By Mary Takach, Charles Townley, Rachel Yalowich, and Sarah Kinsler

DOI: 10.1377/hlthaff.2014.1083
HEALTH AFFAIRS 34,
NO. 4 (2015): 662–672

Making Multipayer Reform Work: What Can Be Learned From Medical Home Initiatives

Mary Takach (mtakach@nashp.org) is a senior program director at the National Academy for State Health Policy (NASHP) in Portland, Maine.

Charles Townley is a policy specialist at NASHP.

Rachel Yalowich is a policy analyst at NASHP.

Sarah Kinsler is a health policy analyst at the Department of Vermont Health Access, in Montpelier. At the time this article was written, she was a policy specialist at NASHP.

ABSTRACT Multipayer collaboratives of all types will encounter legal, logistical, and often political obstacles that multipayer medical home initiatives have already overcome. The seventeen multipayer medical home initiatives launched between 2008 and 2014 all navigated four critical decision-making points: convening stakeholders; establishing provider participation criteria; determining payment; and measuring performance. Although we observed trends toward voluntary payer participation and more flexible participation criteria for both payers and providers, initiatives continue to vary widely, each shaped largely by its insurance market and policy environment. Medical home initiatives across the United States are demonstrating that multipayer reform, although complex and difficult to implement, is feasible when committed stakeholders negotiate strategies that are responsive to the local context. Their experiences can inform, and perhaps expedite, negotiations in current and future multipayer collaborations.

Reforming the US health care system will require multiple payers working in a coordinated fashion to bring about changes in the way health care providers and systems deliver care.[1,2] Providers and health systems can afford to make necessary investments and long-term improvements to meet health system goals when they are working with common signals or expectations from payers and are receiving reliable funding streams that cover significant proportions of their patient populations.

A strong example of payers working together to drive delivery and payment reforms is the medical home model, which is gaining traction in the United States.[3] There have been some mixed results concerning the model's ability to produce desired cost and quality outcomes.[4] However, the uptick in multipayer medical home collaboration suggests that payers are finding common ground in the belief that investments in primary care infrastructure create value[5–8] and may provide a foundation on which to base other reforms, such as accountable care organizations and bundled payment.[9]

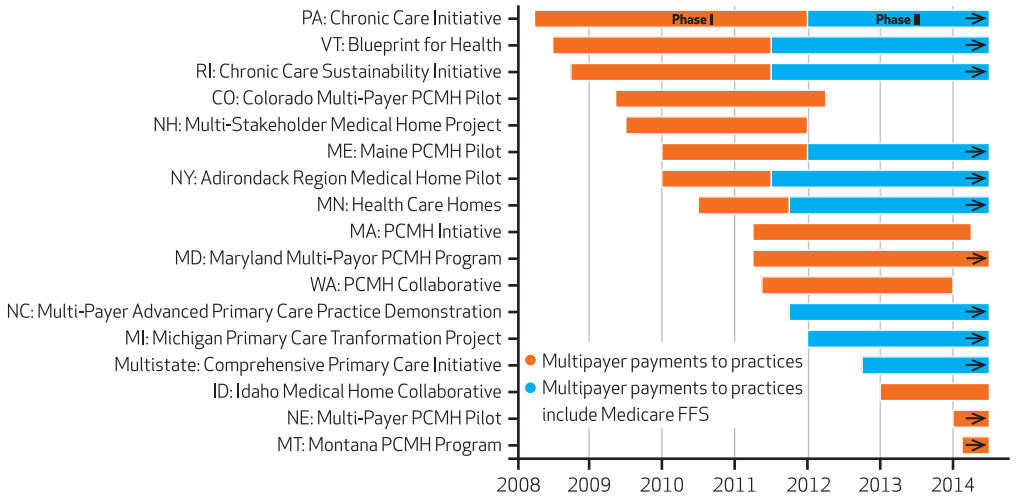
Multipayer payment reform of all types will encounter legal, logistical, and often political obstacles that multipayer medical home initiatives have already overcome. It is particularly important to look at the lessons learned through medical home collaborations before implementing more complex payment models.

