CHCS Center for Health Care Strategies, Inc.

Policy Brief

Creating Physician-Support Entities in Medicaid

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IN BRIEF

With Medicaid poised to absorb 16 to 20 million additional beneficiaries in 2014 as a result of the Affordable Care Act (ACA), the imperative to improve primary care capacity for Medicaid populations has never been stronger. Physician-support entities (PSEs) offer an emerging opportunity to enhance the capabilities of evolving physician networks.

PSEs can be based on physician, health plan, or community organizations that form to provide quality improvement, performance measurement, health information technology, care management, and leadership support to practices. PSEs can also serve as building blocks to help establish more organized Accountable Care Organizations. Through support from The Commonwealth Fund, this brief summarizes insights from a group of national experts to outline eight strategies for Medicaid agencies to catalyze the successful creation of PSEs.

In the midst of current state budget crises, Medicaid agencies are seeking ways to address increasing health care expenditures. To do so, state officials are largely relying on traditional approaches of cutting benefits and provider rates or enrolling patients in managed care. However, if states want to bend the long-term cost-curve, they will ultimately have to support provider redesign efforts to better manage patient populations at the point of care. Such care delivery transformation can ensure better care at lower costs for Medicaid beneficiaries.

The epidemic of chronic disease within the Medicaid population and its impact on health spending are staggering. Front-line responders in the management of chronic disease include primary care physicians, nurse practitioners, and the teams of health care professionals working with them. These caregivers face tremendous stressors, such as low payment rates, growing patient panels, and isolation from their peers. This is particularly true for smaller primary care practices that serve high numbers of low-income individuals, including many from racially and ethnically diverse populations.[1,2]

Moving from our current fragmented medical system to a high performance health system requires a focus on enhancing primary care capacity and potentially sharing supports across practices.   To truly transform care delivery, physician practices need supports, including new expertise, team members, and financing mechanisms. Networks of physicians that join together can potentially share resources among practices to enhance their efficiency. Helping networks of physicians with similar goals and values increase their capacity to care for the growing number of low-income patients with chronic disease represents a new frontier for Medicaid agencies.

With Medicaid poised to absorb 16 to 20 million additional beneficiaries in 2014 as a result of the Affordable Care Act (ACA), the imperative to improve primary care capacity for Medicaid populations has never been stronger. Physician-support entities (PSEs) offer an emerging opportunity to enhance the capabilities of evolving physician networks. PSEs can be based on physician, health plan or community organizations that form to provide quality improvement, performance measurement, health information technology, care management, and leadership support to practices. Over time, they could even evolve into accountable care organizations (ACOs), providing a new care delivery model to better serve the nation's most vulnerable beneficiaries of publicly financed care.

Based on a meeting with national experts in fall 2010 (see next page for participant list) supported by The Commonwealth Fund, this brief outlines eight strategies for Medicaid agencies to catalyze the successful creation of PSEs.

> "We need to consider how Medicaid can use its leverage as a major purchaser to energize and catalyze primary care transformation."
>
> ***Richard Baron, MD, Greenhouse Internists (currently Director of Seamless Care Integration, Centers for Medicare & Medicaid Services)***

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Eight Ways for Medicaid Agencies to Help Create Practice-Support Entities

Recommendation 1: Articulate Goals Clearly

Medicaid leaders can help articulate the goals of PSEs to promote improvements in the health and health care outcomes of an entire community of patients. To redefine primary care delivery, Medicaid agencies must be committed to shifting from a volume-based care delivery approach to a value-based model. In addition to supporting clear population and clinical outcomes, Medicaid should also clarify its expectations related to controlling health care spending. By fostering a local, population-based strategy, Medicaid can encourage local communities of caregivers to self-organize and re-organize themselves to achieve these outcomes.

> "We need to figure out what we want primary care to be accountable for, such as population health, and move from our current system of atomized care to networks of care that deliver better value."
>
> ***David Labby, MD, PhD, Associate Medical Director, CareOregon***

Recommendation #2: Help Physician Champions to Form PSEs

Medicaid agencies and their clinical leaders (e.g., Medicaid Medical Directors) can be catalysts in identifying physician champions who can advocate for PSEs. Providers need to build and own the roots of change or the transformation will seem superficial and imposed. Medicaid agencies can foster linkages between isolated practices and help empower physicians and their teams to self-improve.

Medicaid, in particular, can identify and bring together practices serving large numbers of Medicaid beneficiaries with chronic diseases to begin this transformation process. In doing so, Medicaid agencies will support the continued evolution of their role from regulator and bill payer to value-based purchaser and facilitator of new care delivery models.

