (EHR) adoption.
- Health care providers may be resistant (at least initially) to certain patient and family-centered quality improvement measurement approaches, such as satisfaction surveys.
- Medical home initiatives can lose focus. Deliberate effort is needed to avoid letting the medical home become a “place” rather than a “model of care.”
- Most medical home initiatives have engaged with specialists (especially dental and mental health providers) in a very limited fashion, if at all. Partnering with these individuals in medical home initiatives has the potential to improve care coordination.
Medical home initiatives take multiple approaches to enhancing care across the four fundamental dimensions of primary care: first contact care, continuity, coordination, and comprehensiveness. A medical home initiative might offer guidance on open access scheduling to make care more accessible. The initiative might also promote the use of patient registries, provide funding for care coordinators, and offer practice coaching on expanding the breadth of services provided. Given the multi-dimensional nature of excellent primary care, medical home initiatives tend to be complex.

Assuring that the various medical home components align to promote system cohesion is key. The model is also more likely to flourish if measured and evaluated – so as to best make the case for continued investment, and to collect data necessary for improvements.

Medicaid and CHIP come to the table with many capabilities in this area. As significant payers, they can join other plans in implementing multi-payer medical home initiatives. Medicaid management information systems (MMIS) capacities can be deployed to support health care providers. Medicaid medical home HIT and HIE incentives can be devised to comport with meaningful use standards, thereby increasing the likelihood that health care providers experience an aligned set of expectations.

Title V agencies are involved in administering health programs such as Women, Infants, and Children (WIC); early intervention (EI); family case management; family planning; school health clinics; and others. Title V agencies can draw on these databases to provide health care providers with more information about the patients they are serving. More generally, Title V officials tend to have experience designing systems of care for vulnerable populations. This expertise can also be valuable in designing integrated systems for broader populations. Additionally, Title V agencies have experience monitoring access to health care, quality of care, and population health. These agencies may be able to offer expertise in evaluating the impact of a medical home initiative. Finally, Title V agencies pursue public health projects, which are frequently community-based. They may have opportunities to teach the public and other stakeholders about the importance of primary care and the value of having a medical home.

**Promoting Systems of Care in Select States**

Systems building has taken many forms across the six states. By integrating education, clinical support, and payment approaches, Illinois offers an example of a systemic approach to improving developmental primary care through the state’s EDOPC program. Illinois Title V, working with a stakeholder advisory group, compiled EDOPC’s educational curriculum. Through EDOPC, health care providers are offered ongoing coaching on appropriate screening tools and billing procedures. Illinois Health Connect, the primary care case management (PCCM) program for certain populations covered by Medicaid, CHIP, and the state-funded program for children who would otherwise be uninsured, uses claims data to offer health care providers ongoing clinical feedback on rates of pediatric developmental screenings. Illinois Health Connect has also implemented a pay-for-performance program that awards bonuses to practices for achieving certain developmental screening benchmarks.

Table 4 offers information on the select states’ approaches to systems building.
### Table 4: Building Systems of Care

