MULTI-PAYER ADVANCED PRIMARY CARE PRACTICE DEMONSTRATION INTERVIEW PROTOCOL

Provider Organizations / Organized Delivery Systems

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Introduction

Thank you for making time to speak with us today. As we mentioned in our email to [name of our contact in their practice / clinic / hospital], we are researchers from RTI, the Urban Institute, and the National Academy for State Health Policy (NASHP), evaluating the Multi-Payer Advanced Primary Care Practice (MAPCP) Chronic Care Initiative.

As previously mentioned in the email we sent you when we set up the interview, we'd like your candid views about this initiative. Specifically, we'd like to focus on learning about the period after Medicare joined the state's initiative and your thoughts on the future. Since we're asking about a number of different periods of time, we have created a visual timeline and logic model to differentiate each time period *[show the respondent the state's timeline and logic model]*.

We are also particularly interested in the impact of the initiative on Medicare and Medicaid beneficiaries generally and special populations (such as those dually eligible for Medicare and Medicaid) specifically. We understand that some changes are system wide and may not affect these groups differently, but other changes that payers or practices make may be tailored to these groups to some degree and have different impacts on these patient populations.

As described in the attachment to our email we sent to you to set up the interview, our evaluation is being funded by the Centers for Medicare and Medicaid Services (CMS). As a condition of participation, CMS expects state staff and participants to cooperate with the evaluation team, but ultimately your decision to participate in this aspect of the study is voluntary. If you do not wish to participate in this interview or answer specific questions, please let us know immediately.

We believe there are minimal risks to you from participation, and every effort will be made to protect your confidentiality. We want to assure you that we will not quote you by name. We will use some quotes in reports, but quotes will not be attributed to an individual or his/her organization.

There are no direct benefits to you from participating in this study. But your insights will be used by federal and state policymakers to better understand the effects of the medical home model on Medicare and Medicaid beneficiaries as well as the challenges involved in running a medical home initiative and becoming and maintaining a medical home. The Institutional Review Boards (IRB's) at RTI International and the Urban Institute have reviewed this research.

Finally, we would like to record our conversation, to ensure our notes from today are complete.

Are these interview conditions OK with you? Do you have any questions before we begin?

Introduction/Background Questions

1. How long have you been with [name of physician organization / organized delivery system]?

2. Please tell me about your roles and responsibilities with [name of physician organization / organized delivery system].

   [If they have been there long:]

3. Please tell me about your [physician organization / organized delivery system] overall. For example, how many physicians and practice sites or locations do you operate? How many hospitals do you own and operate?

   a. What is your approximate payer mix, particularly your percent Medicare and Medicaid? What is the mix of health care professionals and other team members or staff in your [name of physician organization / organized delivery system]?

   b. Where is your [physician organization / organized delivery system] located? Where do your staff physically work (e.g., on site at the practices)?

   c. Please describe the practices in this Chronic Care Initiative, including how they compare to other practices in your physicians organization or organized delivery system that are not participating in the Chronic Care Initiative.

   d. Please describe what other departments or individuals in the [name of physician organization / organized delivery system] provide support to the participating practices for medical home development and other activities related to the Chronic Care Initiative.

4. What is your [physician organization / organized delivery system]'s primary role with respect to medical home development and practice transformation?

5. Which of the following activities does your [physician organization / organized delivery system] engage in to support the practices:

   a. Internal learning collaboratives?

   b. Practice coaching or facilitation?

   c. Leadership or staff training?

   d. EHR/HIT and disease registry support?

   e. Performance measurement and monitoring?

   f. Performance incentives?

   g. Other contracts with practices or other health care provider organizations?

6. How does your [physician organization / organized delivery system] interact with practices?

Progress / State Implementation

7. If you were involved Pennsylvania's Chronic Care Initiative implemented *prior* to January 2012, what features of the Chronic Care Initiative are most important for your organization and participating practices?

    a. What were the major strategies used prior to January 2012 to implement medical homes? How successfully were they implemented?

8. Now that Medicare and Medicaid have joined the effort, what features of the Chronic Care Initiative are most important for your organization and participating practices?

    a. What changes were made to accommodate Medicare's participation, if any, or to accommodate the Medicare beneficiaries now being served by the Chronic Care Initiative?

    b. How does your own [physician organization / organized delivery system]'s activities fit with activities sponsored by the state, such as the learning collaborative, practice coaching, performance measurement and monitoring?

