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# Innovative Medicaid Initiatives to Improve Service Delivery and Quality of Care:

# A Look at Five State Initiatives

*Prepared by:*

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September 2011

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# kaiser commission medicaid and the uninsured

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## I. Executive Summary

Medicaid is a vital program and component of the U.S. health care system. It currently covers approximately 60 million Americans, including one in three children. Medicaid is expected to become an even broader method of coverage for low-income people as a result of the Patient Protection and Affordable Care Act (ACA). The program is jointly financed by states and the federal government, but is administered by states within broad federal guidelines. States generally have the flexibility to determine who is eligible, what benefits are covered, how care is delivered, and how and what providers are paid. As a result, Medicaid programs across the country differ significantly. A number of states have used their flexibility to develop innovative payment and delivery systems designed to coordinate and improve quality of care. This brief highlights care coordination and related efforts in Alabama, Oklahoma, Oregon, Pennsylvania and Washington. The information in the report is based on site visits and analysis of these initiatives from November 2009 through March 2010. The report highlights new opportunities created by the ACA to continue to move forward with innovative delivery and payment models.

***All five states are implementing patient centered medical home (PCMH) models to improve care coordination, service, and quality, and to strengthen the primary care and health care delivery system.*** The specific definition of a PCMH and the survey tool used to assess or recognize practices or clinics varied across states. In 2008, the National Committee for Quality Assurance (NCQA) released PCMH "recognition" standards. Pennsylvania was the one state in this study using the NCQA standards to assess their practices' PCMH capabilities, while the other states developed their own PCMH recognition criteria and assessment tools. This later approach allowed states to tailor standards, based on input from key stakeholders, to better meet the needs of their specific state and Medicaid practices. The scope of the state's PCMH initiative also varied on several dimensions (single payer versus multi payer, narrower or broader target population).

***The five states were using a variety of PCMH payment methods.*** States were using fee-for-service (FFS), FFS plus a case management fee or per-member-per-month (pmpm) payments as a base payment method. For example, Alabama's Patient First uses a traditional fee-for-service payment system and tiered pmpm case management fee. In addition to base payments, states were using a mix of incentive based payments including lump sum payments and grants to develop PCMH infrastructure or related new care approaches; additional targeted payment rates, including higher pmpm rates to more advanced medical homes based on their score or level on recognition surveys; and shared savings or other pay-for-performance mechanisms. For example, Oklahoma and Pennsylvania used pay-for-performance to target payments to medical practices that met risk-adjusted quality and, sometimes, utilization performance standards.

***Study states were also using a variety of strategies to strengthen primary care capacity and skills.*** Such strategies include collaboratives, practice coaches or facilitators, care managers or social service coordinators, and information feedback loops. CareOregon and Pennsylvania were using collaboratives; these are typically short-term (6- to 15-month) learning systems that bring together experts and a number of clinic or practice teams and sometimes hospitals to implement PCMH and facilitate care coordination.[1] Oklahoma and Pennsylvania were also using coaches and practice facilitators, experts in practice redesign and change, to work directly with medical practices to implement PCMH initiatives. Care managers or social service coordinators also work with Medicaid practices to deliver intensive disease management services for high cost populations or to coordinate physical and/or behavioral health care services. For example, Washington's Molina MCO added

behavioral health to better integrate care for behavioral, social, and medical care needs. In all study states there were efforts to develop better information feedback loops so that providers could better manage their patient populations. Such information might include which patients have multiple chronic conditions or mental illness, when they are in the emergency department or hospitalized, and when they do or do not fill prescriptions.

***States are utilizing Health Information Technology (HIT) to complement PCMH.*** Study states were using HIT in a variety of ways to collect and report quality measures, implement new payment models, and develop electronic health records. For example, Alabama's Together for Quality (TFQ) uses HIT to support an online data sharing platform for state Medicaid and human services agencies, chronic disease management, and basic electronic health record (EHR) functions. Washington's Molina Program uses cell phones to stay in close contact with vulnerable enrollees in the Washington Medicaid Integration Partnership (WMIP) program. The HITECH (Health Information Technology for Economic and Clinical Health) programs that were established with funding from the American Recovery and Reinvestment Act (ARRA) provide additional funds and opportunities to harness HIT, particularly related to the development of electronic health records (EHR) and health information exchanges (HIE). Many believe that EHRs and HIEs are essential infrastructure for PCMHs because they allow for the effective exchanges of information between primary care providers and specialists, hospitals, ancillary providers (e.g., laboratories and pharmacies), other state programs (e.g., disease management), and patients themselves. EHRs can also enable a practice or clinic to proactively manage its patient population, provide evidence based care, and engage in ongoing quality improvement efforts. Pennsylvania facilitated access to some types of HIT (i.e., electronic disease registry), by providing a lump sum payment to practices to cover the time/cost of entering required patient information from paper charts into the registry. Some states, like Oklahoma, pay practices or clinics with greater EHR capability higher rates.

***Study states show that there are several lessons that were key to implementing reforms.*** Articulating a clear vision, collaborating with key stakeholders, communicating effectively, and strengthening the state's own capacity, were some key lessons. When discussing PCMH programs specifically, informants noted the importance of: building on the strengths of the existing Medicaid program; focusing on the program goals, rather than any particular definition of a PCMH; developing payment approaches that are fair, feasible, and adequate; considering additional ways to support both providers and beneficiaries; and planning for and investing in data collection and evaluation. Finally, key informants from these states discussed ways to try to sustain and replicate these innovations amidst political turnover and fiscal challenges. Insight from successful models, coupled with new opportunities available through the ACA, such as renewed focus on wellness and prevention, Medicare PCMH demonstrations, options to develop Accountable Care Organizations (ACOs) and new demonstration authority provided under the Center for Medicare and Medicaid Innovation (CMMI) will help other states move forward with successful delivery and payment options.

## II. Introduction

Medicaid is a vital program and component of the U.S. health care system. It currently covers approximately 60 million Americans, including one in three children. Medicaid is expected to become an even broader method of coverage for low-income people as a result of the Patient Protection and Affordable Care Act (ACA). The program is jointly financed by states and the federal government, but is administered by states within broad federal guidelines. States have the flexibility to determine who is eligible, what benefits are covered, how care is delivered, and how and what providers are paid. As a result, Medicaid programs across the country differ significantly. A number of states have used their flexibility to develop innovative payment and delivery system reforms designed to coordinate and improve quality of care.

Most states have increasingly relied on different forms of managed care to organize and deliver services to Medicaid beneficiaries. Currently, about 70 percent of Medicaid enrollees receive some or all of their services through managed care. One key principle of managed care is to improve access to and coordination of care by ensuring that enrollees have a designated primary care provider and by relying heavily on preventive and primary care. Under traditional risk-based managed care, health plans contract with networks of providers and are paid a fixed monthly capitation payment for each enrollee. The plans then assume financial risk for the patient and are required to provide a defined set of services. Capitation can give states more predictability over costs. States can also use an array of quality measures and performance incentives to help hold managed care plans accountable for the quality of care they provide to Medicaid enrollees.

Primary Care Case Management (PCCM) programs are a blend of fee-for-service and conventional managed care. The state contracts with a provider – usually the Medicaid beneficiary's primary care physician – to provide basic care and to coordinate and authorize any needed specialty care or other services from other physicians or managed care plans. The primary care physician is paid a small case management fee per-member-per-month (pmpm), and other services are usually paid on a fee-for-service basis. As of June 30, 2008, 29 states operated 35 PCCM programs with a total enrollment of 6.7 million Medicaid beneficiaries. In rural areas, where MCOs are less likely to operate due to low population density PCCM is the predominant form of Medicaid managed care.