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<td>COLORADO</td>
<td>• Multi-payer initiative led by Health TeamWorks distinct from Medicaid/CHIP CMHI.</td>
<td>• Health Team-Works medical home multi-payer program targets internal and family medicine practices. • Medicaid/CHIP initiative is pediatric-focused.</td>
<td>• Integrated Healthy People 2010 objectives in initiative evaluation.</td>
<td>• CMHI designed around pre-existing policy goal of boosting EPSDT screening rates. • Though CMHI pays enhanced rates only for children covered by Medicaid and CHIP, initiative hopes to achieve transformation that will benefit all children, regardless of payer. • CCHAP employs practice coaches who assist with practice QI. The Department of Health Care Policy and Finance provides funding for medical home navigators employed by Family Voices Colorado. The CCHAP practice coaches and the Family Voices Colorado medical home navigators meet regularly to discuss interaction with practices, results of family surveys, and progress on the medical home index form.</td>
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<tr>
<td>ILLINOIS</td>
<td>• IHC, the Medicaid PCCM program, serves both adult and pediatric populations.</td>
<td>• Four-part approach to evaluation consists of tracking patient experience, cost savings, improved clinical/process outcomes, and provider satisfaction. • Evaluation indicates that IHC saved the state about $150 million in fiscal year 2009.</td>
<td>• Illinois Title V’s Cornerstone data system contains information on WIC, EI, family case management, and other service utilization data. IHC is working to share information from this data system with PCPs. • EDOPC program developed and implemented jointly by Title V, Medicaid, and other stakeholders. • Healthcare and Family Services and Title V collaborate on case management provided to pregnant women, infants, and some high-risk children. They collaborate on the Assuring Better Child Health and Development (ABCD) III, Project Launch, Perinatal Depression initiative, and other initiatives that are designed to build the MCH infrastructure. • Title V needs assessment identified advancing medical homes for women and children as priorities.</td>
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<td>IOWA</td>
<td>• The Medical Home System Advisory Council is developing plans for a multi-payer initiative.</td>
<td></td>
<td>• Medicaid funds Title V to provide support for basic care coordination services for all Medicaid children. • Cooperative agreement between Title V and CHIP provides for clinician outreach staff. • Title V and Medicaid jointly fund a toll free information and referral hotline. • Medicaid provides daily updates to Title V of newly enrolled children. Information is accessed electronically by local Title V agencies.</td>
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### Table 4: Building Systems of Care

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<td><strong>Minnesota</strong></td>
<td>• 2008 legislation calls for health care homes for all insured individuals subject to state regulation.</td>
<td>• HCH program will serve children and adults.</td>
<td>• ICSI engaged to identify outcomes consistent with the Institute for Health-care Improvement’s Triple Aim.</td>
<td>• As of June 2010, the PCC program has launched, while the broader HCH program is still in development. PCC will soon share certification standards with the HCH program.</td>
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<td>• PCC program (for Medicaid fee-for-service beneficiaries with multiple chronic conditions) serves children and adults. PCC will be phased out as the HCH program is implemented.</td>
<td></td>
<td>• PCC program pays large case management fees. Medicaid feels these are appropriate given the high-needs focus of the program. The state plans to extend payments for patients with less complex needs under the HCH program.</td>
</tr>
<tr>
<td><strong>Pennsylvania</strong></td>
<td>• All significant payers except Medicare and Medicaid fee-for-service are participating in CCI.</td>
<td>• CCI has selected specific conditions to focus on, including diabetes and pediatric asthma.</td>
<td>• Executive order requires evaluation and outcomes measurement tracking.</td>
<td>• HCH practices will be required to meet outcome benchmarks to maintain HCH certification (and hence enhanced payment).</td>
</tr>
<tr>
<td><strong>Texas</strong></td>
<td>• Health Home Pilot will be pediatric-focused.</td>
<td>• Health Homes Pilot RFP includes information on a comprehensive evaluation that will be conducted after two years. The evaluation will examine measures pertaining to quality, experience, process, and costs.</td>
<td></td>
<td>• The EPIC IC medical homes program is collaborating with the CCI to address chronic diseases in children. The two programs participate in joint learning sessions with practices and collaborate via the Pennsylvania chapter of the AAP. In addition, a number of pediatrics practices participate in both initiatives across the state.</td>
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**Policy Considerations and Challenges**

**Promote system integration in the most critical areas.** While officials generally view systems integration as desirable, state officials have found that integration is more critical in some areas than others. For example, health care providers are generally used to (albeit not always satisfied with) the different payment methods used by different health plans. By contrast, health care providers are frustrated by competing, uncoordinated, resource-intensive quality improvement programs. As an official wrote, if “each funder is doing their own quality improvement process... a provider that serves Medicaid, Medicare, CHIP and private insurance might have six-eight initiatives vying for his time!” Listening to stakeholder input, initiative leaders may selectively invest resources in harmonizing the areas where disparate practice would be of greatest concern.