Seventeen multipayer medical home initiatives were launched in the United States between mid-2008 and mid-2014, representing geographically and politically diverse states and regions (Exhibit 1). Numerous issues were encountered during the implementation of multipayer medical homes.[1,10]

Our analysis focuses on four issues that data gleaned from multiple sources indicate are germane to any multipayer reform: convening stakeholders; establishing criteria for provider participation; determining payment; and mea-

EXHIBIT 1

Timeline For Multipayer Medical Home Initiative Payments



SOURCE Authors' analysis of data from National Academy for State Health Policy. Medical home and patient-centered care [Internet]. Portland (ME): NASHP; c 2013 [cited 2015 Feb 9]. Available from: http://www.nashp.org/med-home-map. **NOTE** PCMH is patient-centered medical home.

suring performance. Through the lens of multipayer medical home implementation, we discuss why these issues are important and how decisions made while navigating them are shaped by a variety of contextual factors, primarily changing local insurance markets and political environments. Understanding stakeholders' options in navigating these four critical issues in multipayer medical home initiatives can inform, and perhaps expedite, negotiations in current and future multipayer collaborations.

Study Data And Methods

DATA The data for this article were derived from several primary and secondary sources. We collected primary data for fourteen of the seventeen multipayer initiatives through consultations with stakeholders who participated in one or more medical home learning collaborative funded by the Commonwealth Fund during 2008–14. These consultations included bimonthly calls, in which implementation progress and barriers were reviewed and entered into a shared web-based spreadsheet for collaborative monitoring; surveys administered before the start of each collaborative, whose results were entered into a spreadsheet for comparison (see online Appendix Exhibit 1 for a survey that served as a template for the learning collaboratives);[11] and e-mail communications. Secondary data sources included initiative web pages, published evaluations, and reports to legislatures.

METHODS We identified seventeen multipayer medical home initiatives that have been launched since the beginning of 2008. Thirteen are still active, and four have ended.[12] For a program to be included in our analysis, participating practices must have received enhanced payments from two or more payers in a planned and coordinated fashion.

We plotted the initiatives on a timeline (Exhibit 1) and compared the features of newer initiatives with those of older initiatives. As mentioned above, our analysis focused on four issues that uniformly surfaced during our consultations.

For the quality measurement section, we limited data collection and analysis to clinical quality measures. We then analyzed the changing insurance markets and political environments that influenced the decision-making processes. One current or former leader from each initiative reviewed this article to verify the data and provide additional context.

LIMITATIONS Our use of secondary data found on initiative-specific websites has several limitations. Public websites are not always up-to-date and may offer a one-sided view of a policy initiative. Furthermore, most of the initiatives are still under way, and formal evaluations have not been completed. Thus, the data available for analysis varied across initiatives, and sources varied in the amount of detail provided.

In particular, we were unable to identify the clinical quality measures required in all seventeen programs. Therefore, we selected a subset for this aspect of our analysis.

Study Results

We identified four critical decision-making points: convening stakeholders, establishing criteria for provider participation, determining payment, and measuring performance. Each is discussed below.

CONVENING STAKEHOLDERS Securing payers', purchasers', and providers' commitment to participate in a multipayer initiative is the most formidable implementation barrier. Stakeholders must consider who will convene the initiative, how to navigate antitrust issues, and how to secure payer and provider participation.

▶**SELECTING A CONVENER:** Identifying a convener with strong leadership ability and credibility with both the payer and provider communities is critical to bringing key stakeholders to the table and keeping them there.[1] Of the seventeen multipayer medical home initiatives in our study, twelve were led by state entities, two by public-private partnerships, two by private organizations, and one by the federal government (Exhibit 2).

State entities—the overwhelming choice to convene multipayer medical home initiatives—offer three unique advantages that improve the chances of success. States are able to offer legislative and executive branch leadership, extensive purchasing power through Medicaid and state employee health plans, and antitrust protection.[13] However, there may be advantages to not having a state entity as a convener: States that convene an initiative and also participate as a payer may not be viewed as neutral. Furthermore, priorities can change with new administrations, and budget pressures can potentially destabilize the state's role in initiatives.

We were surprised to learn that budget pressures had this effect in only one initiative: In Pennsylvania, the Chronic Care Initiative moved from the Governor's Office to the Department of Health. The initiative has continued. However, a 2014 Milbank Memorial Fund study concluded that the leadership change at the state level contributed to several payers' dropping out.[1]

▶**ADDRESSING ANTITRUST ISSUES:** There are significant legal barriers to collaboration among multiple payers. Cooperating and collaborating to set prices and payments is a violation of federal antitrust law. However, state officials and other stakeholders may be granted immunity from federal antitrust law through the state-action doctrine, provided they meet a two-prong test: clear articulation that the anticompetitive behavior is endorsed as state policy, and active state supervision.[14]

Nine of the seventeen initiatives used legislative or executive branch state-action policies to provide antitrust protection (Exhibit 2). Most of these initiatives were then able to align payment methods and amounts across payers. Conveners in the eight initiatives without state-action immunity protection were able to facilitate the alignment of payers on other key design features (for example, practice participation requirements and performance metrics). However, payers negotiated directly with each practice to set payment amounts.