A growing number of states are building on PCCM models to better coordinate and manage care for beneficiaries. These strategies are often referred to as medical home or patient-centered medical home (PCMH) models. Since 1998, North Carolina has been implementing the Community Care of North Carolina (CCNC), an enhanced medical home model of care that uses local non-profit community networks comprised of physicians, hospitals, social service agencies, and county health departments to provide and manage care. Within each network, each enrollee is linked to a primary care provider, who assumes responsibility of managing the patient's care, including acute and preventive care, managing chronic illnesses, coordinating specialty care, and providing 24/7 on-call assistance. Case managers are integral members of each network, and they work in concert with physicians to identify and manage care for high-cost, high-risk patients. The networks work with primary care providers and case managers to implement a wide array of disease and care management initiatives that include providing targeted education and care coordination, implementing best practice guidelines, and monitoring results. The program has built-in data monitoring and reporting to facilitate continuous quality improvement on a physician, network, and program-wide basis. An evaluation of enhanced PCCM programs in North Carolina and four other states (AR, IN, OK, PA) indicates that they may perform equal to or better than capitated MCOs on

measures of access, cost, and quality, if sufficient resources are devoted to their design, implementation, management, and funding.[2] At the same time, the lack of direct control over hospital use – primary care providers were not at financial risk for hospitalization and the programs had no contracts with hospitals to give them leverage over utilization – was an obstacle to achieving savings.

As of 2009, at least 31 states had implemented initiatives to promote patient-centered medical homes (PCMH) for their Medicaid and Children Health Insurance Program (CHIP) enrollees.[3] Definitions for medical homes vary, but, in broad terms, it has been characterized as a clinic or practice, led by a primary care physician or other medical professional (such as a specialist or an advanced practice nurse), that provides care that is "accessible, continuous, coordinated, and delivered in the context of family and community."[4] In addition, medical homes can be customized for different Medicaid sub-populations.

State Medicaid agencies have attempted to support PCMH efforts with other strategies. Specifically, some states were rethinking the role of Medicaid managed care organizations (MCOs) and disease management efforts and moving toward more direct work with providers through learning collaboratives and practice coaching. States are also implementing changes in provider payments and making investments in health information technology (HIT), including disease registries and electronic health record's (EHR) efforts to support PCMH models. Some Medicaid agencies have also participated in multi-payer initiatives with private health plans,[5] and now have an opportunity to partner with Medicare through the Advanced Primary Care Practice Demonstration.[6] Despite the variation in Medicaid programs, many states were using some common strategies. Often, Medicaid PCMH models and initiatives were ahead of Medicare and many commercial payers.

**Study Purpose and Methods**

The purpose of this report is to provide an in-depth look at innovative delivery and payment models in five states. The report highlights various types of care coordination efforts, with a focus on patient centered medical homes (PCMHs) and how states are implementing them, as well as, how care models have evolved over time. This report also briefly discusses how Medicaid agencies and states may build upon and complement current efforts through new opportunities established in the ACA. To gather information and data for the report, three-person teams conducted 1.5 to 2-day sites visits in each of the five study states during November 2009 and March 2010. The five states and initiatives included in our study are: Alabama's Patient First Program; Oklahoma's SoonerCare; Oregon's CareOregon and Healthy Oregon Act; Pennsylvania's Rx for PA initiatives relating to patient-centered medical homes and Chronic Care Initiative; and Washington's WMIP program. See Appendix A for more detail on the study design.

We begin this report with a brief summary of what five states are doing, particularly with respect to PCMHs and related care coordination efforts. Next, we discuss how they are going about implementing these initiatives. Then, we describe lessons that the states have learned to date. Finally, we conclude with a discussion of the implications and potential next steps, particularly how states can successfully leverage recent efforts to improve Medicaid care coordination and new opportunities in the ACA to continue improving service delivery and quality.

## III. Brief Overview of State Initiatives

At the time of this study, all five states were in the process of implementing innovative programs to improve Medicaid service delivery and quality, with the goal of improving the health of the Medicaid or broader population. Below are brief descriptions of each of the five states' initiatives in place at that time, while table 1 provides basic information on each of these state's Medicaid programs.

***Alabama Patient First.*** The Alabama Patient First program is a statewide PCCM / PCMH model designed to integrate and coordinate care. The program began in 1997 as a traditional PCCM operating as part of the state's Medicaid program under a 1915(b) waiver. The program was eliminated due to budget cuts for nine months in 2004, but then reinstated in December 2005 by overlaying their traditional PCCM program with the PCMH model. The Together for Quality (TFQ) Electronic Health Records (EHR)/Health Information Technology (HIT) initiative complements the PCMH effort. The program uses an itemized (tiered) case management fee and shared savings program, in addition to direct fee-for-service (FFS) reimbursements.

***SoonerCare Choice.*** The Oklahoma Health Care Authority (OHCA) runs SoonerCare Choice. The program transitioned from a managed care delivery model in urban areas and PCCM in rural areas, to a partially capitated PCCM throughout the state in 2003. SoonerCare Choice operates statewide for the Medicaid population with a PCMH. The program is supported by a nurse care management program, a Health Management Program (HMP) for care coordination and disease management, practice management facilitation, and Health Access Networks (HAN). Having altered the partial capitation approach, the program now uses a three-component payment system for a PCCM-evolved medical home model, which includes: a visit-based FFS component, a monthly care coordination payment, and performance-based incentives.

***CareOregon and the Healthy Oregon Act.*** The CareOregon runs both the Care Support and System Innovation (CSSI), and the Primary Care Renewal (PCR) projects to assist with coverage of the state's Medicaid population. CSSI provides grants to help providers implement specific improvement projects and PCR provides resources to assist with the implementation of the PCMH. The Healthy Oregon Act passed in 2007 and includes: payment reform, PCMH, health insurance exchanges, quality and performance standards, use of comparative-effectiveness research, health information technology (HIT) planning, workforce development, and public health initiatives. The Act will be implemented statewide for all populations by the Oregon Health Authority in 2011.

***Rx for Pennsylvania and the Chronic Care Initiative (CCI).*** The Rx for Pennsylvania and the Chronic Care Initiative (CCI) is a multi-payer, multi-stakeholder initiative to support the implementation of PCMHs and the Chronic Care Model (CCM). Rx for PA also addresses the access to, quality of, and affordability of care. CCI uses lump sum payments for start-up costs, plus PMPM rate enhancements, and pay-for-performance (P4P) incentives.

