MULTI-PAYER ADVANCED PRIMARY CARE PRACTICE DEMONSTRATION EVALUATION

INTERVIEW PROTOCOL

State Officials

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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 of State Health Policy (NASHP), evaluating the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration. 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.

We'd like your candid views about this initiative. We want to assure you that we will not quote you by name without getting back in touch with you to get your permission first. We would like to record our conversation, to ensure our notes from today are complete. Is this OK with you? Do you have any questions before we start the interview?

About the Respondent

1. *[Before Visit]* What is your role in [name of state agency]?

2. *[Before Visit]* How long have you worked on [name of state]'s [state-specific name of PCMH initiative]?

Background

3. Briefly describe the major goals of the [state-specific name of the PCMH initiative]?

    a. How were key stakeholders, including consumers or patients, involved in setting the goals for [state-specific name of the PCMH initiative]?

    b. How are key stakeholders, including consumers or patients, currently involved in monitoring the implementation of [state-specific name of the PCMH initiative] and providing input on any aspects that need to be more fully articulated or refined?

4. What major changes did the state have to make to support the [state-specific name of PCMH initiative], prior to Medicare joining in [2011/2012]? (For example, structure and staff to create safe harbors for Medicaid managed care plans and private payers to agree on a common payment approach? Changes to Medicaid managed care contracts? Consultants or other infrastructure to support practice transformation and the collection and reporting of quality measure data for payment or public reporting.)

5. What are your sources of funding for the [state-specific name of PCMH initiative]? How sustainable is this funding?

6. How has the political environment in your state affected the [state-specific name of PCMH initiative]?

7. What strategies were successful in convincing payers to participate in [name of state]'s [state-specific name of PCMH initiative]?

    a. What strategies were non-starters in trying to recruit these payers?

    b. How long did it take to convince these payers to participate?

8. What do you expect from the payers as a participant?

9. What do payers expect to get from their involvement?

10. What challenges have private and/or public (Medicaid) payers faced in the course of participating in [name of state]'s [state-specific name of PCMH initiative]?

11. What challenges have you encountered working with the participating payers (private, Medicaid, and Medicare) as you got the [state-specific name of PCMH initiative] up and running?

12. What are some ongoing challenges you face with participating payers?

Getting the Demonstration Up and Running

13. How has implementation of [name of state]'s [state-specific name of PCMH initiative] gone since CMS joined the initiative? (e.g., agreements with practices and/or plans, data collection, payment)?

    a. What has gone well?

    b. What hasn't gone so well?

14. What factors have most affected the state's ability to implement the [state-specific name of PCMH initiative] since CMS joined the initiative? (We are most interested in factors external to this initiative like the state budget, other Medicaid reforms, or other federal initiatives.)

    a. *[Optional] [If needed:]* Why were these factors the most influential? How have they helped or hindered? Has the influence of any of these factors changed since Medicare joined the [state-specific name of PCMH initiative]?

15. What changes [were / are being] made to [name of state]'s [state-specific name of PCMH initiative] to accommodate Medicare's [and Medicaid (if joined at the same time)]'s participation in this multi-payer initiative?

    a. Is [name of state] providing new information or services to participating [medical home / health care home] practices to specifically address the needs of Medicare [and Medicaid (if joined at the same time)] patients, including dual eligibles? If so, please describe. If not, why not?

        i. Do any of these new services focus on improving access? If so, how?

        ii. *Do any of these new services focus on improving* care coordination or care transition, including transitions from hospital to home? If so, how?

    b. Is [name of state] doing anything specifically aimed at helping practices serve special populations? Special populations can include: Medicare and Medicaid dual eligibles; children; racial and ethnic subgroups; non-English speakers; people living in rural or inner-city areas; and persons with chronic illnesses, mental illnesses, and disabilities. If so, please describe. If not, why not?

    c. How likely do you feel that you will be able to implement all of these changes successfully?

    d. What are the major challenges to implementing these changes?