9. How is the implementation of the Chronic Care Initiative with Medicare and Medicaid's involvement going so far?

    a. What has gone well?

    b. What hasn't gone so well?

10. What do you think are the strengths and weaknesses of the Chronic Care Initiative?

11. What new or persistent challenges do you anticipate in the future, if any?

12. What new opportunities for improvement do you anticipate in the future, if any?

Payment and Infrastructure

[Note to interviewer: try to ask about (1) the time it took to implement any practices changes discussed; and (2) the cost of implementing or sustaining any practices changes discussed]

13. Prior to Medicare joining the Chronic Care Initiative, participating practices received payments from Medicaid and private payers to engage in medical home-related activities. How do the participating practices use these medical home payments? For example, did they invest in disease registries or EHR infrastructure, hired additional staff, etc.?

14. We understand that as a participant in Pennsylvania's Chronic Care Initiative, your [office / clinic / hospital] receives two type of per member per month (PMPM) payments: the physician coordinated care oversight services PMPM and the coordinated care fees PMPMs. We also understand that practices are eligible for shared savings payments. What are the

strengths and weaknesses of the shared savings payment component with respect to supporting continued practice transformation and key outcomes?

15. Are participating practices engaging in additional activities now that they also are receiving medical home payments from Medicare?

    a. *[If so:]* What are those activities?

    b. *[If not:]* Why not?

16. Do you think that Medicare's medical home payments are adequate to allow your [physician organization / organized delivery system] and the practices you support to continue to invest in medical home development and sustain effective medical home activities?

    a. What kinds of infrastructure or care processes do the Medicare medical home payments support?

    b. What kinds of activities are the medical home payments not sufficient to support but that could be beneficial?

17. What are the strengths and weaknesses of the current payment methodology (since Medicare joined the Chronic Care Initiative) for [physician organizations / organized delivery systems]? For the participating practices?

18. How are employed physicians generally paid in [name of physician organization / organized delivery system]? Is it primarily productivity based or is there some portion tied to performance metrics or other factors?

    a. Has the [physician organization / organized delivery system]'s or organized delivery system's payment model been altered for employed physician since this Chronic Care Initiative began? If so, how. Please briefly describe.

Health Information Technology

19. What types of health information technology capabilities does [name of physician organization / organized delivery system] use to carry out its functions? For example, do you use web portals maintained by payers, electronic disease registries, or electronic health records?

    a. Can you track services provided to patients in each participating practice and other owned or affiliated practices? If so, how do you do this?

    b. To what extent can you readily exchange health information with participating practices? Other practices or facilities (e.g., specialists, hospitals, long-term care facilities)?

    c. What are the major benefits of the health information technology that you use?

d. What are the primary challenges you face, either because of any health information technology capabilities you are lacking or with the health IT that you have?

20. What additional health IT features would help your [physician organization / organized delivery system] do a better job assisting participating practices? Providing care coordination to patients?

21. Has your [physician organization / organized delivery system] registered for and Medicare and/or Medicaid meaningful use (MU)? If so, which program and have you attested to adopt, implement, and upgrade (AIU) or stage 1 MU?

Performance Monitoring

22. We understand that before Medicare joined, practice performance was measured and monitored on a relatively small set focused on diabetes and pediatric asthma. These were collected by practices and reported to Pennsylvania Academy of Family Physicians (PAFP) and the Improving Performance in Practice (IPIP) initiative. Now that Medicare has joined, the set of measures has been expanded to preventive services for children and adults, as well as care for patients with diabetes, asthma (ages 5-40), hypertension, and ischemic vascular disease. These measures are reported to PAFP and then the state. What is your organization's view of the measure set? What are its strengths and weaknesses of these measures?

    a. How does the [name of physician organization / organized delivery system] assist in these quality measurement efforts?

    b. What type of results do they focus on in these quality measurement efforts?

        i. Are these quality results broken out by payer type (e.g., Medicare, Medicaid, commercial payers?)

    c. What does your [physician organization / organized delivery system] usually do with these quality results? How about the participating practices?

    d. *[If not already identified:]* What specific changes, if any, have participating practices made based on these results?

        i. Have participating practices taken any special actions targeted at Medicare, Medicaid, or other special patient populations?

        ii. Are there any special issues or challenges to reaching Medicare or Medicaid beneficiaries or special populations? Please describe briefly.

    e. We understand that under the shared savings component, practices are eligible for shared savings payments that will take into consideration practice performance on key quality and cost metrics. What are the strengths and weaknesses of using these measures to determine the distribution of shared savings?