▶**SECURING PAYER PARTICIPATION:** Five of the first ten initiatives (those in Maryland, Minnesota, Pennsylvania, Rhode Island, and Vermont) used legislative mandates or executive branch action to secure commercial payers' participation (Exhibit 2).[15] Although payer mandates help secure a critical mass of payers, self-funded employer plans and their administrators are excluded as a result of the Employee Retirement Income Security Act of 1974. This has remained a major challenge for most initiatives, since self-funded employer plans often cover a sizable number of patients on providers' panels.

In Colorado, participating practices received medical home payments for only approximately 20 percent of their patients because of self-insured employers' lack of participation.[16] Rhode Island sought to address this by requiring carriers to make payments on behalf of the employers (Chris Koller, president of the Milbank Memorial Fund and former health insurance commissioner for the State of Rhode Island, personal communication, July 28, 2014).

None of the multipayer medical home initiatives launched after mid-2011 used a mandate to secure payer participation. Mandates are often politically unfeasible. In addition, the insurance market has changed dramatically, with more payers already administering their own medical home programs. Conveners have had to work with payers to integrate their existing programs into a multipayer initiative.

In 2011 the Center for Medicare and Medicaid Innovation secured payer participation in its Comprehensive Primary Care initiative[17] by issuing a solicitation to payers that set forth its vision for delivery and payment reforms. (Note that although this initiative spans seven regions, listed in the Exhibit 2 Notes, the Innovation Center treats it as one multipayer initiative.) Applicants were expected to provide both non-visit-based payments and shared savings to participating medical homes, but they were free to propose their own methods and amounts for both types of financial support.[18]

▶**SECURING PROVIDER PARTICIPATION:** Providers are a critical constituency and have played key leadership roles in provider outreach, education, and advocacy efforts in all seventeen initiatives. Ultimately, initiatives must balance

EXHIBIT 2

Overview Of Multipayer Medical Home Initiatives Launched During 2008–14

State, dates	Convener(s)	State action immunity	Commercial payer participation	Practice selection or medical home designation
PA, phase 1 (2008–11)	State entity: Pennsylvania Governor's Office of Health Care Reform	Yes	Voluntary	Selected through a competitive process; NCQA PCMH recognition required, including some otherwise optional standards at specified levels
VT (2008–present)	State entity: Department of Vermont Health Access	Yes	Mandatory[a]	NCQA PCMH recognition required
RI (2008–present)	State entity: Rhode Island Office of the Health Insurance Commissioner	Yes	Voluntary 2008–10; mandatory 2010–present	Selected through a competitive process; NCQA PCMH level 3 recognition required
CO (2009–12)	Private organization: HealthTeamWorks	No	Voluntary	Selected through a competitive process; NCQA PCMH recognition required
NH (2009–11)	Private organization: New Hampshire Citizens Health Initiative	No	Voluntary	Selected through a competitive process; NCQA PCMH recognition required
ME (2010–present)	Public-private partnership: Dirigo Health Agency's Maine Quality Forum; Maine Quality Counts; Maine Health Management Coalition	No	Voluntary	Selected through a competitive process; NCQA PCMH recognition required and state-developed core expectations must be met
NY (2010–present)	State entity: New York State Department of Health	Yes	Voluntary	NCQA PCMH level 2 or 3 recognition required
MN (2010–present)	State entities: Minnesota Departments of Health and Human Services	No	Mandatory	State-developed Health Care Home certification required
MA (2011–14)	State entity: Massachusetts Executive Office of Health and Human Services	Yes	Voluntary	Selected through a competitive process; NCQA PCMH recognition required, including some otherwise optional standards at specified levels
MD (2011–present)	State entity: Maryland Health Care Commission	Yes	Mandatory[b]	Selected through a competitive process; NCQA PCMH recognition required, including some otherwise optional standards at specified levels
WA (2011–13)	State entities: Washington State Health Care Authority; Washington State Department of Social and Health Services	Yes	Voluntary	Selected through a competitive process based on PCMH competencies and readiness in which formal medical home designation was favored
NC (2011–present)	Public-private partnership: Community Care of North Carolina, Inc.	No	Voluntary	BCBS of North Carolina–developed Blue Quality Physician Program recognition required, which includes NCQA recognition
MI (2012–present)	State entity: Michigan Department of Community Health	No	Voluntary	BCBS of Michigan–developed Physician Group Incentive Program standards or NCQA PCMH level 2 or 3 recognition required
PA, phase 2 (2012–present)	State entity: Pennsylvania Department of Health	Yes	Voluntary	NCQA PCMH recognition required, including some otherwise optional standards at specified levels and additional state-developed standards
Multistate (2012–present)[c]	Federal government: Center for Medicare and Medicaid Innovation	No	Voluntary	Selected through a competitive process based on use of health information technology, participating payer penetration, and other CMS requirements
ID (2013–present)	State entity: Idaho Department of Health and Welfare	Yes	Voluntary	Selected through a competitive process; NCQA PCMH recognition required, including some otherwise optional standards at specified levels; additional payer-specific standards must also be met
NE (2014–present)	State entity: Nebraska Legislature	No	Voluntary	If participating insurers choose to require practice recognition or accreditation, they must accept NCQA PCMH, Joint Commission, URAC, or Nebraska Medicaid PCMH Pilot standards
MT (2014–present)	State entity: Montana Office of the Commissioner of Securities and Insurance	Yes	Voluntary	Participating insurers must accept NCQA PCMH, AAAHC, or Joint Commission standards

