February 2013

Evaluation of the Multi-Payer Advanced Primary Care Practice Demonstration

Interview Protocols

Office of Management and Budget Clearance Package and Data Collection Instruments

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RTI INTERNATIONAL

Supporting Statement for
Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration: Interview Guides

RTI International

February 2013

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A. BACKGROUND

On September 16, 2009, Secretary of Health and Human Services, Kathleen Sebelius, and the Director of the Office of Health Reform, Nancy-Ann DeParle, announced the establishment of the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration, under which Medicare joined Medicaid and private insurers as a payer participant in state-sponsored initiatives to promote the principles that characterize advanced primary care, often referred to as the "patient-centered medical home" (PCMH). CMS selected eight states to participate in this demonstration: Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota. These states vary on a number of important dimensions, such as features of their public (Medicaid) and private insurance markets, delivery system, prior experience with medical home initiatives, and nature of their state-sponsored multi-payer initiative.

The PCMH care delivery model is a potentially transformative health system innovation, combining changes in provider payment and primary care structure and care processes. Evaluations of medical home models have shown mixed results to date, with some studies showing positive effects and others not showing statistically significant effects. Many findings to date have been preliminary, have had limited generalizability to multi-payer initiatives and the Medicare population, and have had some limitations in their study design (e.g., no comparison group). Although some positive outcomes from the medical home model have been shown to be significant, critical questions remain unanswered. For example, the impacts of the PCMH provider payment models and medical home transformation process on health outcomes and the U.S. health care system, particularly from a cost perspective, are largely unknown (Berenson et al., 2011; Crabtree et al., 2010; Steiner et al., 2008; Bitton et al., 2010).

CMS is conducting an evaluation of the demonstration to assess the effects of advanced primary care practice when supported by Medicare, Medicaid, and private health plans. As part of this evaluation, qualitative and quantitative data will be collected and analyzed to answer research questions focused on: 1) state initiative features and implementation, including various payment models; 2) practice characteristics, particularly medical home transformation; and 3) outcomes, including access to and coordination of care, clinical quality of care and patient safety, beneficiary experience with care, patterns of utilization, Medicare and Medicaid expenditures, and budget neutrality.

This OMB application seeks approval to conduct in-person, semi-structured interviews to inform CMS's evaluation of the MAPCP Demonstration. These interviews will be conducted with six types of respondents from each of the eight participating states:

- Physicians and administrators of participating practices and/or health systems
- Individuals representing provider associations
- Individuals representing payer organizations
- Individuals representing Office of Aging staff and patient advocates

- Leaders of community health teams and networks

- State officials

These interviews will be conducted by staff of CMS's evaluation contractor, RTI International, and RTI's subcontractors, The Urban Institute and the National Academy for State Health Policy. They will be conducted at the mid-point and end of the demonstration.

A.1 Need and Legal Basis

The interviews are part of a mixed-methods evaluation strategy for studying the process of, and barriers and facilitators to, transforming practices into PCMHs and for assessing the effects of the PCMH model on access, quality, and cost of care. Mixed-methods research is well-suited for accomplishing the goals of this evaluation, as different methods yield different insights. While quantitative methods (e.g., Medicare claims data analysis) are well-suited for outcomes or summative evaluation, qualitative methods (e.g., interviews, focus groups) are necessary for process or formative evaluation (Patton, 1990 and 1996; Sofaer, 1999). The combination of these methods can provide a comprehensive understanding of the nature of each state PCMH initiative, their implementation, the process and degree of practice transformation, and perceived outcomes for patients, practices, and purchasers (Creswell, 2009). Qualitative methods are particularly useful for evaluating health policy interventions, providing a more complete understanding of the interventions themselves and the context in which they are taking place, the views of different stakeholders, the unexpected outcomes, and the state and program conditions or factors more likely to be associated with success (Ragin, 1999; Rist, 1994; Sofaer, 1999; Yin, 1999).

For this evaluation, the interviews will provide us with answers to fundamental "what, how, and why" questions such as:

- How did the state initiatives arise?

- What are their goals?

- How were features of the state initiatives, such as the payment model and other efforts to support practice transformation (e.g., learning collaboratives), chosen and implemented?

- How do the state initiatives facilitate transformational activities within the participating practices?