> "We need to turn Medicaid agencies into learning organizations that can be disseminators of knowledge."
>
> ***David Meyers, MD, Director, Center for Primary Care, Prevention, and Clinical Partnerships, Agency for Healthcare Research and Quality***

National Small Group Consultation

Through support from The Commonwealth Fund, CHCS convened the following national experts in fall 2010 to address how Medicaid could facilitate practice-support entities to improve care for low-income populations served by publicly financed care.

Cheryl B. Aspy, PhD
Professor, Family & Preventive Medicine
Oklahoma University

Richard Baron, MD
Greenhouse Internists (currently Director of Seamless Care Integration, Centers for Medicare & Medicaid Services)

Roger Chaufournier
Chief Executive Officer, CSI Solutions, LLC

Marshall Chin, MD
Professor of Medicine, University of Chicago

Bill Golden, MD
Medical Director, Health Policy
Division of Medical Services, Arkansas Department of Human Services

David Kelley, MD
Chief Medical Officer, Office of Medical Assistance, Pennsylvania Department of Public Welfare

Mat Kendall
Acting Director, Office of Provider Adoption Support, Office of the National Coordinator for Health IT

Mary Kennedy
Senior Policy Adviser, Center for Medicaid, CHIP, and Survey & Certification

David Labby, MD, PhD
Associate Medical Director, CareOregon

Ann Lefebvre
Associate Director, North Carolina Area Health Education Centers Program

Ian McCaslin, MD
Director, Missouri HealthNet Division, Family Support Division, Department of Social Services

David Meyers, MD
Director, Center for Primary Care, Prevention, and Clinical Partnerships, Agency for Healthcare Research and Quality

Lynn Mitchell, MD
Deputy Commissioner, Prevention and Preparedness Services, State of Oklahoma Department of Health

Edward Schor, MD
Assistant Vice President, The Commonwealth Fund

Richard Seidman, MD
Medical Director, LA Care Health Plan

David Share, MD, MPH
Vice President, Value Partnerships, Blue Cross Blue Shield of Michigan

Patricia Simino Boyce, PhD, RN
Independent Consultant

Dennis Weaver, MD
President & CEO, EastPoint Health

Recommendation #3: Assist in Defining PSE Services

Medicaid agencies can play a key role in defining the support services that PSEs can provide to practices, including: (a) direct technical practice supports; (b) adaptive supports to practice team members; and (c) direct supports to patients. Direct technical support to practices could include assistance in workflow and process re-engineering; practice management; enhanced access; quality improvement training; clinical decision support; and electronic health record (EHR) adoption. These direct services are highly technical in nature and are often time-limited (i.e., implementing and using a registry). Often these types of technical support services, particularly those related to practice management, will be most sought out by participating practices.

For many practices, however, adaptive support, such as leadership and change management capacity, may be more critical and harder to provide. Often practices must learn or re-learn how to engage team members, manage a highly complex change process, and facilitate productive peer-to-peer interactions. Adaptive change concepts are often characterized as services that, as one physician said, "physicians don't know they want, but if they don't get, they won't succeed." Adaptive support can be provided by shared learning communities, on-site practice coaches or facilitators, and/or different leadership courses. Adaptive supports also tend to be ongoing rather than time-limited.

> "The transformation process is not a linear or a one-time process. We need ways to catch practices before they fall off the transformation track and can't get back on."
>
> ***Ann Lefebvre, Associate Director, North Carolina Area Health Education Centers Program***

Direct supports to augment traditional provider-based patient care are currently being re-defined by Medicaid agencies as they look to establish patient-centered medical home or health home models. PSEs can help practices implement a team-based care model by providing health coaches and community health workers for patients with chronic care needs, and nurse care managers, behavioral health professionals, and social workers for those with more complex health, behavioral, and social needs. PSEs could provide these services in the community or at the practice site. In addition, PSEs can work to facilitate linkages between primary care practices and programs supported by community-based organizations.

Emerging Examples of Physician-Support Entities (PSE)

As payers and providers seek to overcome atomized, fragmented delivery systems, PSEs have begun to emerge in markets across the country. These new entities include provider-, health plan-, and community-based models:

Provider-Based PSEs – Blue Cross Blue Shield of Michigan (BCBSM) is supporting more organized systems of care by offering financial incentives to independent physician practices to form physician organizations (POs). The resulting POs are often based on the vestiges of Independent Physician Association (IPA) networks, but have new responsibilities related to population management, quality improvement and performance measurement, care management, and patient-centered medical capacity.

Health Plan-Based PSEs – Health plans can function as PSEs with enough market share, willingness, and expertise to support primary care transformation. For example, CareOregon, a statewide Medicaid managed care organization, recently created the Primary Care Renewal Project. The project provides infrastructure support, team-based care, and financial incentives to participating providers.

Community-Based PSEs – Community-based PSEs have a governance structure that encourages participation from payers, providers, patients, and families. Oklahoma Medicaid is piloting Health Access Networks, convening universities, county medical associations, and private corporations to support overall community quality improvement goals. In New York State, the Adirondack "POD" pilot organizations function as geographically distinct PSEs within a multi-payer medical home program.