***Washington Medicaid Integration Partnership (WMIP).*** The Washington Medicaid Integration Partnership (WMIP) began in 2005 in Snohomish County for adult SSI beneficiaries. The program provides Coordinated Care Teams (CCTs) who manage everything from primary, specialty, and substance abuse care, to skilled nursing facility placement, disease management, and transportation. The state pays a fully capitated payment to Molina Health Care, a private managed care organization, to cover all provided services (including physical, mental health, chemical dependency treatment and long-term care services).[7]

## Table 1

| | Alabama | Oklahoma | Oregon | Pennsylvania | Washington | United States |
|---|---|---|---|---|---|---|
| Total Medicaid Enrollment (#), FY2007 | 918,800 | 719,200 | 512,600 | 2,090,200 | 1,163,300 | 58,106,000 |
| | | | | | | |
| Medicaid Enrollment as a % of Total Pop, FY2007 | 20% | 20% | 14% | 17% | 18% | 19% |
| Poverty Rate (income <100% FPL) as a % of Total Pop, 2008-2009 | 22% | 18% | 16% | 16% | 15% | 20% |
| Income Eligibility Limits for Low-Income Parents as a percentage of poverty, Medicaid or Medicaid Look-Alike, January 2011 | 24% | 53% | 40% | 46% | 74% | N/A |
| | | | | | | |
| Medicaid Managed Care as a % of Medicaid, as of June 30, 2009 | 66.5% | 88.5% | 88.1% | 82.1% | 86.0% | 71.7% |
| Medicaid Enrollment in Capitated (Commercial or Medicaid-only MCO) as of June 30, 2009 | 0 | 0 | 338,547 | 965,188 | 581,587 | 23,460,663 |
| Medicaid Enrollment in PCCM as of June 30, 2009 | 443,327 | 412,473 | 12,207 | 262,583 | 4,495 | 7,275,241 |
| | | | | | | |
| Medicaid Spending per Enrollee, FY2007 (All enrollees) | $3,945 | $4,595 | $5,441 | $7,159 | $4,665 | $5,163 |
| Medicaid-to-Medicare Fee Index, All Services, 2008 | 89% | 100% | 90% | 73% | 93% | 72% |
| Total Medicaid Spending (Million $s), FY2009 | $4,416 | $3,938 | $3,678 | $17,232 | $6,603 | $366,471 |

***Source: Kaiser State Health Facts, Accessed August 31, 2011***

## IV. Major Patterns and Themes Across Programs

All five states are implementing the PCMH model in order to improve care coordination, service, and quality, and to strengthen the primary care and health care delivery system. As described above and shown in Table 2, all five states had PCMH initiatives underway or fully implemented. While all five PCMH models share many similar features, they also differ in important ways.

**Table 2**

| | AL<br>Patient 1st | OK<br>SoonerCare | OR<br>Care Oregon and Health Authority | PA<br>Rx for PA | WA<br>WMIP |
|---|---|---|---|---|---|
| **Assessment or Recognition Standards** | State Standards | State Standards | State Standards | NCQA Standards | State Standards |
| **Payment Method or Incentive** | FFS plus case management fee; Shared Savings Program | Partial capitation to FFS | One-time grant funds and PCMH incentive payments | Start-up costs, then pmpm and P4P | Fully Capitated Program |
| **Other Efforts to Strengthen PCP Practices or Care Management** | Yes,<br>Some patient focused | Yes,<br>Provider, patient, and community focused | Yes,<br>Provider focused | Yes,<br>Primarily provider focused, beginning to focus on patients / community | Yes, attempting to better reach WMIP members |
| **Single or Multi-Payer** | Medicaid only | Medicaid only | Considering multi-payer | Multi-payer | Medicaid only |
| **Target population** | Adults:<br>Excluding Aged or dual eligibles | Adults:<br>Excluding Aged or dual eligibles | Adults:<br>Excluding Aged or dual eligibles | Adults and some children:<br>Excluding Aged or dual eligibles | Adult SSI beneficiaries |
| **Scope** | Statewide | Statewide | Statewide | Statewide | Regional |
| **Role of State in Initiative** | Leading | Leading | Complementing MMC Plan and Leading | Leading | Complementing MMC Plan |
| **EHR and HIT efforts** | Yes,<br>Together for Quality | Yes, have focused on real time data and started wider efforts | Starting | Started with disease registries, working to facilitate EHR adoption and upgrade and other efforts | Plan used cell phones to stay in contact with members |

### Setting Definition and Recognition Standards

Most medical home pilot projects start with the development of a specific PCMH definition that seeks to identify the goals of the program, key provider structures, and activities. The PCMH definition often builds on principles or guidelines issued by professional societies and other organizations.[8] States also have to choose among a wide array of existing, off-the-shelf PCMH survey tools or develop their own survey tool to assess practices' or clinics' capacity to function as medical homes. These states sometimes use these survey scores to define different PCMH levels (e.g., higher scores are

associated with higher levels, and ultimately greater PCMH capacity) that can be used to assess practices' progress toward full PCMH implementation over time and make differential payment (e.g., clinics or practices achieving higher PCMH levels receive a higher pmpm payment rate).[9]

***NCQA standards.*** In 2008, The National Committee for Quality Assurance (NCQA) released "recognition" standards for medical homes. These standards have been used in many medical home demonstrations, particularly those conducted by commercial health plans, long accustomed to working with NCQA.

Pennsylvania was the one state in this study using the NCQA (2008) standards in their initiative. They have a multi-payer effort, with involvement of both commercial and Medicaid MCOs. Pennsylvania decided to use the NCQA standards because the MCOs were already familiar with NCQA and its other programs (i.e., The Healthcare Effectiveness Data and Information Set, or HEDIS©, used by health plans to measure performance on dimensions of care and service); they preferred to not develop and administer new PCMH recognition criteria, and they wanted to have a common standard across plan types, products, and providers.

***State-specific definitions and standards.*** The four other states in the study chose to use their own definition and recognition criteria for the PCMH. One benefit of this approach is it allows a state to tailor standards, based on input from key stakeholders, to better meet the needs of their specific state and Medicaid practices. For example, Washington used a broader definition of a medical home than is typically used to focus on different target populations (i.e., adult SSI beneficiaries) and a wider array of providers, in an effort to integrate medical, mental health services, chemical dependency treatment, and long-term care.

CareOregon has accommodated a diverse population of beneficiaries and clinic types by building additional flexibility into their Primary Care Renewal program, allowing clinics to select eight measures to focus on and receive quality improvement payments. Oklahoma and Alabama have both drawn on elements from the NCQA (2008) tool, but have attempted to develop a model that would be less costly and burdensome on providers to apply for and implement. The Oklahoma model allows mid-level practitioners, which was not permitted under NCQA's 2008 standards (but is now permitted in their 2011 PCMH standards). Although Pennsylvania uses NCQA standards, they sought and received approval from NCQA to use their tool for nurse practitioner managed clinics as well. In Alabama, the state chose not to rely explicitly on NCQA (2008) standards, primarily due to the cost and perceived burden on providers, but rather they are developing their own set of qualifications that support the NCQA principles. States choosing not to use the NCQA (2008) standards also cited concerns with the infrastructure-intensive nature of the standard, which had 46 percent of its items related to HIT.

In a recent analysis, the Urban Institute did a side-by-side comparison of ten national and state medical home assessment instruments, including NCQA's 2008 and new 2011 tool and Oklahoma's tool. It found that the NCQA instrument was strongest on practice infrastructure, especially related to the use of HIT, while the Oklahoma instrument allocated the largest share of its questions to traditional elements of primary care, including access to care, comprehensiveness of care, continuity with the same health professional, and care coordination. Moving ahead, states may reconsider whether it is still beneficial to develop their own PCMH assessment tool given the range of PCMH provider survey tool options and their respective pros and cons. Besides the new NCQA tool (2011),

the AAAHC, Joint Commission and URAC have also developed and recently released PCMH assessment tools.[10]

**Setting Payment Methods to Develop a PCMH**

The five states were using a variety of PCMH payment methods, oftentimes in combination with each other and evolving over time.[11] It is important to distinguish between the base payment methods that physician practices or clinics receive, from the marginal, enhanced payments that they may receive. For example, pay-for-performance provides extra payment to practices or clinics for achieving thresholds on specific quality or utilization measures, on top of the routine payments. Sometimes the enhanced payment incentives conflict with the incentives built into the basic payment structure. For example, a fee-for-service base method may provide incentives to increase volume of services, which may conflict with a bonus payment for improved quality or reduced utilization. In the context of payment for PCMH development, payers have tended to leave the base payment method intact, while providing some enhanced payments for medical home activities.