- Pennsylvania Medicaid managed care organizations participate as payers in the state’s multi-payer Chronic Care Initiative. Practice participation agreements between practices and initiatives explicitly identify one set of outcome and process measurements that will be tracked.
- By aligning Medicaid PCCM payment policy with Title V messaging, the aforementioned Illinois EDOPC program emphasizes an important policy goal – increasing developmental screening rates – using multiple strategies.

**Align financial incentives with medical home initiative goals.** In many cases, the goals of medical home initiatives are designed to comport with preexisting agency goals, such as bending the cost curve, increasing developmental screening rates, ensuring access to health care providers, or others. In this sense, initiatives can build on existing foundations. Whether the goals are new or old, state agencies can work to ensure that financial incentives support initiative goals.

- Colorado decided that a key goal of the state’s Medical Home Initiative would be to increase adherence to EPSDT developmental screening guidelines – a pre-established state goal. As such, enhanced Medicaid and CHIP payment is delivered to medical home practices in the form of enhanced reimbursement for well-child screenings. (These rates are enhanced relative to the rates paid to non-medical home practices.)
- Minnesota’s Primary Care Coordination program is limited to Medicaid fee-for-service beneficiaries with very complex health care needs. The Primary Care Coordination program invests in intensive case management services with the aim of keeping complex patients as healthy as possible and out of the hospital. While per member per month care coordination fees for medical home initiatives serving general populations tend to range from $2-6, the biannual care coordination fees paid under the Primary Care Coordination program amount to $40.50-$76.42 per member per month depending on patient complexity.73 Medicaid feels these high care coordination fees are appropriate given the high-needs focus of the Primary Care Coordination program. The Health Care Home program is also based on complexity-adjusted payment that concentrates payment where the clinic work and effort of care coordination occur. The Health Care Home program supports coordination of care for beneficiaries with one or more major complex conditions with rates from $10 to $60 per member per month.

**Provide clinical practices with enhanced information and support care coordination.** While financial incentives are important, medical home initiatives can provide other important types of support to clinical practices by integrating previously siloed systems. This support may take the form of offering health care providers information that traditionally exists in unavailable databases. For instance, in Illinois, Title V’s Cornerstone data system contains information on WIC, EI, family case management, and other service utilization data. Illinois Health Connect is working to share this data about patients with their primary care providers. The hope is that with additional information, primary care providers will be able to better understand and help address some of the daily challenges patients and families face in managing care. Additionally, information from the Department of Healthcare and Family Services (e.g., eligibility/enrollment, pregnancy status, and certain service utilization data) is shared with the Title V-funded programs identified above through Cornerstone.
Medical home initiatives have taken steps to support practices (especially small and rural practices) by offering community utility-type services to promote information sharing and care coordination. For instance, it may not be practical or efficient for a solo practitioner to employ a dedicated care coordinator. Medical home initiatives can develop arrangements to share practice support infrastructure and avoid service delivery gaps. Iowa Title V's 1st Five Healthy Mental Development Initiative, for example, provides primary care providers with access to an external care coordinator who links the child to intervention services. The care coordinator, in turn, “closes the loop” with the primary care provider and informs him/her of the referral status. Whether or not an initiative chooses to offer this type of intensive support system, it is important to carefully consider care coordination strategies for practices of all types.

**Integrate public health activities.** Initiatives may also draw on existing disease prevention and health promotion services programs in their states, such as anti-smoking and anti-obesity campaigns. For instance:

- Several health care provider education documents produced by Illinois Health Connect make references to the state’s Tobacco Quitline.
- Minnesota’s Health Care Home practice certification standards include a requirement for “ongoing partnership with at least one community resource.”