- Which aspects of the state initiatives have been successful and which have required retooling?

- What challenges have the states and participants faced in implementing the state initiatives?

- What adjustments did the states and participants make to accommodate Medicare's participation in the initiative?

- What anticipated and perceived effects do the state initiatives have on practice transformation, quality, and efficiency?

The information collected through these interviews is critical to CMS in determining whether the MAPCP Demonstration model should be expanded under Medicare, and if so, what modifications and/or supports would be needed to implement similar innovations in other states and practices in the future.

A.2 Information Users

These interviews will be used by CMS to understand:

- The implementation and evolution of the state initiatives

- The implementation and practice transformation process

- The perceived effects of the state initiative and, over time, identify the features of state initiatives most responsible for the observed impacts (positive or negative)

This information will help CMS decide whether the MAPCP Demonstration model should be expanded under Medicare, and if so, what modifications and/or supports would be needed to implement similar innovations in other states and practices in the future.

The results will also be used by policymakers, payers, healthcare purchasers, primary care practices, and Medicaid and Medicare beneficiaries in the following ways:

- Local and state governments will have information from key stakeholders about their perceptions on implementation and the effectiveness of their initiatives as well as suggestions about potential areas for program improvement

- Payers and healthcare purchasers will have information to help them to know whether their payment models and program activities (e.g., learning collaboratives, practice coaches) are effective or whether modifications are warranted

- Primary care practices will have data to inform them about what other practice changes may be beneficial to enhance the quality and safety of care, efficiency of care delivery, access to care, and other outcomes

- Patients will directly benefit from any improvements implemented by policymakers, payers, purchasers, and their primary care practices

This information also will facilitate diffusion and implementation of similar initiatives in other states, if this demonstration is successful.

A.3 Use of Information Technology

The interviews will make minimal use of information technology. Skilled and experienced interviewers from the evaluation team will lead each discussion and a dedicated note taker will capture participant responses. Audio recorders will be used as a back-up to assure the completeness and accuracy of the notes. Data will be managed and analyzed in NVivo, a powerful and widely used qualitative data analysis software program (QSR International, Doncaster, Australia; Bazeley, 2007; Richards, 2009; Sorensen, 2008). The research team has significant experience in managing and analyzing large primary qualitative data sets with this type of software.

A.4 Efforts to Identify Duplication

The evaluation has been designed to comprehensively address the evaluation questions while minimizing the burden placed on the states, their partners (e.g., state evaluators), demonstration participants (e.g., practices and community health teams), and Medicare and Medicaid beneficiaries and special populations.

Interviews are designed to complement other primary and secondary data collection and analysis (see section A-1 for more details). That is, they will build on and fill information gaps rather than duplicate information from other sources of data. Interviews will be used only when primary or secondary data from states or their evaluators cannot be obtained to fully answer the evaluation research questions.

CMS and its evaluation contractor and subcontractors have taken numerous steps to ensure that the information to be collected through these interviews are not readily available from existing sources. We have examined secondary qualitative documents and resources publicly available and have reviewed the states' MAPCP applications and other documentation and communications provided to CMS. In addition, we are seeking to collaborate with the states on future data collections. Furthermore, since programs vary by state we will be tailoring each state's interview protocols to best understand the programs and to minimize the collection of data. By tailor, we mean either deleting questions that are not relevant given a particular states initiative, or making slight modifications to the questions to reflect specific or unique elements of the state's initiative (e.g., name of the effort, when it began, provider payment method). For example, some states have operated or participated in medical home initiatives prior to the MAPCP Demonstration via Medicaid and/or multipayer initiative with commercial health plans, while others have not. If a state has not previously operated or participated in a Medicaid or multipayer medical home effort, we will not ask respondents in that state questions related to prior medical home initiatives. Furthermore, due to unique features of the initiatives being implemented in four states (Vermont, Michigan, North Carolina, and Pennsylvania), we have submitted separate protocols for certain state officials and providers in those states. This will enable us to ask more targeted questions of these respondents and to avoid questions that are not relevant.

Thus, the information collected through the interviews should not duplicate any other effort and should not be obtainable from any other source.

A.5 Involvement of Small Entities

Some interviews will be conducted with individual physician participants who have elected to participate in the MAPCP Demonstration. Advocacy and community groups that are involved in medical home initiatives in some states also may be small entities comprised of fewer than five staff.