The mix of base and enhanced payments together comprise the incentives that attempt to transform primary care practices into medical homes. Three types of base payments have been used by states—fee-for-service (FFS), fee-for-service (FFS) with a case management fee, and per-member-per-month (pmpm) or capitation (full or partial). Fee-for-service has been the traditional base payment model for providers, with the latter two added as Medicaid programs evolved, with the advent of primary care case management (PCCM) and Medicaid Managed Care programs. As described in the introduction, states may have one or both of these types of programs in place today, along with a mix of incentive-based payment models. Medicaid programs or state regions (e.g., more rural areas) dominated by PCCM typically use fee-for-service with a case management fee as the base payment method. Similarly, Medicaid programs or state regions (e.g., urban areas) dominated by managed care programs may use pmpm payment to providers rather FFS as the base payment method.

***Base Payment Methods***

***Fee-for-Service (FFS) payment***. Fee-for-service is the traditional method of payment for medical services in which providers are paid for each service they provide. In Medicaid, bills are generally submitted by providers to the state Medicaid agency for reimbursement. The FFS model can provide incentives to increase utilization, and it is often difficult to manage and coordinate care because the payment method does not support these activities. FFS is still used across payers and geographic areas where managed care plans are not available. In addition, moving from FFS to a new payment method can be complex and costly. Some medical groups or clinics are unable or unwilling to assume and manage the financial risk associated with other methods, like pmpm or capitation. Physicians and practices that rely heavily on Medicaid tend to have relatively little financial reserve and typically lack the infrastructure required to manage financial risk.

***Fee-for-Service (FFS) with Case Management Fee.*** Primary Care Case Management (PCCM) programs are a blend of fee-for-service and conventional managed care. The state contracts with a provider – usually the Medicaid beneficiary's primary care physician – to provide basic care and to coordinate and authorize any needed specialty care or other services. The primary care physician is paid a small case management fee per-member-per-month, and other services are usually paid on a fee-for-service basis. For example, Alabama's Patient First uses a traditional fee-for-service payment system and tiered pmpm case management fee.

***Per-member-per-month (pmpm) payments.*** Some states use pmpm, or a fixed fee for each beneficiary enrolled in a managed care plan. States may use fully or partially capitated payment models. The Medicaid MCOs, in turn, negotiate contracts and associated payment mechanisms and rates with doctors, clinics, and hospitals. MCOs may use either pmpm or FFS as the base payment for providers. States can also use a pmpm payment model to pay health professionals directly. Pennsylvania and Washington both include a pmpm capitation payment as a component of their payment methods to providers.

***Enhanced Payment Methods:***

As states design and implement PCMH programs, their decision about related payment reforms is shaped by their current base payment methods and ways that they can be combined with enhanced payment methods. These enhanced payment methods include: lump sum payments and grants to develop PCMH infrastructure or related new care approaches; additional targeted payment rates, including higher pmpm rates to more advanced medical homes based on their score or level on recognition surveys; and shared savings or other pay-for-performance mechanisms.

***Lump sum payments and grants.*** Some states use one-time, lump sum payments or grants for PCMH development and innovation. For example, Pennsylvania's PCMH program made lump sum payments to primary care practices to cover the expense of the NCQA PCMH recognition application process and to get patient medical record information into the electronic disease registry. CareOregon used grants in their Care Coordination and Systems Integration (CCSI) program when they launched in 2005 to help providers within their network implement specific projects that would improve health care delivery and outcomes in their practices.

***Targeted fees or enhanced payment rates.*** Building on FFS with case-management fees or pmpm payment models, some initiatives have relied on additional fees or enhanced pmpm rates to achieve medical home goals or to reach advanced medical home levels or tiers, such as adopting electronic medical records, maintaining 24/7 access, or providing higher levels of case management or care coordination. For example, Pennsylvania paid practices or clinics a higher pmpm as they increased their medical home level (1 through 3) as measured by the NCQA (2008) tool. Alabama allowed practices to add services to receive enhanced rates.

***Shared savings or other pay-for-performance mechanisms*.** Alabama also uses a shared savings program, in which performance and efficiency measures are calculated on the practices panel. If savings are achieved in the Medicaid program, the state shares 50 percent of savings with physician practices. A report card and "pay-stub" for each practice is produced, and their portion of any shared savings is based on their performance in each category or pool (performance or efficiency) independently. In some states, like Oklahoma and Pennsylvania, P4P mechanisms were also added to the base payment models and other enhanced payment methods, so practices were eligible for bonuses based on their risk-adjusted quality and, sometimes, utilization performance.

In sum, these five states PCMH payment methods combine their base payment method(s) with enhanced or marginal payment methods in novel ways. In addition, these payment models often evolve over time as states gain more experience with them, and assess whether they are working. For example, Oklahoma moved away from contracting with managed care organizations, by initially paying health systems partial capitation, and then moving to fee-for-service (FFS). The payment system in Oklahoma now is made up of three components, including a visit-based FFS component, a monthly care coordination payment, and performance-based incentives.

***Value Based Purchasing.*** States, like Pennsylvania, have also utilized value-based purchasing strategies to provide incentives to MCOs and primary care practices to implement PCMHs. Individually or collectively, these strategies can help states encourage both MCOs and providers to make the changes necessary to support a PCMH model. Examples include: using their managed care purchasing process to support PCMH through modification of MCO selection criteria and contracts; selecting, using, and reporting health plan performance measures related to PCMH development, care processes, or outcomes; and aligning managed care plan and provider incentives to focus on certain sub-populations or care processes.

Multi-payer efforts have the potential to enhance the impact of these value-based purchasing strategies and payment incentives to implement PCMHs, as more of a practice's or clinic's population becomes included in the program and subject to the chosen payment model. Currently, most practices and clinics have conflicting or weak incentives for transformation and performance improvement because they deal with multiple, uncoordinated payers and programs and only a minority of their patient populations are included. However, when major payers like Medicaid, Medicare, and commercial insurers coordinate their PCMH efforts, practices and clinics have greater incentive to respond due to the number of patients included.

**Working Directly with and/or Supporting Practices and Clinics**

One theme that emerged across the five states in this study is that state Medicaid agencies are using a variety of tactics to strengthen primary care capacity and skills. These tactics include: collaborative, practice coaches or facilitators, care managers or social service coordinators, and information feedback loops.

***Collaboratives.*** Some states have used collaboratives to enable providers to work together to learn more about PCMHs, how to implement them, and ways improve their performance. Collaboratives are a structured way for provider organizations to come together and learn from each other and from recognized experts in focused topic areas where they want to make progress. A Collaborative is typically a short-term (6- to 15-month) learning system that brings together a number of teams from practices or clinics and sometimes hospitals.[12] Plans like CareOregon and states like Pennsylvania are using collaboratives to help implement PCMH.

***Practice coaches or facilitators.*** Coaches and practice facilitators are experts in practice redesign and change. They typically spend much more hands-on-time with practice staff on site to help them identify practice strengths and areas for improvement. Coaches and practice facilitators may strategize ways to improve practical leadership and teamwork, ways to overcome barriers to change, and methods for ongoing improvement, such as practice redesign and rapid plan-do-study-act (PDSA) cycles.