State Title V agencies are also required to conduct needs assessments every five years to identify service and capacity capabilities and challenges. Illinois Title V considered access to medical homes in the state’s most recent needs assessment. In response to the findings, the agency identified advancing medical homes for children and women as priorities for 2010-2015. As of early 2010, strategies for moving forward were in development.

Initiatives may take a population-based approach to promoting medical homes and strong primary care through the strategic use of traditional and social media campaigns. They may also avail themselves of federal public health resources.

**Pursue practice-wide transformation.** While many medical home initiatives focus on improving care for select beneficiaries, others have worked to change the way health care providers care for all patients. For example, even though the Colorado Medical Home Initiative pays enhanced rates only for children covered by Medicaid and CHIP, the agency reports that its investments in practice coaching have improved care for children covered by other payers.

Multi-payer medical home initiatives, whereby payers join together in aligning enhanced payment for medical home practices, have great potential to effect practice-wide change. At least 15 states are participating in or planning to participate in multi-payer medical home initiatives.

- In Pennsylvania, Medicaid managed care organizations participate in the state’s multi-payer Chronic Care Initiative. As of November 2009, the Chronic Care Initiative covered more than 650,000 adults and children across its four regional rollouts.
- In Colorado, Health TeamWorks leads a multi-payer medical home initiative designed to cover up to 30,000 patients. Seven commercial payers are participating.

**Collaborate to evaluate.** Whether a medical home initiative is single or multi-payer, outcomes measurement and evaluation are key. Collaboration with agency partners can help identify outcomes to measure. For instance, officials in Colorado’s Department of Health and Environment saw an opportunity to build on Healthy People 2010 goals in assessing the Colorado Medical Home Initiative. Healthy People 2010 measures have been incorporated in the Colorado Medical Home Initiative evaluation. Meeting attendees emphasized the value of following Colorado’s lead and taking advantage of preexisting evaluation designs. To this end, initiatives may consider looking outside state borders at evaluation efforts underway in other states. Other examples of evaluations include:
Illinois Health Connect is taking a four-pronged approach to measurement. They are tracking:

1. **Patient experience of care**, as assessed by surveys,
2. **Cost savings**, as calculated by actuaries,
3. **Process and clinical outcomes improvements**, especially at the population-level,
4. **Health care provider satisfaction**.

Illinois has taken steps to publicize savings generated by the medical home program.80

Minnesota Title V has developed a family experience of care survey that asks not only standard questions such as “Did your doctor spend enough time with you?” but also ascertains time missed from school and work due to illness.

**Challenges**

The lack of alignment between statewide HIT programs and medical home initiatives is one of the most frequently identified obstacles to enhancing medical home “systemness.” When deployed with care, HIT can facilitate team-based, comprehensive, ongoing, and coordinated patient-centered primary care.81 When deployed haphazardly, however, HIT efforts can undermine these medical home tenets by diminishing provider-patient contact, reducing practice efficiency, and promoting fragmentation. In many states (and to some extent, at the federal level), HIT efforts are being executed with limited attention to how such efforts can support medical homes. Many initiative leaders see opportunities to better integrate HIT and HIE efforts in their states with medical home programs.

A second common challenge is scalability – ensuring that medical home transformation can be spread both deep and wide.82 Practices chosen for participation in pilots often start with unusually strong foundations. Early-adopting practices also tend to be enthusiastic and willing to embrace transformation. Transformation beyond this group can be more challenging. Resources that were adequate to support transformation in a limited number of early adopters may be inadequate to support transformation more broadly.

A third common challenge is integrating Federally Qualified Health Centers (FQHCs) into state medical home efforts. While FQHCs’ mission of serving vulnerable populations is shared by Medicaid programs, there tends to be only limited collaboration between these programs. However, given the wide range of medical and social services that FQHCs tend to offer and their geographic dispersal, there is the possibility of FQHCs serving innovative roles in state medical home initiatives. Specifically, at least one state has worked to establish FQHCs as community utilities that can provide intensive support services for Medicaid beneficiaries with complex health needs.83 Health reform provides $11 billion between 2011 and 2015 for enhanced investments in community health centers. It is possible that this new funding could give impetus to more fully integrating FQHCs into state medical home initiatives. The new funding, however, could also lead some private practices to feel disadvantaged by FQHCs that receive higher payment to care and treat Medicaid beneficiaries. This potential for increased tension, as well as the historic silos that separate agencies, may make it difficult to integrate FQHCs into medical home programs.

