MULTI-PAYER ADVANCED PRIMARY CARE PRACTICE DEMONSTRATION EVALUATION
INTERVIEW PROTOCOL

Provider Organizations

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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) Demonstration.

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]?

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

3. Please describe the mix of health care professionals and other team members or staff in your [name of physician organization].

4. What are your physician organization's primary activities?

    a. What are your major activities with practices? How does your physician organization interact with practices?

    b. What types of infrastructure and support does your physician organization provide to practices to support medical home development and medical home activities?

    c. What role do you have in distributing incentives for MiPCT? For other incentive programs?

    d. Do you have other contractual relationships with practices?

5. Where is your physician organization located? Where do your staff physically work (e.g., on site at the practices)?

    a. How about your care coordinators?

Progress / State Implementation

6. What features of the Michigan Primary Care Transformation Project do you think are the most important?

    a. What do you think are the strengths and weaknesses of the Michigan Primary Care Transformation Project?

7. Were you involved in the BCBSM PCMH PGIP *prior* to January 2012?

    [*If yes]:*

    a. What were its most important features?

    b. What were the major strategies used to implement medical homes during that time period before January 2012? How successfully were those strategies implemented?

8. What changes, if any, were made to the BCBSM PCMH PGIP or Michigan Primary Care Transformation Project to accommodate Medicare joining?

9. How is the implementation of the Michigan Primary Care Transformation Project with Medicare and Medicaid's involvement going so far?

    a. What has gone well?

    b. What hasn't gone so well?

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

11. 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]

12. How were physician organizations paid for the support they provided to practices prior to January 2012—before Medicare and Medicaid joined MiPCT? What major changes, if any, have been made since Medicare and Medicaid joined? How are they paid now?

13. We understand that each payer contributes to an incentive pool that is distributed to the POs based on their performance and improvement. How are those payments distributed to practices? How do you think these payments will be used?

14. Prior to Medicare and Medicaid joining the Michigan Primary Care Transformation Project, participating practices received payments from Blue Cross Blue Shield of Michigan to engage in medical home-related activities. Do you know how the participating practices used these medical home payments?

15. What kinds of infrastructure or care processes do the Medicare medical home payments support at the PO level? At the practice level? Are participating practices engaging in any additional activities now that they are receiving Medicare and Medicaid medical home payments on top of its medical home payments from private payers?

    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 and the practices you serve to continue to invest in medical home development and sustain effective medical home activities?

    a. What kinds of activities are the Medicare payments not sufficient to support but that could be beneficial?

17. What are the strengths and weaknesses of the current payment methodology (since Medicare and Medicaid joined for this demonstration) for physician organizations? For practices?

Health Information Technology

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

    a. Can you track services provided to patients? If so, how do you do this?

    b. To what extent can you readily exchange health information with primary care practices? Other practices/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?

19. What additional health IT features would help your physician organization do a better job assisting practices? Providing care coordination to patients?

Performance Monitoring

20. We understand POs assist practices with collecting data and submitting reports to MiPCT.

    a. What types of data do practices collect? Chronic condition data? Quality and safety data?

    b. How does your PO assist in the data collection and submission?

    c. What do you think practices usually do with these quality results?

    d. What specific changes, if any, have participating practices made based on these results?

    e. How is this different from what practices did before January 2012 as part of BCBSM's PGIP PCMH Initiatives?

21. 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?

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 specialists are an example 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), 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.]

22. Does [name of physician organization] hire care managers to provide care coordination?

    a. *[If yes:]* Please describe the services you provide.

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

23. How do you identify people who need help or how do they get connected with care managers?

    a. Are there any differences in how you identify or are assigned Medicare or Medicaid beneficiaries, or other special populations, for care coordination services? 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. *[If yes:]* Please describe.

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

24. How do care coordinators coordinate patient care between the primary care practices you work with and other providers or facilities, such as hospitals, long term care facilities, medical or surgical specialists, and behavioral health providers?

25. Do you, and if so how do you:

    a. Follow up with patients after they are discharged from a hospital? ER?

    b. Perform medication reconciliation?

    c. Provide linkages to community services, or social services?

    d. Work with patients to address challenges they may face accessing care?

    e. Work with patients to address challenges they may face caring for themselves?

26. What are some reasons why you might contact patients?

    a. How do they react when you contact them?

    b. How successful are these contacts with patients?

c. To what extent do you assist patients in getting them access to non-clinical supports (e.g., transportation to doctor appointments, social or community-based health services) that could benefit their health or access to needed health care?

27. To what extent are you in communication with patient's family members or other caregivers?

    a. What are some reasons why you might contact them?

    b. How do they react when you contact them?

    c. How successful are these contacts?

28. What are some reasons why you might contact other providers, practices, or facilities (e.g., hospitals, pharmacies)?

    a. How do they react when you contact them?

    b. How successful are these contacts with other providers, practices, or facilities?

29. How do you track and manage information you receive from patients, their caregivers, and their other providers?

    a. How are patients' practice clinicians and staff made aware of pertinent information you gather from these various sources?

    b. How does this information get incorporated into the patient's medical records?

Wrap-up

30. What major areas will your physician organization 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?

31. What advice would you give to other states or physician organizations if the Michigan Primary Care Transformation Project 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 organizations in medical home implementation?

32. Given what you know now, what would you have done differently, both prior to and after Medicare and Medicaid's involvement in the Michigan Primary Care Transformation Project?

33. Is there anything we have not discussed about the Michigan Primary Care Transformation Project or about the Medicare MAPCP Demonstration that you feel would be important for our National Evaluation Team to know?