Both Oklahoma and Pennsylvania were using practice coaches and facilitators. In Oklahoma, practice facilitators typically spent two weeks on site working intensively with the practice staff and then checked back in with them at regular intervals. While, in Pennsylvania, practice coaches were used to provide more direct, hands on assistance than the learning collaborators. In the Southeast region of Pennsylvania, each practice was assigned a practice coach whose role was to facilitate practice change and National Committee for Quality Assurance (NCQA) recognition by supporting and ensuring proper use of the disease registry, implementation of other interventions, completion of monthly reports, and proper interpretation of the feedback on reported quality measures. The quality measures were primarily process measures related to targeted chronic conditions, like

diabetes. Coaches were registered nurses with management experience who had trained through the national Improving Practice in Performance (IPIP) program, a physician-based, chronic care–focused quality improvement program that is supported by the American Board of Medical Specialties (ABMS) Research and Education Foundation and funded by the Robert Wood Johnson Foundation. The IPIP coaches contacted practices at least monthly during the first year of the intervention through individual site visits, phone consultations, and e-mails.

***Care managers or social service coordinators.*** States can employ care managers or social service coordinators directly or they can be employed by the Medicaid MCO. These positions are often centrally located, at the state or MCO offices, but they are increasingly working more directly with or co-locating in high volume Medicaid practices or practices that have a particularly challenging Medicaid population. Oklahoma, particularly through it focus on high-risk and high-cost enrollees in their Health Management Program (HMP), Pennsylvania, and Washington's Molina MCO, were using care managers and social services coordinators in a variety of ways to complement their PCMH efforts.

For example, Oklahoma launched HMP, a relatively traditional disease management program, partially in response to data showing that nearly four percent of their enrollees accounted for fifty percent of their costs. They use the HMP program to target 5,000 of their highest-risk, highest-cost enrollees with more intensive in-person services directed at the top 1,000 of this cohort.

Some of the largest MCOs in Pennsylvania were considering ways that they could better leverage or deploy their own case managers to complement PCMH efforts in the practices, and to coordinate physical and/or behavioral health care services. Ideas like: more continuity of case managers working with practices and their clinicians and staff, more timely communication and sharing of data, and co-location in select practices, were in progress or under consideration.

Finally, Washington's Molina MCO added behavioral health and other staff in an effort to focus on high-risk beneficiaries, better integrate care, and address behavioral and social, as well as, medical needs. Molina's Care Coordination Teams (CCTs) were revamped from the original design, where patients were assigned a CCT that consisted of a nurse or other licensed professional, and a non-licensed care specialist. Believing that CCT were not staffed correctly, Molina later revised the staffing and structure of the CCT by adding these other types of providers and staff. Under this revised model, an enrollee or patient is not assigned a nurse if no medical needs are apparent in his or her initial assessment. As part of this revision, Molina also moved the CCTs, which had originally been its own department, into the company's general case management department. The state itself was monitoring these changes to assess whether they were consistent with Molina's contract and the impact they were having on enrollees.

***Information Feedback Loops.*** Both states and Medicaid MCOs have a wealth of information that providers can use to better manage their patient population, in the short and long term. On a day-to-day basis, practices implementing a PCMH want to know key things, such as which patients have multiple chronic conditions or mental illness, when they do or do not fill prescriptions, and when they are in the emergency department or hospitalized. States (Alabama, Oklahoma, Oregon, and Pennsylvania) and MCOs (CareOregon, plans in Pennsylvania, and Molina in Washington) are working to give providers the information they need to better manage patients in real time, ideally on a daily basis, and to collect and report more performance measures at the practice level. To do this, states are pursuing a variety of HIT initiatives to support PCMHs and other reform initiatives.

**Structuring the Initiative**

***Focusing on Medicaid-only versus Multi-payer Efforts.*** Four of the five states in this study had a Medicaid-only approach, with only Pennsylvania having an explicit multi-payer initiative that included almost all of the commercial and Medicaid MCOs. The benefits of a Medicaid-only approach is the ability to design initiatives that best fit the states' Medicaid plans, providers, and beneficiaries' needs. In addition, since there are fewer stakeholders than in a multi-payer initiative, the state may be able to achieve consensus and design and implement programs more quickly. In states like Alabama and Oklahoma, where the absence of Medicaid MCOs and the presence of a state health care authority (in the later—Oklahoma), the Medicaid-only approach allowed the states to relatively quickly develop and implement decisions about the PCMH payment method and other challenging aspects of the program.

In some states, Medicaid alone may not have sufficient autonomy, authority, or market power to facilitate significant change among providers. Therefore, multi-payer efforts can give providers a greater incentive to change, when combined with other incentives, such as common goals and performance standards, simplifying program and practice management. The PCMH effort in Pennsylvania has also illustrated how some of the potential challenges to multi-payer efforts, such as antitrust concerns about insurers colluding, can be overcome.

Given the potential advantages of multi-payer initiatives, as well as provisions in the ACA that allows Medicare to participate in state PCMH initiatives, several additional states in this study were considering them and more states may consider them in the future.[13] One multi-payer initiative that has recently gotten underway is the Medicare Advanced Primary Care Practice Demonstration. This demonstration is the first time that Medicare, Medicaid, and commercial insurers will work together and partner with states in an effort to implement medical homes and ultimately improve quality and lower costs. The eight states selected to participate are Maine, Michigan, Minnesota, New York, North Carolina, Pennsylvania, Rhode Island, and Vermont. Ultimately, these eight states efforts will include approximately 1,200 medical homes serving up to one million Medicare beneficiaries.[14]

***Targeting versus Broader Population and Statewide Initiatives.*** Four of the five states PCMH initiatives in our study focused on the general Medicaid population or adults and children (non-aged, non-duals). Although they may have been piloted in a region of the state, all initiatives were being or had been implemented statewide. The rationale for this approach was that prevention, care coordination and management, and a strong primary care system are important for all beneficiaries. Keeping all patients as healthy as possible prevents problems and costs to the state down the road and medical home initiatives help to develop and maintain the kind of primary care system capacity states feel they need. In addition, it builds on and leverages existing PCCM program and other related state initiatives.

However, some argue that it may be better to focus PCMH initiatives on specific sub-populations or regions where the benefits of medical homes might have greater relative effectiveness. This is both because a relatively small portion of beneficiaries account for the majority of costs, and because it may be easier to implement programs in smaller areas and/or for specific population sub-groups. This has proven true for past programs and initiatives. For example, the initial medical home concept developed in pediatric primary care practices emphasized the opportunity to improve care delivery to a subset of children with special needs.

Another possible state approach is to focus on specific sub-populations, through complementary initiatives at the state or MCO-level, rather than on the PCMH program itself. For example, as mentioned above, states and MCOs can develop and implement programs that focus on high-risk populations. While the state or MCO may be well suited and positioned to run disease management programs or other complementary initiatives, integrating these efforts is a challenge. Co-location of staff in primary care practices or clinics is one method that is used. For example, in Washington, the Molina MCO operates a mental health facility in which WMIP primary care providers are also located. The goal of this co-location is to promote care integration and expand access. Other strategies, such as timely and efficient information exchange, may also facilitate integration. However, it is not yet clear if targeting PCMH efforts to specific populations is more effective than complementing them with these other kinds of initiatives led or carried out by the state or plans. Although several past state and MCO care management and coordination efforts have not been as effective as anticipated, they have provided useful insights and lessons for the future.