SOURCE Authors' analysis of data from the initiatives. **NOTES** See Exhibit 1 for full initiative names. NCQA is National Committee for Quality Assurance. PCMH is patient-centered medical home. CMS is Centers for Medicare and Medicaid Services. BCBS is Blue Cross Blue Shield. AAAHC is Accreditation Association for Ambulatory Health Care. [a]Participation is mandatory for carriers with a market share of more than 5 percent. [b]Participation is mandatory for carriers with $90 million or more in premium revenues. [c]The Comprehensive Primary Care initiative is active in seven regions: Arkansas (statewide); Colorado (statewide); New Jersey (statewide); New York (regional: Capital District and Hudson Valley); Ohio and Kentucky (regional: Cincinnati and Dayton); Oklahoma (regional: Greater Tulsa); and Oregon (statewide).

payers' desire for flexibility and competitive advantage with providers' desire for aligned payer expectations, payments, and quality reporting requirements.

ESTABLISHING CRITERIA FOR PROVIDER PARTICIPATION Selecting provider participation criteria offers stakeholders the most important opportunity to shape initiative goals. There is a great deal of variation across the initiatives that reflects evolving tools and initiative priorities.

▶**ADOPT EXISTING STANDARDS:** Selecting off-the-shelf standards is the most expedient way for multiple payers to measure core competencies for providers and systems. Thirteen initiatives required practices to meet standards developed by the National Committee for Quality Assurance (NCQA), the Joint Commission, the Accreditation Association for Ambulatory Health Care, or URAC (Exhibit 2).

Initiatives can also adopt standards developed by commercial payers—a strategy seen in markets where a dominant commercial payer's standards are already prevalent. For example, in Michigan, PriorityHealth and Medicaid accepted Blue Cross Blue Shield of Michigan's medical home designation standards.

▶**MODIFY EXISTING STANDARDS:** When gaps are identified in the national standards, stakeholders have customized them to reflect local priorities. This approach was common in medical home initiatives using early NCQA patient-centered medical home standards. Stakeholders in Maryland and Massachusetts designated otherwise optional elements as "must pass" or required higher scores in areas thought to be most closely aligned with meaningful practice change and improved care management.

Another option has been to attach initiative-specific requirements to national standards (Exhibit 2). The Maine Patient Centered Medical Home Pilot added ten core expectations to NCQA requirements in areas such as achieving cost efficiencies, integrating behavioral health with primary care, and engaging patients and families.[19]

▶**DEVELOP INITIATIVE-SPECIFIC CRITERIA:** Developing new standards in lieu of adopting or modifying an existing set is time- and resource-intensive, but it enables stakeholders to fully customize the model. Only Minnesota has developed its own initiative-specific standards.

Two initiatives (the Comprehensive Primary Care initiative and the Washington Patient-Centered Medical Home Collaborative) did not require providers to seek external medical home designation. Specifically, the Comprehensive Primary Care initiative's practice solicitation emphasized key medical home competencies (particularly the adoption and use of health information technology) and articulated a series of milestones that support the delivery model.[20]

▶**ACCEPT A VARIETY OF STANDARDS:** The two most recent multipayer initiatives (in Montana and Nebraska) gave participating payers and providers choices. They could select from a variety of national or homegrown qualification programs (Exhibit 2).