Again, the interviews have been designed to avoid duplication of other efforts and to be of minimal burden to participants.

A.6 Less Frequent Collection

The interviews will be conducted twice - at the middle and end of the 3-year demonstration. This frequency allows for the collection of information and feedback at critical points in the demonstration that are necessary for addressing the evaluation research questions while being respectful of participants' time and resources.

A strength of the qualitative data collection plan is its timeliness for obtaining relatively early insights about implementation, practice transformation, and perceived outcomes, which can be used to make improvements to and MAPCP Demonstration and, in turn, increase the likelihood of program success. These early insights also can be used to inform the development of quantitative data collection instruments.

A.7 Special Circumstances

There will be no special circumstances.

A.8 Federal Register/Consultation Outside the Agency

The 60-day Federal Register Notice was published on May 31, 2012 (77 FR 32118). We received comments from two commenters. The response to those commenters is attached to this PRA package.

The first commenter, a state agency, had no recommended changes to CMS's planned information collection in relation to this evaluation, but voiced strong support for the medical home model of care and for CMS's efforts to support it through the MAPCP Demonstration and the Comprehensive Primary Care Initiative. The other commenter, a patient advocacy group, described specific patient-centered principles, strategies, policies, and practices that they believe are important features of the medical home model, and recommended considering addressing these areas in the evaluation of the MAPCP Demonstration. They also urged CMS to consider incorporating these areas in any expansions of the MAPCP Demonstration. In response to the second commenters comments, we added a few questions and probes to our interview protocols where possible and appropriate in an attempt to obtain moore specific responses from interviewees on topics specified by the second commenter, including access to care, consultation with patients and families outside of regular business hours, and specific mechanisms that support transitions across care settings.

A.9 Payments/Gifts to Respondents

No remuneration will be offered to the interview participants. We anticipate that interviewees have sufficient interest in the MAPCP Demonstration that they will be willing to participate without compensation. To facilitate participation, interviews will be held at the participant's location. Telephone will be used only if the person is unavailable during the time we will be in the state.

A.10 Confidentiality

Personnel to be given access to interviews and/or individual identifiers will be trained on the significance and protection of confidentiality, particularly as it relates to controlled and protected access to interview notes and summary files. Further, materials will be sent to potential interviewees describing the purpose and the voluntary nature of the interviews and will convey the extent to which respondents and their responses will be kept confidential. We pledge privacy to the fullest extent possible. We will use a file-naming convention (denoting the state, type of organization and interviewee's role) to de-identify the names of individuals and their affiliations for the interview notes and NVivo 9 database. As previously described on page 3, NVivo 9 is a computer software package used to analyze qualitative data. The notes and the database will be stored on a secured server and password-protected computers.

A.11 Sensitive Questions

Information collected in the interviews is not of a sensitive nature. Questions are confined to interviewee experiences, opinions, and perspectives regarding the MAPCP Demonstration. Some interviewees might have views that are critical of state or federal initiatives or particular participating organizations (e.g., health plans, health systems or practice, community organizations). We will handle such insights with sensitivity and confidentiality in mind and will not share nor attribute the identities of those individuals or their organizations in an identifiable way in any written or oral communications.

A.12 Burden Estimates (Hours and Wages)

Six types of interviews lasting 30 to 90 minutes will be conducted in two rounds:

1. Physicians and administrators of practices and/or health systems participating in the MAPCP Demonstration (including North Carolina's care managers and community based care networks, Pennsylvania's physician organizations, and Michigan's provider organizations) (length of interview: 30 to 60 minutes)
2. Individuals representing local chapters of physician and clinical professional associations (length of interview: 60 minutes)
3. Individuals representing payer organizations, including Medicaid (length of interview: 60 minutes)
4. Individuals representing Office of Aging and patient advocates (length of interview: 45 minutes)
5. Individuals representing community health teams and networks, where applicable, as some states do not include these kind of teams or networks in their initiative (including

respondents from Vermont's Support and Services at Home program) (length of interview: 45 minutes)

6. State officials (including respondents from North Carolina's Division of Aging and Adult Services) (length of interview: 90 minutes)