**Harnessing Health Information Technology (HIT)**

Finally, states are utilizing HIT to complement PCMH and other efforts. As noted, timely information is needed to better coordinate and manage care for beneficiaries, collect and report quality and other performance measures to practices and the public, and implement new payment models. Alabama's Together for Quality (TFQ) is an example of how states can use HIT to complement PCMHs. The TFQ initiative incorporates an online data sharing platform for state Medicaid and human services agencies, chronic disease management, and electronic health records (EHR) functions. Pennsylvania uses a common disease registry and the support for its practices to input the necessary patient data and learn how to use it. While, Washington's Molina Program uses cell phones to stay in close contact with vulnerable enrollees in the Washington Medicaid Integration Partnership (WMIP) program.

As the HITECH (Health Information Technology for Economic and Clinical Health) programs that were established with funds from the American Recovery and Reinvestment Act (ARRA) are implemented, states and providers will have additional opportunities to harness HIT. Three HITECH programs that are particularly useful for supporting delivery system reforms, like PCMHs, are: Medicaid and Medicare payment incentives for electronic health record (EHR) adoption, implementation, or upgrade (AIU) and meaningful use (MU); Regional Extension Centers (RECs) that provide technical assistance to providers seeking to participate in the incentive programs; and grants to states to develop health information exchange (HIE) infrastructure. Medicaid programs are working to leverage these and other HITECH programs to modernize their state HIT infrastructure, reform their payment and delivery systems, and ultimately improve quality and reduce costs.[15]

Many believe that EHRs and HIE are very useful tools, if not essential infrastructure, for achieving the ultimate goals of PCMH efforts. Accessible and continuous care coordination requires that primary care providers effectively and efficiently exchange information with specialists and hospitals, ancillary providers (e.g., laboratories and pharmacies), other complementary state programs (e.g., disease management), and patients themselves (e.g., through enrollee or patient web-portals). In addition, a practice's or clinic's ability to proactively manage its patient population, provide evidence based care, and engage in ongoing quality improvement efforts, is facilitated by the information provided by EHRs.

The emphasis placed on HIT in current PCMH assessment surveys, demonstrate its importance. A recent survey of 10 PCMH recognition tools found that HIT is the second most heavily emphasized domain, behind care coordination. For example, NCQA's tool has a relatively heavy emphasis on HIT capacity, with 46 and 40 percent of the items (2008 and 2011 versions respectively) dedicated to this area. Other PCMH assessment tools place less weight on HIT capacity, but nonetheless, acknowledge its importance.[16]

Some payers also believe that HIT capacity is so important they provide support or incentives for practices to invest in and use it. For example, Pennsylvania facilitated access to some types of HIT (i.e., statewide electronic health record, electronic disease registry), and a lump sum payment was given to practices to cover the time/cost of entering required patient information from paper charts into the registry. Some states, like Oklahoma, also pay practices or clinics with greater EHR capability higher rates, by either directly assessing their EHR capability or using PCMH assessment instruments that require EHR and HIT capacity to achieve the highest score or level (i.e., Level 3 recognition in the 2008 NCQA tool).

## V. Lessons Learned

Based on their experiences, our key informants identified a number of lessons that may be useful to other states as they consider implementing reforms to improve Medicaid service delivery and quality. Some of these lessons were more general and useful for rolling out any major initiative, while others were more specific to particular initiatives, like implementing a PCMH.

### Lesson #1: Vision, Collaboration, Communication, and Administrative Capacity are Critical Elements of Success

It is often deceptively hard to articulate a clear and concrete vision of what an improved health care system would look like in the future. State officials and key stakeholders can become bogged down by the complexity, problems, and perceived constraints of the current system. Collaboration, both within state government and with outside stakeholders, is critical for success. For example, strengthening the primary care workforce and educating and engaging beneficiaries, may lead Medicaid officials to work more closely with other state agencies (e.g., mental health, public health, education) as well as providers and community groups. Some respondents also noted that identifying and focusing on more targeted initiatives helps build stakeholder interest. At the time, state fiscal issues, as well as, the potential passage of ACA, heightened the possibility of real reform, leading to greater interest in and opportunities for collaborative and active stakeholder participation.

Both state officials and key stakeholders noted the importance of good communication, that is frequent, transparent, both formal and informal, and bi-directional (i.e., receiving as well as giving information). Most people we spoke with felt that this ultimately improves the PCMH program design and increases the chance of successful implementation. Although a few noted that the collaboration process can be very time consuming and occasionally results in program features that are less than ideal, due to the power of some groups or compromises that are made.

In Oklahoma, a group of physicians that make up the Medical Advisory Task Force have been instrumental in initiating and designing key initiatives over the past couple years. Examples include the switch from capitation to FFS and the implementation of medical homes. Pennsylvania spent almost a year working with key stakeholders to design the Chronic Care related PCMH initiative and then months meeting and working with South East region practices that were interested in

participating in the early implementation of the program. As other regions of the state became engaged, Pennsylvania conducted similar outreach initiatives, and used insights from the pilot, to expand the program statewide. In contrast, the Washington WMIP staff felt that the opposition of key community groups was a primary obstacle to the program's initial implementation, although they were eventually able to move forward with the program.

Finally, some informants, from both the state and other stakeholder groups, noted that additional efforts could be made to communicate with beneficiaries. Appropriate and useable materials (e.g., for low health literacy levels, in diverse languages, etc.) to explain changes and beneficiaries' roles in new programs like PCMH and other care coordination and disease management initiatives, need to be created and effectively disseminated.

Strong leadership and administrative capacity is necessary to move a new initiative related to delivery system reform forward and to sustain it in the long run. In the study states, Governors and Medicaid Directors were able to keep reform efforts from falling apart or stalling. The Patient 1st program in Alabama was actually shuttered for nearly two years, but strong leadership within the gubernatorial administration enabled the state to re-start and revitalize the program in 2005. However, officials also noted that it was critical to try and institutionalize changes. For example, even if major efforts are led by the Governor's Office, as in the case of Pennsylvania, they need to find a "permanent home" in the existing bureaucracy and programs, and knowledge of key staff must somehow be maintained. Otherwise, initiatives are less likely to be sustained through election cycles and changes in leadership.

States may require expertise in plan or provider payment, quality improvement techniques, quality measurement and reporting, and HIT. States can build internal capacity or contract for outside expertise. For example, Oklahoma shifted from contracting with Medicaid MCOs to hiring and developing more capacity in-house. Pennsylvania had a relatively small, core staff to implement the Rx for PA, but, they also effectively utilized consultants to develop the specific plans and facilitate collaboration and communication with various stakeholders.

In Washington, WMIP had strong champions with the state agency in the early days of the program. These individuals had a vision for the program and the political clout to see it implemented. This was particularly the case for getting long term care (LTC) services included in the WMIP. The champions of the program have since left the agency and support for the program and particularly the inclusion of LTC services has greatly diminished. At the time of our site visit in late 2009, the agency responsible for LTC services had put in a formal request to remove LTC from WMIP. Individuals with policy vision are clearly needed to develop initiative models (particularly those that cross agency lines), but staff to keep the vision alive and to run the program is equally important.

**Lesson #2: Medical Home Models Can Build on Existing Programs and Focus on End Goals**

Each state has its own unique Medicaid program, patient and provider populations, and political climate—all of which have an important influence on how and whether PCMH initiatives get off the ground. In moving forward, states need to leverage existing expertise and resources in practices and in the Medicaid program as a whole. This involves deciding upon a scope and scale that is small enough to be manageable and flexible, yet large enough to still result in meaningful change.