Cooperation among public and private health care payers and purchasers in support of the medical home model tends to be of great value. A fourth common challenge is establishing this cooperation. Particularly significant hurdles include: building trust among competitors, harmonizing quality improvement programs, and aligning disparate payment methods without running afoul of anti-trust laws.

Meeting attendees noted several additional obstacles to increasing medical home “systemness.”

- Many patients, families, and health care providers are unaware of medical home support services available to them. Finding and funding the best outreach techniques are challenges.
- Provisions of the Family Educational Rights and Privacy Act (FERPA) limit the information school-based health programs can share with medical homes.
• The Employee Retirement Income Security Act (ERISA) limits the ability of state medical home initiatives to ensure access to medical homes for those covered by self-insured employers.
Conclusion

Having originated in the pediatric community in the 1960s, there is now a clear broad-based national movement towards the medical home model. Stakeholders (including large payers) are mobilizing to advocate for the model, and are frequently investing in it themselves. Federal legislation devotes considerable resources to testing and paying for medical homes, and federal agencies continue to develop initiatives to test and spread the medical home model.

States provide services and supports for vulnerable populations, serve as major health care payers, and are interested in broadly advancing the health of their populations. Given these roles and the national context, states have been active in developing, implementing, supporting, and evaluating medical home initiatives. In many cases, states have been at the forefront of current practice, testing innovative approaches to paying for enhanced care, supporting internal practice transformation, and developing shared practice support systems.  

State officials operate in complex policy environments, where expertise, resources, and authority are generally spread across agencies. As such, state medical home initiatives stand to gain when agencies partner with one another. In practice however, officials face many barriers to collaboration – especially in terms of culture, time, and staffing. Many states have found that the barriers are surmountable – and worth surmounting. Cultures can be changed, time can be found, and staffing can be adjusted. As discussed here, medical home initiatives in Colorado, Illinois, Iowa, Minnesota, Pennsylvania, and Texas have benefited from interagency collaboration. Table 5 offers a summary of key policy considerations that emerged from discussion among officials in these leader states.

Establishing a foundation for interagency partnership enables Medicaid, CHIP, and Title V agencies to collaborate over time to engage patients and families, engage health care providers and practices, and build systems of care. State interagency collaboration may in turn serve as a strong foundation to take advantage of opportunities for collaboration with private stakeholders and federal partners. By reaching beyond their agencies, officials in leader states report that their medical home initiatives are stronger – and better positioned to deliver medical homes that improve outcomes, bend the cost curve, and meet the challenge of strengthening the nation’s primary care system.
### Table 5: Key Policy Considerations in Collaborative Medical Home Building

#### Laying the Foundations for Partnership at the Agency Level
- Shared goals, visions, and definitions are fundamental.
- Elected leaders can set the stage for collaboration.
- Foster a culture of collaboration.
- Institutionalize collaboration through written agreements.
- Form standing committees.
- Use state, federal, and private expertise and resources.
- Anticipate challenges, such as organizational inertia and transient staffing.
- Prepare to adjust plans on the basis of local and changing realities.

#### Engaging Patients and Families in Policymaking
- Engage patients and families in planning, implementation, and evaluation.
- Adopt patient/family-friendly policies.
- Encourage health care providers to engage patients and families in practice transformation and quality improvement.
- Provide patient/family education and training.
- Recognize that certain vulnerable populations are harder to engage than others. Take steps to find, value, and embrace hard-to-hear voices.
- Anticipate challenges in learning to view patients and families as policymaking partners – not just care recipients.

