

### The Role of FQHCs in State-led Multi-payer Medical Home Collaboratives

	<b>Pennsylvania</b>	<b>Rhode Island</b>	<b>Vermont</b>
<b>Lead State Agency</b>	Governor's Office of Health Care Reform	Office of Health Insurance Commissioner	Blueprint for Health Vermont Department of Health
<b>Dates</b>	<ul style="list-style-type: none"> <li>• May 2008 (1<sup>st</sup> rollout of statewide plan)</li> <li>• May 2009 (3<sup>rd</sup> rollout in southwest PA)</li> <li>• 3 years to implement each roll out</li> </ul>	<ul style="list-style-type: none"> <li>• October 2008</li> <li>• 2 year pilot</li> </ul>	<ul style="list-style-type: none"> <li>• July 2008 (Pilot 1)</li> <li>• 2 year pilot</li> </ul>
<b>Origins</b>	<ul style="list-style-type: none"> <li>• Executive Order created Chronic Care Commission 2007</li> <li>• Commission developed a strategic plan to merge PCMH with Chronic Care work</li> </ul>	<ul style="list-style-type: none"> <li>• OHIC statute to direct health plans to work on affordability issues</li> <li>• FQHC/HRSA work in Health Disparities Collaboratives.</li> <li>• Chronic Care Collaborative begun by QIO</li> <li>• CHCS grant to convene payers and provide financial support for project management</li> </ul>	<ul style="list-style-type: none"> <li>• Grew from 2006 legislation (Act 191) establishing 6 original Blueprint communities charged with improving health care and prevention for the most prevalent chronic conditions.</li> <li>• Legislation in 2007 (Act 71) called for multi-payer approach (sustainable financial reform) including mandate for commercial insurers to participate.</li> </ul>
<b>FQHC and/or PCA stakeholder participation</b>	Governor's Chronic Care Commission, Steering Committees	Chronic Care Sustainability Initiative (CSI) stakeholder group, Steering Committees	Executive Committee for the Blueprint, Blueprint Advisory groups, local workgroups
<b>Payers</b>	16 commercial payers that include Medicare Advantage & Medicaid managed care	Medicaid FFS, Medicaid Managed Care, all RI-based commercial payers, Medicare Advantage	Medicaid, Medicare (costs subsidized by state), 3 major commercial insurers
<b>Diseases Targeted</b>	Asthma (pediatrics) or diabetes (adults)	Diabetes, depression, coronary artery disease (adults)	All chronic conditions. In addition, health management for general population, disease prevention, and wellness.
<b># practices/ FQHCs</b> <b>Selection of practices</b>	<ul style="list-style-type: none"> <li>• In first roll-out (Southeast PA) 32 practices including 7 FQHCs (Mary Howard Health Center, Project Salud, Rising Sun, PHMC Health Connection, Health Annex, Abbottsford-Falls, Quality Community Health Care)</li> <li>• In first roll-out, all practices that applied were accepted. Subsequent rollouts have competitive process.</li> </ul>	<ul style="list-style-type: none"> <li>• 5 practices including 1 FQHC (Thundermist).</li> <li>• Practices self-selected.</li> </ul>	<ul style="list-style-type: none"> <li>• 3 Blueprint communities (based in hospital service areas). One community includes 4 of the 6 FQHC sites of Northern Counties Health Care and a provider-based RHC, Corner Medical.</li> <li>• Practices selected through a competitive process.</li> </ul>