The estimated length of each interview includes time to review the interview processes and to obtain verbal informed consent. We will request that each interview be conducted with one interviewee. However, some organizations may request that additional people participate during some or all of the interview, given the topics to be discussed. For example, a state official leading the demonstration may answer some questions, but request that other members of his or her staff answer others during the interview or separately. However, each interview will be attended by no more than three individuals. We estimate that half of the interviews will be conducted with one individual or interviewee (i.e., one interviewer and interviewee), and the other half of the interviews will be conducted with two or more interviewees, as many times people will request that several staff from their organization participate. To estimate the cost of burden, we used an average of two interviewees per interview. Wage calculations are based on the mean hourly wages as indicated in the "National Compensation Survey: Occupational Wages in the United States, May 2011," by the U.S. Department of Labor, Bureau of Labor Statistics.

The maximum number of respondents (by state and category) that will participate in semi-structured interviews during *each* round is shown in **Exhibit 1.** A total of 472 respondents will be interviewed in each round. We will conduct two rounds of interviews during the course of the demonstration, meaning that we will interview 472 respondents in the eight states at two points in time (i.e., approximately twelve months apart), for a total of 944 respondents interviewed (472 x 2).

Estimated annual time and wage burden during *each* round is shown in **Exhibit 2.** The total estimated time burden for each round is 478 hours, which is slightly higher than the number of respondents (472) because some individuals will be interviewed for 45 minutes and others will be interviewed for one and a half hours. The total estimated time burden for two rounds is 956 hours (478 x 2). The total estimated wage burden for each round of interview is $33,253.62. The total estimated wage burden for the entire evaluation (2 rounds combined) is $66,507.24.

Exhibit 1.
Maximum number of respondents by interview site and respondent type (472 respondents) per round

State	Practice / Health System Physicians and Administrators (1)	Individuals Representing Physician Associations	Individuals Representing Payer Organizations	Individuals Representing Office of Aging and Patient Advocates	Individuals Representing Community Health Teams and Networks (2)	State Officials (3)	Total Respondents
ME	36	2	6	6	4	6	60
MI	36	2	6	6	0	6	56
MN	36	2	6	6	4	6	60

State	Practice / Health System Physicians and Administrators (1)	Individuals Representing Physician Associations	Individuals Representing Payer Organizations	Individuals Representing Office of Aging and Patient Advocates	Individuals Representing Community Health Teams and Networks (2)	State Officials (3)	Total Respondents
NY	36	2	6	6	4	6	60
NC	36	2	6	6	4	6	60
PA	36	2	6	6	0	6	56
RI	36	2	6	6	4	6	60
VT	36	2	6	6	4	6	60
Total	288	16	48	48	24	48	472

(1) Includes North Carolina's care managers and community based care networks, Michigan's provider organizations, and Pennsylvania's organized delivery systems
(2) Includes Vermont's Support and Services at Home (SASH) program. MI and PA do not have community health teams or networks
(3) Includes North Carolina's Division of Aging and Adult Services

Exhibit 2.
Estimated respondent hourly and wage burden by respondent type (478 burden hours for an estimated $33,253.62 wage burden) per round

Respondent Type	Number of Respondents	Length of Interview (hrs)	Total Burden Hours	Mean Hourly Wage Rate*	Total Wage Burden
Practice / Health System Physicians and Administrators [1]	288	1	288	$85.26	$24,554.88
Individuals Representing Physician Associations [1]	16	1	16	$85.26	$1,364.16
Individuals Representing Payer Organizations [2]	48	1	48	$51.64	$2,478.72
Individuals Representing Office of Aging and Patient Advocates [3]	48	0.75	36	$21.07	$758.52
Individuals Representing Community Health Teams and Networks [3]	24	0.75	18	$21.07	$379.26
State Officials [4]	48	1.5	72	$51.64	$3,718.08
Total	472		478	—	$33,253.62

*Based upon the mean hourly wages, "National Compensation Survey: Occupational Wages in the United States, May 2011," U.S. Department of Labor, Bureau of Labor Statistics. http://www.bls.gov/oes/current/oes_nat.htm#b29-0000
[1] Family and general practitioners
[2] Civilian workers
[3] Community and social service occupations
[4] Management occupations

A.13 Capital Costs

There are neither capital or startup costs, nor are there any operation and maintenance costs to the interview participants.