23. Practices participating in the Chronic Care Initiative have been receiving beneficiary utilization files from CMS/RTI that show some quality measures, and hospital and ER utilization information (dates, principal diagnosis, hospital name) for their Medicare patients. Are you familiar with these files? If so, what do practices do with these data?

    a. What aspects of those files do you believe have been most useful in helping participating practices change the way they deliver care?

    b. What features are not as helpful, or need improvement?

    c. *[If not already identified:]* What specific changes, if any, have participating practices made based on these data?

24. Do you monitor practice's utilization and cost information?

    [If yes:]

    a. What do you monitor?

    b. What do you do with the data you collect?

    c. Do you provide feedback to practices?

    d. Do you help them develop strategies to improve on any performance measures where they appear to have quality gaps?

Coordination of Care

[Note to interviewer: (1) Try to ask respondents to identify medical home features that contributed to the observed impacts, or features that could be added to the initiative to improve outcomes. (2) More specific examples of impacts to care might be discussed during the interview. For example, referrals to community resources and specialists are examples of care coordination. Other more specific examples that may be discussed in this section are: timeliness and continuity of care, coordination with specialists (physician and mental health), medication reconciliation, discussion of current and potential changes to a patient's drug regimen, shared decision-making, patient self-management, provision of information such as test results to patients in a way that is easy to understand, health literacy, discussion of patient medical history, proactive care (e.g. generating lists of patients who need to come in for an office visit), and active reminders about tests, treatment, and/or appointments.]

25. Does [name of physician organization / organized delivery system] hire care managers to provide care coordination?

    a. *[If yes:]* Please describe the services they provide. Where do they work?

    b. *[If no:]* Why not?

26. Now we'd like to discuss with you how beneficiaries access care coordination or management services and their experiences with it. Please comment on patients overall, but also on whether there are any differences for Medicare or Medicaid beneficiaries or special populations of patients. Special populations can include: Medicare and Medicaid dual eligibles; children; racial and ethnic subgroups; people living in rural or inner-city areas; and persons with chronic illnesses, mental illnesses, and disabilities.

    a. How do you identify people who need care coordination and management help or how do they get connected with these staff in the participating practices or [name of your organization]?

    b. Are there any differences in how your practices or organization identify or are assigned Medicare or Medicaid beneficiaries, or other special populations?

        i. *[If yes:]* Please describe.

        ii. *[If no:]* Why not?

27. Since Medicare joined the Chronic Care Initiative in January 2012, what impacts has it had on patients?

    a. Is there evidence of improvements in:

        i. Access to care?

        ii. Coordination of care? (e.g., care transitions)

        iii. Patient and family caregiver participation or behavior? (e.g., patients engaging more in decisions and managing their care, use of patient and family advisory boards for practice quality improvement efforts)

        iv. Increased delivery of preventive services? (e.g., cancer screenings, smoking cessation, weight management, influenza vaccination)

        v. Reduced use of acute care? (e.g., emergency department visits, hospitalizations, readmissions)

        vi. Improved health care quality, patient safety, and patient experience and/or satisfaction?

        vii. Other?

    b. If Medicaid participated in [state-specific name of MAPCP demonstration] prior to Medicare joining the initiative in [2011/2012], what impact has the initiative had on Medicaid beneficiaries and special populations? Special populations can include: Medicare and Medicaid dual eligibles; children; racial and ethnic subgroups; people living in rural or inner-city areas; and persons with chronic illnesses, mental illnesses, and disabilities.

Wrap-up

28. What major areas will your [physician organization / organized delivery system] be focusing on in the next year, or what changes will you be making?

    a. What do you see as the facilitators (or critical factors) of successful implementation?

    b. What do you see as the barriers or major challenges to implementing these changes?

29. What advice would you give to other states or [physician organizations / organized delivery systems] if the Chronic Care Initiative were to be extended or expanded to include them?

    a. What advice would you give to CMS (Medicaid and Medicare)? Any particular advice on the role of [physician organization / organized delivery systems] in medical home implementation?

30. Given what you know now, what would you have done differently, both prior to and after Medicare and Medicaid's involvement in the Chronic Care Initiative?

31. Is there anything we have not discussed about the Chronic Care Initiative or about the MAPCP Demonstration that you feel would be important for our National Evaluation Team to know?