#### Engaging Health Care Providers and Practices
- Encourage practice change through enhanced payment.
- Tailor approaches to meet health care providers' practice transformation needs.
- Partner with health care provider organizations.
- Provide feedback to practices.
- Promote continuous quality improvement.
- Educate health care providers and practices.
- Anticipate challenges such as focusing on quality improvement – not just cost savings.

#### Building Systems of Care
- Promote system cohesion in the most critical areas.
- Align financial incentives with medical home initiative goals.
- Provide practices with enhanced information and support care coordination.
- Integrate public health activities.
- Pursue practice-wide transformation.
- Collaborate to evaluate.
- Consider how HIT efforts can support the initiative.
- Consider how to integrate FQHCs.
- Anticipate challenges in spreading change both wide and deep.
Appendices
Appendix A

Making Connections: State Medicaid, CHIP, and Title V Collaborating to Build Medical Homes

March 10, 2010 • National Harbor, MD

Participant List

Colorado

- Christy Blakely, MS, Director, Family Voices Colorado
- Sandeep Wadhwa, MD, MBA, State Medicaid Director, Department of Healthcare Policy and Financing
- Kathy Watters, Director, Children with Special Health Care Needs Unit, Department of Public Health and Environment

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- Margaret Kirkegaard, MD, MPH, Medical Director, Illinois Health Connect
- Michelle Maher, Chief, Bureau of Managed Care, Department of Healthcare and Family Services

Iowa

- M. Jane Borst, RN, MA, Chief, Family Health Bureau, Department of Public Health
- Jennifer Vermeer, MPA, State Medicaid Director, Department of Human Services
- Debra Waldron, MD, MPH, Clinical Associate Professor of Pediatrics, Division of General Pediatrics and Adolescent Medicine, University of Iowa Children’s Hospital

Minnesota

- Carolyn Allshouse, State Coordinator, Family Voices of Minnesota
- Maggie Diebel, RN, MPH, Director, Division of Community & Family Health, Department of Health

Pennsylvania

- Melita J. Jordan, CNM, MSN, APRNC, Director, Bureau of Family Health, Department of Health
- David Kelley, MD, MPA, Chief Medical Officer, Office of Medical Assistance Programs, Department of Public Welfare
- Renee Turchi, MD, MPH, Director, EPIC IC Pennsylvania Medical Home Program, Medical Director, Special Programs, St. Christopher’s Hospital for Children, Drexel University School of Public Health

Texas

- Jose Gonzalez, MD, JD, MSEd, Medical Director, Medicaid and CHIP Division, Health and Human Services Commission
- Carol Harvey, Senior Program Officer, Any Baby Can
- Lesa Walker, MD, MPH, Director, Title V Children with Special Health Care Needs, Department of State Health Services

Additional Officials and Meeting Organizers

- Melinda Abrams, MS, Vice President, Patient-Centered Coordinated Care, The Commonwealth Fund
- Michelle Alletto, MPA, Senior Manager, Public Policy & Government Affairs, Association of Maternal & Child Health Programs
- Trebeby Brown, Senior Program Manager, Children and Youth with Special Health Care Needs, Association of Maternal & Child Health Programs
• O. Marion Burton, MD, FAAP, President, American Academy of Pediatrics
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• Catherine Hess, MSW, Senior Program Director, National Academy for State Health Policy
• Lynda Honberg, MHSA, Program Director, Division of Services for Children with Special Health Needs, Maternal and Child Health Bureau, Health Resources and Services Administration
• Neva Kaye, Senior Program Director, National Academy for State Health Policy
• Michele Lawler, MS, RD, Deputy Director, Division of State and Community Health, Maternal and Child Health Bureau, Health Resources and Services Administration
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• Suzanne Montasir, MPH, Program Manager, Division of Children with Special Needs, National Center for Medical Home Implementation, American Academy of Pediatrics
• Lauren Raskin Ramos, MPH, Director of Programs, Association of Maternal & Child Health Programs
• Fan Tait, MD, FAAP, Associate Executive Director and Director, Department of Community and Specialty Pediatrics, American Academy of Pediatrics
• Mary Takach, RN, MPH, Program Manager, National Academy for State Health Policy
• Angela Tobin, MA, LSW, Medical Home Policy and Education Analyst, National Center for Medical Home Implementation, American Academy of Pediatrics
1 The medical home is sometimes referred to as the health home, health care home (HCH), or advanced primary care (APC). For consistency, this report uses the term “medical home” unless referring to a particular initiative that uses different terminology.