A.14 Costs to Federal Government

Total costs associated with two rounds of interviews are estimated to be $2,210,364 for recruitment, interview facilitation, travel, meeting notes and analysis. The annualized costs are approximately $1,105,182 for each round of interviews; the two rounds will occur over a two-year period. These costs are funded through an existing CMS contract with RTI.

Federal FTE costs are expected to be negligible. The Project Officer (GS 14-5, annual salary $119,238) for the CMS contract with RTI may be required to spend 0.2% of her time each year on the administration of this interviews ($238 of annual salary).

A.15 Changes to Burden

There are no changes to the burden. In response comments, we added a few questions and probes to our interview protocols where possible and appropriate in an attempt to obtain moore specific responses from interviewees on topics specified, including access to care, consultation with patients and families outside of regular business hours, and specific mechanisms that support transitions across care settings.

A.16 Publication/Tabulation Dates

The semi-structured interview data, which does not constrain the interviewee's answers to fixed response categories as in a structured interview or survey, will be analyzed using well-established, rigorous qualitative methods and non-statistical techniques. For example, we could analyze all interviewee responses to questions on particular topics such implementation experience and lessons learned to identify common patterns and themes across all states. We also could compare and contrast the responses from interviewees in different states or responses of policymakers and program leaders to those of participating physicians and practice staff or health plans. The latter approach would help us to understand the diverse perspectives on the same program. Finally, the perspectives of interviewees can be compared to secondary qualitative or quantitative data that is descriptive in nature (Bradley et al., 2007; Devers, 1999; Miles & Huberman, 1994).

These qualitative results will be reported in three reports. The Second Annual Report will be completed in March 2014. The Third Annual Report will be completed in March 2015. The Final Report will be completed in January 2016. Additionally, the RTI/Urban/NASHP team plans to develop peer-reviewed publications and conference presentations that will be reviewed and approved by CMS prior to submission.

A.17 Expiration Date

The OMB expiration date will be displayed on all disseminated data collection materials.

SUPPORTING STATEMENT – PART B

Collections of Information Employing Statistical Methods

This information collection does not employ statistical methods.

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ATTACHMENT A
30-DAY FEDERAL REGISTER NOTICE

ATTACHMENT B
ADVANCE LETTERS

E-mail Recruitment Letter

Dear [DR./MS./MR.] [LAST NAME]:

I am writing to ask for your help with an important study of the "medical home" model of advanced primary care. RTI International (RTI), a not-for-profit research organization, and their collaborating partner organizations, the Urban Institute and the National Academy for State Health Policy (NASHP), has been contracted by the Centers for Medicare & Medicaid Services (CMS) to conduct an evaluation of the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration, which includes the [NAME OF RESPONDENT'S STATE PCMH INITIATIVE] in which you participate. Part of the evaluation includes conducting in-person interviews with employees of physician practices participating in the MAPCP Demonstration, and key individuals representing physician associations, payer organizations, Office of Aging staff and patient advocates, community health teams and networks, and state officials.

We are interested in speaking with you to find out how implementation of this demonstration has been progressing, and what changes, if any, you are beginning to see as a result of participating in this demonstration.

In a few days, a representative from RTI or the Urban Institute will contact you to request your participation in an in-person interview, which will be held sometime in the [Spring / Summer / Fall / Winter]. The interview will last no longer than [45 minutes / one hour / 90 minutes], and will take place at a location of your choosing.

Please be assured that your participation is completely voluntary and that all perspectives you provide during the interview will be kept confidential to the extent provided under law. Refusal to participate will not affect your practice or organization in any way. Neither you nor your [practice/organization] will be individually identified in our analyses or reports submitted to CMS. This study has been reviewed and approved by RTI's Institutional Review Board.

If you have questions about this study in general, please call or e-mail me at (202) 728-1968 or toll-free at 1-800-334-8571, extension 2-1968, or nmccall@rti.org. If you have any questions about your rights as an interview respondent, you may call RTI's Office of Research Protection toll-free at 1-866-214-2043.

Your help is extremely important to the evaluation of this demonstration, and we thank you for considering this request.

Sincerely,

Nancy McCall, RN, PhD
RTI Project Director
MAPCP Demonstration Evaluation

ATTACHMENT C
INTERVIEW PROTOCOLS