State Medicaid programs vary based on eligibility levels; services included in the benefits package; the approaches or programs used, such as the mix of Medicaid MCOs and Primary Care Case

Management (PCCM) programs; provider payment levels; and characteristics of participating providers (e.g., number of providers, size of provider groups, heavily or less heavily serving Medicaid's share of the practice). These aspects of the Medicaid program influence fundamental aspects of a PCMH program. Some informants noted that the structure of PCCM programs provide a good platform to transition to PCMH.

Even ambitious and comprehensive PCMH initiatives can be implemented incrementally. States can start in select geographic areas or specific population groups (adults and children or specific chronic conditions), and then incrementally expand them after learning from experience and making program improvements and adjustments. Broader efforts typically mean additional stakeholders, increased collaboration and communication needs, and additional capacity (administrative and providers). PCMH models can greatly benefit from EHR adoption, implementation, or upgrade (AIU) and meaningful use (MU), particularly because of the incentives and supports from HITECH funding. However, simpler HIT efforts, such as stand- alone disease registries, may be good, feasible options in the shorter run, while a more advanced EHR, other HIT, or Health Information Exchange infrastructure is being developed.

It is important for states to consider the goals, scope, and scale of PCMH projects. The goals of the initiative guide the operational definition of the PCMH. As previously noted, the states in this study mostly developed their own definitions and recognition processes based on the goals of the initiative and the scope and scale of the desired program. States that develop their own PCMH definition may identify further opportunities to integrate PCMHs with other parts of the health and human services system. For example, they may attempt to build bridges with key organizations that are involved in the full continuum of care: local communities and other social services; prevention or disease management organizations; acute care; and behavioral health providers. This "bottom-up" approach was thought to be a good way to produce the kind of collaboration needed for success. Moving ahead, states may reconsider this approach, as updated or new off-the-shelf tools become available and improve.

**Lesson #3—Design Payment Methods to Support Outcomes**

Just as there are unique aspects of state Medicaid programs and variation in PCMH definitions and certification criteria, a wide range of options exist for paying for medical homes. Medicaid and other payers are just beginning to experiment with and better understand how to purchase a medical home. This includes examining the strengths and weaknesses of various payment options and related issues, like performance measurement (e.g., how to combine quality and cost measures) and how to incentivize links between PCMHs and other health care organization and resources. In addition, and as noted repeatedly, one size does not fit all. Different states and different circumstances may require different payment approaches.

Informants in this study stressed that, whatever specific payment methods are developed, they must be perceived as fair, feasible, and adequate to support the desired changes and outcomes. Both PCMH initiative leaders and providers want to be assured that whatever methods are used to pay for basic medical home services and/or reward excellent performance, are valid, capture key dimensions of medical homes and/or desired outcomes, and are risk-adjusted to take into account differences in practice populations. At the same time, any new payment method has to be feasible to implement for state officials and providers.

Typically, this requires starting simply, selecting a relatively small number of performance measures to gain experience from and build upon. For some measures, existing claims data is inadequate, so new sources of data that are not overly burdensome must be identified and developed. Any payment mechanism has to be adequate to stimulate not only the primary care practice transformation, but the system-wide changes needed to improve population outcomes. In addition to a robust and well-developed payment system that rewards good performance, some up-front investment is also typically required to develop the necessary purchaser and provider infrastructure.

The research literature has found that earlier provider payment changes like P4P have been promising but have ultimately produced mixed results in part because the provider incentives have not been large or powerful enough to induce the desired changes. Multi-payer efforts, like the one in Pennsylvania, could potentially help overcome this problem by strengthening purchasing power and strengthening providers' incentives. In addition, changing primary care providers' in-office practice alone may be insufficient to change the broader health care system. Incentives for primary care practices and other key organizations to work together (e.g., hospitals, community health resources) or incentives for patients to help manage their own care, may also be required to achieve the desired outcomes. Additionally, in Oregon and Pennsylvania, the state found that providing initial start-up funds gave providers the initial capital necessary to do the kinds of structural changes that would be difficult to do with increased reimbursement alone, for example making physical changes to the office facility and hiring additional support staff (behaviorists, case managers, etc.).

One respondent also emphasized the importance of assessing return on investment (ROI), "we needed to plan a return on investment analysis for each major group—state, plans, providers—right away. You have to be able to ask and answer the question, what will I need to see to pay for this again?" This individual noted that even if there is a great deal of good will and effort, each stakeholder ultimately wants to know that their investment is resulting in the desired short and long-term quality and cost results.

**Lesson #4—Consider Additional Supports to Providers and Beneficiaries**

Several states provided other supports to primary care practices and clinics to help them strengthen their practice redesign and quality improvement capacity and transform into PCMHs. These supports include: collaboratives, practice coaches or facilitators, employing nurse care managers and/or social service coordinators, providing more timely information, and assistance with or direct provision of EHRs and/or other HIT. Respondents noted that besides strong financial incentives, primary care practices and their staff needed help in transitioning to PCMH models. Clinicians and staff needed assurances that, although implementing a PCMH takes some initial time and hard work but, it does not mean additional work, slowdowns, or loss of revenue long term. Moreover, the implementation of PCMHs may actually increase their own satisfaction by making their practices or clinics work more effectively and efficiently, leading their patients have better outcomes, and improving the overall system to be more stable and sustainable.

Interviewed primary care practices and clinics noted that Medicaid MCOs could be very supportive of PCMH efforts as well, especially in states where they have a large presence. For example, in states where plans cover medications, the MCO medication record/data is very helpful in managing patients. Similarly, if the state has a behavioral health carve out, collaboration with and data from the behavioral health MCO can be very valuable. Finally, MCOs, in general, often have care coordination and chronic disease management knowledge and expertise, as well as staff (e.g., case

managers). Plans' willingness and ability to try things like co-location of these staff in practices or clinics is an example of how they can work to support PCMHs in a way that may be a win-win for all. Providers themselves can potentially hire these additional staff, alone or in conjunction with other providers, while making sure their duties do not duplicate expertise and staff resources that MCOs already have.

Achieving the ultimate aims of the PCMH requires beneficiaries' engagement, which can be encouraged by the state, managed care plans, and providers. Respondents felt that there should be more proactive outreach and education for beneficiaries, in an attempt to get them more engaged in the process. Efforts should be made to help them better understand their roles and responsibilities, and to improve their self-management and other related skills. In short, a medical home is not complete without the full participation and engagement of all members – patients and providers.

Some states have attempted to increase participation and engagement with either the PCMH population or more targeted patient populations. For example, Alabama has developed beneficiary or patient materials that explain its Patient First program and, as previously described, Washington's WMIP and Molina MCO has given some patients cell phones and training on how to use them when they needed assistance. These examples demonstrate that additional communication and support from the state and/or managed care plans for beneficiaries outside the confines of the traditional office-visit is highly valuable. In the future, these efforts could potentially be coupled with incentives to beneficiaries—that is, pay-for-performance-for-patients (P4P4P),[17] to complement pay-for-performance for providers.

**Lesson #5—Plan for and Invest in Data, Performance Measurement, and Evaluation**

Major efforts to improve Medicaid service delivery and quality require good quality and cost measures, and the ability to share them with key stakeholders. While states have been investing in these areas for some time, they may not have the data and measures they need for new efforts like PCMH. For example, they may not have algorithms to assign patients to medical homes or they may have been collecting data and measuring performance at the MCO or hospital level, but not at the primary care practice or clinic level. Without such data, it is impossible to implement some new forms of provider payment (e.g., shared savings or some other performance based payment system) or provide practices with feedback on their performance that can help them improve.