Payment

16. *[Optional] [Before Visit]* What new payment approaches did private health insurance plans and self-insured employers [and Medicaid (if participating prior to MAPCP start)] adopt as part of the initial implementation of [state-specific name of PCMH initiative], before Medicare joined this initiative as a payer in [2011/2012]?

    a. *[Optional]* How long did it take for these payers to implement these payment changes?

    b. *[Optional] [Before Visit]* What additional changes, if any, did they have to make once Medicare joined the [state-specific name of PCMH initiative] in [2011/2012]?

Other Required State Infrastructure Changes

17. What changes did you have to make to the [state-specific name of PCMH initiative] for it to meet the MAPCP Demonstration eligibility criteria?

18. How did Medicare joining the [state-specific name of PCMH initiative] affect state and payer support and involvement?

Practice Transformation

[Note to interviewer: try to ask about the cost of implementing or sustaining any practices changes discussed]

19. We understand your state uses [name of state's medical home assessment or recognition tool]. Why did you select or develop that tool?

    a. How well do you feel it assesses a practice's medical home capabilities?

    b. How do you use this medical home assessment or recognition information? For example, do you use it guide to learning collaborative activities? To determine practice payment levels?

20. Please describe briefly the kinds of technical assistance or supports the [state-specific name of PCMH initiative] is providing to support the development of greater medical home capacity as reflected in medical home assessment or recognition tool level or score? For example, learning collaboratives, practice coaching or consultation, care coordinators, etc.

    a. What are the strengths of the technical assistance and practice supports put in place by [state-specific name of PCMH initiative]?

    b. What are the challenges or areas for improvement needed with respect to technical assistance or practice supports put in place by [state-specific name of PCMH initiative]?

21. What major changes have participating [medical home / health care home] practices made since the [state-specific name of PCMH initiative] began in [year that the state-specific name of PCMH initiative began]?

    a. How, if at all, do you feel these changes impact patient access? We are particularly interested in the impact on Medicare, Medicaid, and special populations.

    b. How, if at all, do you feel these changes impact care coordination or care transitions, including from transitions from hospital to home? We are particularly interested in the impact on Medicare, Medicaid, and special populations.

    c. How, if at all, do you feel these changes impact patient and family engagement? For example, identifying and involving key family members involved in care, self-management skills, and development of care plans or shared decision making?

    d. What additional changes have practices made since Medicare joined the [state-specific name of PCMH initiative] in [2011/2012]?

    e. To what extent were these changes aimed at addressing the needs of Medicare and Medicaid beneficiaries or other special patient populations? Please provide an example.

22. We understand that in [name of state]'s [state-specific name of PCMH initiative], practices receive payment for [insert state-specific description of what practices receive payments for, how frequently, etc.]. How do participating practices use their medical home payments from Medicare, Medicaid, and private payers?

    a. In your opinion, did these payments from Medicaid and the private payers provide health care providers enough resources to invest in needed medical home infrastructure? Briefly describe why or why not.

    b. Now that Medicare has joined [state-specific name of PCMH initiative] as a payer, do practices now have enough resources to develop medical home infrastructure and to sustain the medical home components? Briefly describe why or why not.

    c. In your opinion, do the medical home payments (from all participating payers) incentivize improvements in clinical process and patient outcomes (i.e., efficient service utilization, quality, patient experience and satisfaction)? Briefly describe why or why not.

23. Have the new [state state-specific name of PCMH demonstration] payments to practices—implemented in [2011/2012]--increased or decreased the number of participating practices, communities, and patients served?

24. Besides practice efforts to become medical homes, some states are implementing additional features (e.g., community health teams or networks, disease management firms) to achieve greater care coordination and improve patient outcomes. What kinds of strategies has your state implemented since [state-specific name of PCMH initiative] began in [year that state initiative began], if any?

    a. Has the state made any adjustments to these programs since [2011/2012] when Medicare joined the initiative?

    b. What is facilitating implementation or working well?

    c. What is hindering implementation or not working as well?

25. What other strategies is the state using to improve care coordination for Medicaid and Medicare beneficiaries or dual eligibles?

    a. Why did [name of state] choose to adopt these other strategies?