DETERMINING PAYMENT Reaching agreement on payment is arguably the most contentious part of multipayer collaboration. Key decisions include determining the degree of alignment across payers, how the payments will be made, for whom the payments will be made, and the appropriate payment amounts.

▶**BALANCE ALIGNMENT AND FLEXIBILITY:** Standardized payment methods and amounts were fundamental features of early multipayer medical home initiatives. Medicaid and commercial payers paid the same amounts using consistent methods in four of the seven initiatives launched before June 2010 (Pennsylvania,[21] Vermont, Rhode Island, and New York; Exhibit 3). For additional information, including specific payment ranges for each payer type, see Appendix Exhibit 2.[11]

There are two primary benefits for providers to standardizing the payment model, including amounts. First, a common payment model reduces administrative burden for providers, allowing them to spend less time reconciling the various payments they receive, and eases budget development. Second, common payment models offer transparency, showing that each participating payer is pulling its weight and has a stake in an initiative's success.

Flexibility, in contrast, offers payers and providers greater opportunity to innovate. In recent years, initiatives have allowed payers far greater flexibility in making payments, which has contributed to considerable variation in payment amounts.

▶**SELECT PAYMENT METHODS:** Requiring payers or practices to adopt new payment methods or adapt their claims or billing systems can discourage participation, particularly if only a small percentage of payers' or practices' business would be related to the initiative. Despite its adverse incentives, fee-for-service is still the predominant, and therefore most feasible, payment method in many markets. Thus, every multipayer medical home initiative built upon existing fee-for-service payment arrangements.

Every initiative with an established payment methodology has used per member per month payments to help cover the costs associated with practice transformation and coordinating patients' care (Exhibit 3). Most initiatives supplemented per member per month payments with

EXHIBIT 3

Multipayer Medical Home Payment Models

State	Participating payers	Payment method(s)	Range of PMPM payments to providers	Payments vary by:
PA, phase 1	Medicaid, commercial	Lump-sum start-up, PMPM, shared savings	Varied, but aligned by region	NCQA level
VT	Medicaid, commercial, Medicare	PMPM, payments to shared teams or networks	$1.20–$2.39	NCQA year and score
RI	Medicaid, commercial, Medicare	PMPM, pay-for-performance, payments to shared teams or networks	$4.00–$8.75	Practice performance
CO	Medicaid, commercial	Lump-sum grants, PMPM, pay-for-performance	Approximately $4.00–$10.00	Payer type and NCQA level
NH	Commercial	PMPM	Proprietary information (approximate average $4.00)	NCQA level
ME	Medicaid, commercial, Medicare	PMPM, payments to shared teams or networks	$6.95–$7.00; commercial: proprietary information	Payer type
NY	Medicaid, commercial, Medicare	PMPM, pay-for-performance, payments to shared teams or networks[a]	$7.00	—[b]
MN	Medicaid, commercial, Medicare	PMPM	$10.14–$79.05; commercial: proprietary information	Payer type and patient complexity
MA	Medicaid, commercial, Medicare (Medicare Advantage only)	Lump-sum start-up, PMPM, shared savings	$2.10–$7.50 plus shared savings	Patient age
MD	Medicaid, commercial	PMPM, shared savings	$3.51–$6.01 plus shared savings	Payer type, NCQA level, practice size (commercial only)
WA	Medicaid, commercial, Medicare (Medicare Advantage only)	PMPM, shared risk	$2.00–$2.50	PMPM decreased after 9 months
NC	Medicaid commercial, Medicare	Enhanced fee-for-service, PMPM, payments to shared teams or networks	$1.50–$5.00	Payer type, NCQA level (Medicare only), patient complexity (Medicaid only)
MI	Medicaid, commercial, Medicare	Enhanced fee-for-service, specific care coordination codes, PMPM, payments to shared teams or networks[c]	$1.50–$6.50 plus retrospective incentive payment	Payer type
PA, phase 2	Medicaid, commercial, Medicare	PMPM, shared savings	$1.51–$6.14 plus shared savings	Program year, patient age
Multistate[d]	Medicaid, commercial, Medicare	PMPM, shared savings	Medicaid and commercial: varies by region and payer; Medicare: $8.00–$40.00 plus shared savings	Payer type, patient complexity, program year[e]
ID	Medicaid, commercial	PMPM	$15.50–$42.00	Practice capabilities (commercial only)
NE	Medicaid, commercial	Unspecified	Medicaid: $2.00–$4.00, commercial: proprietary information	PCMH tier (Medicaid)
MT	Medicaid, commercial	In development	Medicaid: in development; commercial: proprietary information	In development