Efficiency gains may occur through the increased use of teams, improved internal workflows, and better managed patient visits.


Robert J. Reid et al.


7 In particular, see: Section 2703 (Medicaid State Plan Option to Provide Health Homes for Enrollees with Chronic Conditions); Section 3021 (Center for Medicare and Medicaid Innovations); Section 3502 (Community Health Teams); and Section 5405 (Primary Care Extension Program).

While penetration does remain limited, it bears noting that numerous medical home projects have launched throughout the country.


14 Calvin Sia et al.

15 Ibid.


24 Collaboration has also been a hallmark of success in medical home initiatives outside the public sector. The work of Geisinger – a large integrated delivery system in Pennsylvania – is particularly noteworthy in this respect.

Ronald A. Paulus, Karen Davis, and Glenn D. Steele.

25 State Medicaid and CHIP agencies tend to be housed in the same state departments. Meeting participants with Medicaid responsibilities were generally very knowledgeable about CHIP activities in their states.


40 Maine's medical home initiative is a leader in this area. In 2006, the Maine Health Access Foundation -- which is supporting the
Maine Patient-Centered Medical Home pilot – funded 160 discussion groups with 1,451 Mainers to “find out what patient-centered, integrated care means to them.” This work, along with a series of formal focus groups conducted in 2008, has served to inform pilot planning. Maine also includes patients/families on its project working group.


43 For a discussion of the role of Parent Partner, see this MCHB-funded report:


52 New York City’s Primary Care Information Project has reported similar findings. In the context of promoting the adoption of HIT and building medical homes, they recommend “establish[ing] workflows, apply[ing] customizations, configure[ing] billing and fix[ing] system bugs before deploying QI.” (Emphasis added.)


56 Robert J. Reid et al.


   http://www.edopc.net.


   http://www.health.state.mn.us/healthreform/homes/education/patientcentered.html.


64 Enhancing Developmentally Oriented Primary Care.

65 Health TeamWorks was formerly known as the Colorado Clinical Guidelines Collaborative (CCGC).

   http://www.coloradoguidelines.org/pcmh/default.asp.


67 This excludes the uninsured, as well as enrollees covered by Medicare and self-insured employers.

   http://www.ihi.org/IHI/Programs/StrategicInitiatives/TripleAim.htm.


70 “[P]ractices that register as PCC providers will eventually be required to be certified as health care homes under the statewide process in order to continue receiving care coordination payments.”


72 Texas Health and Human Services Commission, Request for Proposals (RFP) and Application for Provider Practices to Participate in the Health Home (Medical Home) Pilot Program (Austin, TX: Texas, 2010). Retrieved 22 July 2010. 


Three such innovative models bear highlighting: the Vermont Blueprint for Health’s community health teams; the Montana Medicaid Passport to Health, Health Improvement Program; and Community Care of North Carolina.


75 Sharon Silow-Carroll.


80 Illinois Government News Network.


83 Montana Department of Public Health & Human Services.

84 Federal agencies have shown a willingness to accommodate the variation in state medical home approaches. See, for instance, the requirements for the Medicare Multi-payer Advanced Primary Care Demonstration (under which traditional Medicare will join a limited number of state medical home initiatives as a payer provided certain conditions are met).