States are beginning to leverage new opportunities to strengthen their data and performance measurement capacity. This is being done through programs, like the HITECH programs, designed to stimulate EHR adoption, implementation, or upgrade (AIU), meaningful use (MU), and Health Information Exchanges (HIEs). In addition, through the CHIPRA Quality Demonstrations, grantee states are developing and implementing a range of quality improvement initiatives in key areas such as use and evaluation of new core quality measures, use of HIT, and delivery system reform, including pediatric PCMH, care management, and school-based health center efforts.[18] These federally-funded initiatives will enhance our understanding of best practices and states' capacity to learn from one another.

Respondents also noted the importance of investing early in high-quality evaluations of PCMH programs. Evaluations of the implementation process can help to identify emerging problems or unanticipated consequences and potential ways to address them. Such evaluations can be used to refine or make mid-course corrections to the program if necessary. Evaluations of the outcomes of the initiatives address the ultimate questions of whether the initiative is having the desired impact on

quality and cost, for which segments of the Medicaid population the program is or is not working, what time frame is required to achieve the desired quality and/or cost goals, etc. Some respondents noted that, while process measures of quality are useful, they do not sufficiently address the question of impact. As one respondent articulated it, "Getting blood pressure and Hemoglobin A1c down is a good start, but isn't going to cut it in the long run…it's not the result we ultimately want to see".

Although Medicaid and state officials have expressed an interest in increasing the use of evaluations, currently they primarily request and fund evaluations only when a waiver application renewal is required. In addition, a variety of factors made evaluations quite difficult in practice, including: tight state budgets, the potential need to merge disparate data sources and collect new data, challenges getting non-participating practices or clinics (i.e., control groups) to provide information, and the need to allow enough time for programs to have a reasonable chance of making an impact.

At the time of our site visits, no state participating in this study had results from an internal evaluation of their PCMH effort. Although, some states, like Oklahoma, had rigorous outside evaluations of other aspects of their Medicaid program. Other states, like Pennsylvania, had agreed to a rigorous outside evaluation of their private plan and provider partners, but could not issue the RFP due to budget pressures. It was time-consuming to secure outside resources for the evaluation and working with outside organizations may make the most rigorous evaluation designs harder or impossible to conduct (e.g., getting pre-PCMH data may be difficult).

Respondents from professional associations and practices agreed that data, measurement, and evaluations were critical, but noted that state officials should be mindful of the potential burden on providers of any data collection request. While practices and clinics generally felt that the states included in this study had been sensitive to this issue, there were isolated examples of what they perceived to be overly burdensome reporting requirements. They also noted that practices already worry about being overwhelmed with change and requirements in new programs like PCMH. Transforming a practice is a significant challenge and Medicaid intensive and/or busy practices may already be overwhelmed.

These findings regarding the need for and challenges of conducting strong evaluations of PMCH demonstration and associated payment changes are consistent with results from a recent national study. Bitton et al (2010) noted that even funded evaluations frequently lack specific plans, comparison groups, and key data, making it more difficult to learn from the rich array of PCMH programs underway across the country.

Finally, informants noted that, despite the challenges of formal evaluations, it was also important to continue learning from the states ongoing experience and the experiences of other states and private plans. Some states in our study informally worked with other states or more formal collaboratives led by government agencies (AHRQ) or private, non-profit organizations (e.g., Center for Health Care Strategies). As one informant described, you have to continue to "do your homework on best practices and what's working and not working".

## VI. Conclusion

This report highlights the major innovations occurring in Medicaid programs across five states that can be built upon and leveraged. In fact, Medicaid programs are ahead of Medicare and many commercial payers in their PCMH initiatives and, sometimes, in related payment reform, care coordination and management efforts, and HIT. Additionally, some informants we interviewed were

thinking about how Medicaid PCMH initiatives fit in broader initiatives across payers, such as Accountable Care Organization (ACO)[19] initiatives led by Medicare, Medicaid, and/or commercial payers.

Looking forward, states' efforts to realign the provider payment and delivery systems are key to improving Medicaid and to successfully implementing coverage expansions in national health care reform. The ACA provides a number of new opportunities for states to improve care delivery in Medicaid. A new "health home" benefit allows states to receive a 90 percent federal match for two years to provide care management and coordination services for individuals with chronic conditions, including dual eligibles. The ACA established the Center for Medicare and Medicaid Innovation (CMMI) to test, evaluate, and expand innovative care and payment models to foster patient-centered care, improve quality, and slow cost growth in Medicare, Medicaid, and CHIP. This includes various PCMH demonstrations like the Medicare Advance Primary Care Practice initiative, as well as potentially complementary demonstrations, such as for Accountable Care Organizations (ACOs). The ACA also established the Federal Coordinated Health Care Office to align Medicare and Medicaid financing, benefits, administration, oversight rules and policies for dual eligibles. This office has already awarded $1 million contracts to 15 states to design models to improve care for the dual eligibles. The ACA also includes several demonstrations that will enable some states to test new payment and delivery system approaches, such as bundling payments around hospital care, setting global payments for safety-net hospital systems, and efforts to encourage healthy lifestyle changes.

Building on current state initiatives and using new options available under the ACA, there are opportunities for Medicaid agencies and states to alter payment and delivery models, perhaps as a further complement to PCMH activities. Such initiatives are critical in helping to reduce care fragmentation, increase care coordination, and improve quality. The challenge ahead will be to conduct timely, feasible, and rigorous evaluations from the rich array of PCMH efforts underway, identify key lessons learned, disseminate that information so states can learn promising or best practices from each other, and to replicate and sustain successful initiatives.

## Appendix A: Study Design

We identified five state initiatives to study through a purposive sampling strategy, seeking to identify "positive outliers" and to learn from them.[20] By definition, these are not typical state Medicaid programs or initiatives, but rather ones that experts felt illustrate innovative and promising strategies from which other states may learn.

However, to enhance the potential to generalize or transfer these findings to other states, we sought a mix of state initiatives that varied on several dimensions. These include: payer involvement (e.g., Medicaid only vs. multi-payer); previous and current role of Medicaid managed care plans (e.g., major role vs. little or no role); new types provider payment and care coordination models (e.g., transitioning from PCCM to PCMH concepts and related payment methods, new chronic disease management initiatives); a range of other quality improvement activities; a range of scope of services included; and region of the country.

We also wanted to avoid initiatives that were already receiving attention or that had completed their evaluations (e.g., Massachusetts, North Carolina, Rhode Island, Vermont) to broaden the understanding of initiatives that are currently being implemented.

To select the sites, we reviewed the literature (published and gray) on developments in Medicaid programs, particularly as they related to provider payment and delivery system changes to improve quality. We also obtained input from several national experts on Medicaid coordination care innovations, and consulted with individuals from several groups, including the Center for Health Care Strategies, National Governor's Association, National Academy for State Health Policy, Medicaid Health Plans of America, and the Association for Community Affiliated Plans.

Three-person teams conducted 1.5 to 2-day sites visits to each of these states during November 2009 and March 2010. We conducted a total of 60 key informant interviews, in addition to reviewing the published and gray literatures, and documents obtained on site. Interviews were conducted with 18 Medicaid and other state officials; 17 senior health plan leaders (e.g., chief executive officer and medical director) from Medicaid managed care or commercial plans, if involved; 18 health care providers, 4 representatives from professional associations, 3 others key stakeholders or informants (e.g., consultants, academics with expertise in state health policy or Medicaid). Interviews covered the same general topics at each site using a broad semi-structured interview guide based on a preliminary conceptual framework that we developed. Given the purposive selection of range of study sites, however, we also included topics specific for each site.

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