Health Information Technology

26. We know that as part of the [state-specific name of PCMH initiative], practices are required to [describe any health IT requirements]. Besides these health IT tools and systems, what other types of health information technology are being used in [name of state]'s [state-specific name of PCMH initiative]? (i.e., are practices required or incentivized to have electronic health records, registries, or to exchange health information with other providers electronically)?

27. What health IT tools or systems do you believe have been most useful to practices in improving care coordination?

28. What about in terms of improving and measuring performance (in terms of quality, utilization, and cost)? What state and/or federal health IT-focused projects or programs does [state] participate in? (e.g., EHR payment incentive programs through Medicaid, regional extension centers, Health Information Exchange grants to the state, Beacon communities)

29. What have [name of state] and the participating payers done to support [medical home / health care home] practices in health IT implementation?

30. To what extent are EHR requirements and related clinical quality measures used by the [state-specific name of PCMH initiative] aligned with Medicare and Medicaid Meaningful Use (MU) measures? For example, have stage 1 MU requirements to collect demographic information, provide on-line access to patients, or report particular clinical quality measures been incorporated into the medical home assessment or recognition criteria?

Data Exchange

31. *[Optional]* What type of utilization, cost or quality information do you receive from payers or practices?

    a. *[Optional] [Before Visit]* How recent is that information?

    b. What additional information would it be helpful to receive?

    c. How aligned are the states' clinical quality measure and other reporting requirements aligned with those required for other CMS programs?

    d. How do you use this information?

32. What other types of data is [state] receiving from payers (e.g., Medicaid managed care plans) and practices about their patients? (This could be program eligibility data, clinical data, or other patient-level data.)

33. *[Optional] [Before Visit]* What kinds of utilization, cost and quality information does the state or the Medicaid managed care plans with which it contracts give practices about their patients?

    a. *[Optional] [Before Visit]* How recent is that information?

    b. What do you expect practices to do with that information?

    c. Is there information that the state would like to provide but does not?

34. What other types of data is [state] giving payers (e.g., Medicaid managed care plans) and practices about their patients? (This could be program eligibility data, clinical data, or *other* patient-level data.)

    a. What barriers has the state faced in doing this?

Outcomes

[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.]

35. Since the [state-specific name of PCMH initiative] began in [year that state-specific *initiative* began], 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.

    i. Prior to Medicare joining the [state-specific name of PCMH initiative], what spill-over effects was the initiative having on Medicare beneficiaries?

36. Since Medicare joined [name of state]'s [medical home / health care home] efforts in [2011/2012], what new impacts do you anticipate for patients, particularly Medicare and Medicaid beneficiaries, including dual eligibles, or other 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.

    a. Do you anticipate improvement 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?

37. What do you see as the major barriers to achieving the goals of this initiative?

    a. What are the major barriers for the state?

    b. For private payers?

    c. For practices, or other affected providers, such as hospitals?

    d. For community health teams or networks?

    e. For patients and family caregivers?

Lessons Learned and Next Steps

38. Since Medicare joined in [2011/2012], how successful has the [state-specific name of *PCMH* initiative] been in getting practices to change the way they deliver care?

39. *Which* features of the [state-specific name of PCMH initiative] do you think have the greatest potential to improve outcomes for Medicare and Medicaid beneficiaries?

    a. Why those features?

40. What lessons has the state learned so far from the [state-specific name of PCMH *initiative*] from being part of the MAPCP Demonstration?

    a. What would the state have done differently, knowing what it knows now?

        i. *[If needed:]* Are there any aspects of your initiative that the state is considering changing?

41. Do you have any recommendations for the other seven states participating in the MAPCP Demonstration? For other states starting a [state-specific name of PCMH initiative]? For CMS or the Medicare program?

42. In the next year, what are the key issues you'll face related to [state-specific name of PCMH initiative]?

43. In the next year, what are the key developments (outside of [state-specific name of PCMH initiative]'s control) that might affect this initiative? (For example, *implementation* of health reform generally, changes in the state government administration, tight state budgets, other health care market developments?)

44. Is there anything else about [name of state]'s [state-specific name of PCMH initiative] and its *impact* on plans, practices or other affected providers (such as hospitals), and beneficiaries that we haven't covered but that would be important for our team to know?