SOURCE Authors' analysis of data from the initiatives. **NOTES** See Exhibit 1 for initiatives' full names and Exhibit 2 for dates. Range of payment is as of July 2014 or the initiative's end date. Some initiatives earmark specific amounts for care management, practice transformation, and so on. The amounts reported include all enhanced payments made to practices, but they exclude the additional payments to shared networks or teams that provide care coordination and care management services. NCQA is National Committee for Quality Assurance. [a]In New York State the shared practice supports are paid from the $7.00 per member per month (PMPM). [b]Not applicable. [c]In Michigan, care coordination payments are passed through to the providers that fund their own care managers. [d]The Comprehensive Primary Care initiative is active in seven regions, which are listed in Exhibit 2, Note c. [e]The average Medicare fee-for-service PMPM decreases in years 3 and 4; commercial plans may adjust their payment similarly, but that information cannot be confirmed because of the proprietary nature of payments.

additional funding streams, including lump-sum start-up payments, enhanced fee-for-service rates, and pay-for-performance (including shared savings).

Pay-for-performance and shared savings models emphasize value over volume. However, matching or attributing a patient to his or her provider can complicate the models' implemen-

tation and jeopardize their success.

Providers participating in West Virginia's Medical Home Shared Savings Pilot originally estimated that 18,000 patients were eligible to participate, but the three participating payers were able to confirm eligibility for fewer than 3,000.[22,23] West Virginia's experience underscores how critical payers' strategies for attributing patients can be in multipayer initiatives. Nonalignment across payers creates confusion for the participating providers as to which patients are eligible for payment, which in turn affects the payments that practices receive.

Multipayer medical home initiatives have avoided payment models that require primary care practices to take on downside risk (for example, bundled, episodic, or global payments). The one exception was in Washington State, and even in that case only a portion of the supplemental patient-centered medical home payments was put at risk.[24]

▶**DETERMINE PAYMENT AMOUNTS:** Many factors determine what payment rates are adequate, although an initiative's scale and target population may be the most important. Four factors are discussed below.

First, payments can be targeted or apply to an entire panel. Differences in program design have contributed to the considerable range in payments across the nation. Large all-payer programs that pay on a panel or population basis, as in Vermont, create an economy of scale that allows payers to pay less for each patient. Large per patient payments are required when payers make only supplemental payments for selected patients or those receiving care, as in Minnesota.[25]

The second factor is gains in provider competencies. Payers in seven of the seventeen initiatives stratified payments based on demonstrated provider competencies (Exhibit 3). For instance, paying more to practices that meet the highest NCQA level (level 3) acknowledges the greater health information technology and staff investment necessary to meet the higher standard.

Three initiatives—the Comprehensive Primary Care initiative, the Pennsylvania Chronic Care Initiative (phase 2), and the Washington Patient-Centered Medical Home Pilot—decided to reduce payments to providers as time went on and as providers achieved core competencies. The Center for Medicare and Medicaid Innovation provided a twofold rationale for reducing average monthly care management payments in the Comprehensive Primary Care initiative: gained provider efficiencies and a shift toward accountable forms of payment.[18] Similarly, providers participating in phase 2 of Pennsylvania's Chronic Care Initiative receive lower monthly infrastructure payments each year and become eligible for a greater share of savings.

The third factor is patient complexity. Payers in eight of the seventeen initiatives varied rates to reflect the added risk and resources associated with caring for sicker or more challenging populations (Exhibit 3). For example, in Minnesota, payers make higher payments based on the number of systems (circulatory, endocrine, and so forth) affected by chronic health conditions. Payments are further increased for patients with severe and persistent mental illness and for those whose primary language is not English.

In multipayer initiatives with both public and private payer participation, it is common to see public payers pay more than private payers. Medicare typically—although not always—pays more than Medicaid.

The fourth factor is the inclusion of small practices and rural providers. Tiered payment can help small practices overcome barriers to participation, such as fewer staff and resources. In Maryland, commercial payers illustrate the power of scale by adjusting per member per month payments by patient volume: Practice sites with fewer than 10,000 patients receive the highest payments, and sites with more than 20,000 patients receive the lowest.