	<b>Pennsylvania</b>	<b>Rhode Island</b>	<b>Vermont</b>
<b>Infrastructure support</b>	<ul style="list-style-type: none"> <li>• Learning collaboratives including \$ for lost revenue time for team to attend 7 days in year one</li> <li>• Web-based patient registry</li> <li>• Practice coaching</li> </ul>	<ul style="list-style-type: none"> <li>• Chronic Care model training (collaborative)</li> <li>• EHR or Electronic Disease Registry</li> <li>• Practice coaching</li> <li>• Care management nurse at each practice</li> <li>• Evidence-based guidelines embedded in clinical practice</li> <li>• Self-management support for patients</li> </ul>	<ul style="list-style-type: none"> <li>• Chronic care model training &amp; Clinical Microsystem training (collaborative)</li> <li>• Funding for expanded EMR use including population management/data sharing/web-based clinical tracking system with eRx</li> <li>• Practice coaching</li> <li>• Care Integration Coordinator at each practice</li> <li>• Each practice has support through multidisciplinary community care teams including VDH Public Health Prevention Specialists</li> </ul>
<b>Reimbursement</b>	<ul style="list-style-type: none"> <li>• In Southeast PA lump sum payments on proportionate share of payer mix based on NCQA level achieved. Payment varies per region/practice based but up to \$4 PMPM for NCQA level III.</li> <li>• Infrastructure development payments (\$ for lost revenue time for teams to attend collaboratives, NCQA application cost, data entry cost)</li> </ul>	<ul style="list-style-type: none"> <li>• \$3 PMPM</li> <li>• Shared payer support for nurse care manager at each practice</li> </ul>	<ul style="list-style-type: none"> <li>• Varies based on NCQA score. Up to \$2.39 PMPM.</li> <li>• Shared payer support for Community Care Teams (5 FTEs)</li> <li>• State subsidizes Medicare share of payment</li> </ul>
<b>Expectations of Providers</b>	<ul style="list-style-type: none"> <li>• Go through Chronic Care Model Collaborative</li> <li>• Progressive level of NCQA PPC-PCMH certification (self audit). Must reach Level 1 PLUS (includes care management) by 18 months.</li> <li>• Track care through registry or EMR linked to registry</li> <li>• Report data through registry</li> </ul>	<ul style="list-style-type: none"> <li>• Go through Chronic Care Model Collaborative</li> <li>• Progressive level of NCQA PPC-PCMH certification (self audit). Must reach Level 1 by 9 months. Level 2 by 18 months.</li> <li>• Report data through registry or EMR linked to registry</li> <li>• Patient engagement and education activities</li> </ul>	<ul style="list-style-type: none"> <li>• Go through Clinical Microsystems training</li> <li>• Progressive level of NCQA PPC-PCMH certification (independent audit). Must reach Level 1 to trigger first payment. Reassessed every 6 months.</li> <li>• Track care through registry or EMR linked to registry</li> <li>• Report data through registry or EMR linked to registry</li> </ul>
<b>Evaluation</b>	<u>Multi-payer database</u> <ol style="list-style-type: none"> <li>1. Engaged providers</li> <li>2. Patient self-care knowledge and skills</li> <li>3. Patient function and health status</li> <li>4. Primary care practice satisfaction</li> <li>5. Appropriate and efficient utilization of services</li> <li>6. Clinical quality of care</li> <li>7. Cost of care</li> </ol>	<u>Multi-payer database</u> <ol style="list-style-type: none"> <li>1. PCMH process measures (NCQA PPC-PCMH score)</li> <li>2. Health outcomes for 3 chronic conditions</li> <li>3. Patient experience of care</li> <li>4. Clinical quality of care</li> <li>5. Cost of care</li> </ol>	<u>Multi-payer database</u> <ol style="list-style-type: none"> <li>1. PCMH process measures (NCQA PPC-PCMH score)</li> <li>2. Health status measures using age, gender, preventive assessments.</li> <li>3. Clinical quality of care</li> <li>4. Cost of care</li> </ol>

Creation of this chart was done with support from a National Cooperative Agreement (NumberU30CS09747-01-00) with the federal Health Resources and Services Administration, Bureau of Primary Health Care (HRSA/BPHC). Copyright © 2009 National Academy for State Health Policy. For reprint permission, please contact NASHP at (207) 874-6524