Furthermore, payers in six initiatives make additional payments to shared practice teams or staff (for example, Vermont's Community Health Teams). This supports practices that cannot afford to hire new staff to meet initiative criteria.[26]

MEASURING PERFORMANCE Measuring performance is less contentious than the other three issues. However, initiative leaders should not underestimate the importance of reaching agreement on a set of common performance metrics, especially if the metrics influence provider payment. Data-driven quality improvement is one of the primary goals of any initiative, and selecting meaningful quality metrics and providing practices with actionable data are key to achieving this goal.[27]

Alignment can often take a year or more.[28,29] Nonetheless, multipayer agreement on performance metrics can help build trust among parties and serve as proof that collaboration is possible.[28] For the two multipayer medical home initiatives launched in 2014 (those in Montana and Nebraska), payer agreement on performance metrics was an integral first step in getting stakeholders to reach consensus on broader system changes.

Multipayer medical home initiatives have used a variety of survey, claims-based, and clinical data to evaluate performance. Of the three sources, clinical quality measures have the greatest

potential burden for practices—particularly those without sophisticated electronic health record systems. Given the incredible variation in performance measures across payers and states,[28,29] multipayer collaboration offers a distinct opportunity to reduce providers' data collection and reporting burden.

▶**REDUCE PROVIDER BURDEN:** There is widespread agreement that providers are being asked to report on too many measures.[27] However, the number of clinical quality measures included in multipayer medical home initiatives has not decreased (Exhibit 4). Instead, recent initiatives have tended to spread measures across numerous clinical conditions instead of using in-depth measures for just a few conditions.

Selecting a wider range of metrics has allowed initiatives to capture a wider range of data while maintaining standardization across participating practices. It also better captures broader health goals instead of focusing on the management of particular diseases. Given the earlier initiatives' focus on chronic diseases, it is not surprising that the early measure sets focused primarily on diabetes and asthma care.

Increasing the range of metrics would theoretically increase the burden on providers. However, more recent initiatives have tended to loosen requirements that all providers report every measure. For example, Nebraska developed a menu of metrics and allowed participating payers and providers to select the measures most important to their populations.[30,31] The disadvantage of this approach is that making direct comparisons of performance across all participating practices becomes harder when payers and practices prioritize different measures.

▶**USE OUTCOME MEASURES:** Reporting clinical quality outcome measures has been a persistent implementation barrier because of variation in the adoption and use of health information technology and interoperability issues. Only one of the eleven clinical quality measure sets analyzed (the set used in Minnesota) prioritized outcome measures over process measures (Exhibit 4).

The trend toward adopting process measures holds true for both newer programs and older programs that are expanding their measure sets. In 2014 Rhode Island added four new process measures.[32] It is important to note, however, that these initiatives also use claims data to determine whether practices achieve desired goals (for example, reduced hospital utilization).

Contextual Factors That Shape Decisions

Initiatives launched in 2014 look very different than those launched in 2008, and existing initiatives continue to evolve over time. We found that as initiatives have developed and matured, decisions made on each of the four key issues identified above have been shaped by two contextual factors: the initiative's local insurance market and its policy environment.

EXHIBIT 4

Overview Of Selected Clinical Quality Measure Sets In Multipayer Medical Home Initiatives

Initiative	Clinical conditions	Total metrics	Required metrics	Process metrics	Outcome metrics
PA: Chronic Care Initiative phase 1	1	6	6	4	2
RI: Chronic Care Sustainability Initiative	8	16	16	11	5
NH: Multi-Stakeholder Medical Home Project	11	32	32	21	11
ME: Maine Patient Centered Medical Home Pilot	11	32	32	21	11
MN: Health Care Homes	7	20	20	4	16
MA: Patient-Centered Medical Home Initiative	11	22	22	17	5
MD: Maryland Multi-Payor Patient-Centered Medical Home Program	17	24	Varies	20	4
PA: Chronic Care Initiative phase 2	3	14	14	11	3
Multistate: Comprehensive Primary Care Initiative[a]	10	11	9	7	4
NE: Multi-Payer Patient-Centered Medical Home Pilot	21	31	Varies	22	9
MT: Montana Patient-Centered Medical Home Program	4	4	3	2	2

SOURCE Authors' analysis of data from the initiatives. **NOTES** See Exhibit 2 for project dates. Clinical quality measure sets could not be identified for all initiatives. Initiatives varied on whether certain clinical quality metrics were categorized as process or outcome. The breakout in the table is based on how the states classified the measures; if the initiative did not provide this detail, the measure was identified and classified using the "measure type" field as found in National Quality Forum. Quality Positioning System [Internet]. Washington (DC): NQF; [cited 2015 Feb 9]. Available from: http://www.qualityforum.org/QPS/. This table does not capture nonclinical quality measures, such as patient experience measures derived from surveys or utilization measures derived from claims. Pennsylvania, Rhode Island, and Minnesota all phased in their reporting requirements; each program was launched with fewer required metrics than shown in this exhibit. [a]The Comprehensive Primary Care initiative is active in seven regions, which are listed in Exhibit 2, Note c.

INSURANCE MARKET DIFFUSION AND INNOVATION The insurance market has changed dramatically since Pennsylvania, Rhode Island, and Vermont set out to test multipayer payment reform in 2008. These innovators broke new ground, leveraging an opportunity to align stakeholders before each payer began a single-payer medical home initiative. Public and private payers across the country have since invested many years and millions of dollars in myriad single-payer programs that employ a range of payment methodologies, medical home standards, and performance metrics. As a result, garnering multipayer support now requires more negotiation and trade-offs than was the case with earlier programs. In areas with robust single-payer initiatives, conveners must have trust, community clout, and skill to illustrate and negotiate the advantages of collaboration.

However, there are times when an innovator develops a model that becomes so dominant that other payers decide it is better to adopt the prevailing standard than to develop their own. As discussed above, the clearest example of this occurred in Michigan, where both private and public payers have accepted Blue Cross Blue Shield of Michigan's medical home designation.

THE POLICY ENVIRONMENT Before 2010, multipayer medical home initiatives were primarily found in states with policy environments conducive to reform, as demonstrated by legislative or executive branch action and state funding to support initiative administration and infrastructure. Since 2010, stakeholders in states without an environment as conducive to reform have leveraged alternative, more flexible strategies to advance multipayer initiatives. Recent initiatives, including those in Nebraska and Montana, show that consensus on provider participation criteria and quality measures can be sufficient to entice payers and providers to participate. In the end, securing a critical mass of payers to finance improved primary care through disparate approaches may trump payment alignment in the eyes of providers.

The most important political change affecting multipayer medical home initiatives, and multipayer reform in general, was the federal government's decision to bring Medicare to the table. The Multi-Payer Advanced Primary Care Practice Demonstration[33] and the Comprehensive Primary Care initiative[17] have added an estimated 1.2 million Medicare beneficiaries to participating multipayer medical home initiatives.

Partnering with Medicare in multipayer reforms will be integral to future health system transformation, and the federal government continues working closely with states to advance multipayer reforms. Twenty-five states received federal support to develop new or expanded efforts through the first round of the Innovation Center's State Innovation Models initiative, and thirty-two additional grants were awarded in December 2014.[34] Many of these states (including Maine, Minnesota, and Vermont) are leveraging the primary care foundation laid down through their medical home initiatives to facilitate the development of accountable care models.[35]

Partnering with Medicare in multipayer reforms will be integral to future health system transformation.

Conclusion

Multipayer reforms are complex and difficult to implement. Nevertheless, our analysis of seventeen medical home initiatives across the United States demonstrates both a growing interest in such collaborations and their feasibility when committed stakeholders negotiate strategies that are responsive to local market and policy environments. As these initiatives build platforms to advance larger delivery system and payment reforms, four lessons have emerged.

First, involving either the state or the federal government—or both—as a convener, payer, or key stakeholder has been a critical factor in multipayer implementation efforts. Second, finding common ground on a few key issues where there is already some general agreement (for example, common measure sets) can create momentum for future system change. Third, timing has an incredible influence on program design: Unless they are aligned from the start, payers are likely to develop their own flavor of a reform, reducing the likelihood (and ease) of alignment later. Fourth, local insurance market and policy environments are nonetheless the ultimate forces that shape implementation.

Future multipayer payment reforms that include medical homes, accountable care, and bundled payment will do well to heed these lessons. Doing so would allow them to better anticipate and navigate known obstacles and improve their chances for successful implementation. ■

Funding for the preparation of this article was provided by the Commonwealth Fund. The authors thank Melinda Abrams of the Commonwealth Fund for her input into this article and her long-time support of state health policy work. The authors thank Taylor Kniffin of the National Academy for State Health Policy (NASHP) and Hayley Mandeville, a former intern at NASHP, for their research support, including the development of the exhibits for this article. Sarah Kinsler is an employee of the State of Vermont. The views expressed in this article are those of the authors alone and not necessarily those of the State of Vermont, and this article is not a State of Vermont publication.

NOTES

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11 To access the Appendix, click on the Appendix link in the box to the right of the article online.

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