Recommendation #4: Encourage Practices to Buy Shared Practice-Support Services

Medicaid can catalyze the development of PSEs by encouraging physician participation and reimbursing them to join. As several health care leaders noted at the CHCS small group consultation, "Currently there is not a big market for practice-support services." Medicaid as a large purchaser can help create such demand. Other purchasers, such as Blue Cross Blue Shield of Michigan, have done so by paying physicians' fees (e.g., a PMPM amount or increasing certain Evaluation and Management codes) for joining a network, creating patient-centered medical homes, and optimizing population level results. Ultimately, physicians need to have market-based influence and some level of accountability to

participate in a PSE. Over time, the PSE will better understand participating providers, tailor services accordingly, and, ultimately, encourage physicians to use value-added services they do not even realize would help their practices.

> "Practices lagging in practice transformation work are beginning to wake up. They realize they need to form networks that create a market for shared practice supports."
>
> ***David Share, MD, MPH, Vice President, Value Partnerships, Blue Cross Blue Shield of Michigan***

Recommendation #5: Build Community-Level Data

Medicaid can drive increased use of electronic health information technology (HIT), such as clinical registries, e-prescribing, EHR adoption and regional health information exchanges (HIEs), by requiring PSEs to be accountable for population-level outcomes. PSEs would thus be motivated to build shared data repositories and provide quality data at the community level accessible to providers, patients, and payers. PSEs could also collaborate with Regional Extension Centers to help small practices serving large volumes of Medicaid patients take advantage of the Medicaid EHR/HIT incentive program and adopt and meaningfully use HIT. Such collaborative efforts might also help in making the case for functional HIEs that could share individual patient-level information to benefit providers, patients, and payers.

PSEs could also provide analytic support to collect physician-level (or practice-level) quality and cost data throughout a community and help identify both outlier patients and providers for specific quality interventions. This community-level analytic support could help groups of providers in setting common priorities for driving overall system performance.

Recommendation #6: Pay for What Medicaid Wants To Buy

As noted by a senior Medicaid official at the fall 2010 meeting, Medicaid currently pays for services "we don't need and doesn't pay for services we do need." Engaging and organizing physicians is critically important, but having a payment model that encourages what Medicaid wants to buy is equally important. Medicaid can begin a conversation with physicians about: (a) what the state wants to buy (i.e., reduction in unnecessary emergency department visits and preventable hospitalizations); (b) how to hold physicians and PSEs accountable (i.e., for both health and health care outcomes); and (c) payment models that can encourage new behavior (i.e., gain sharing or incentives based on outcomes).

Financing models should include both payment to the participating network physicians and the PSE itself. For example, practices could receive additional funding via a care management PMPM payment or enhanced visit rates plus incentives based on outcomes for both the individual physician and community performance. The PSE could get a financial reward based on community performance as well. In addition, states may need to consider heterogeneous payment models for PSEs and practices as they move along the transformation continuum, particularly as PSEs move toward ACO-type shared saving arrangements over time.

As part of this discussion, Medicaid should be transparent about cost savings and bring the primary care community together with specialists and hospitals to have such a dialogue. Given that primary care is a small part of overall health care spending, encouraging conversations among primary, specialty, and hospital care about joint outcomes can seed the creation of ACOs and other local solutions to health care spending.

> "We need to consider what we want primary care to be accountable for, such as population health, and help move from volume to value by linking payment models to desired outcomes."
>
> ***David Kelley, MD, Chief Medical Officer, Office of Medical Assistance, Pennsylvania Department of Public Welfare***

Recommendation #7: Engage Other Payers

In many communities, Medicaid will need to partner with other payers to engage enough practices to effectively support a PSE. Although Medicaid may have enough influence with practices that serve a high proportion of Medicaid patients, it will need buy-in from other payers to influence a broader community of providers. Broadly aligning the goals and expectations across payers could serve to more rapidly catalyze practice transformation and the successful formation of PSEs.

Medicaid can build on current multi-payer medical home efforts and expand such programs to include a broader array of supports for primary care practices. Medicaid programs can capitalize on recent health home provisions in the ACA to support financing of practice-support services for Medicaid

beneficiaries while simultaneously engaging with other payers about a broader, multi-payer effort.

Medicaid can also capitalize on its role as a facilitator to bring together other state payers (such as state employees and the newly formed state health insurance exchanges) and other dominant private payers in the market. Finally, Medicare and Medicaid, along with other payers, could use opportunities through the Center for Medicare and Medicaid Innovation to support the development of PSEs that could potentially participate in the Medicare Shared Savings Program for ACOs.

> "Fifty percent of practices in a community are needed to shift the paradigm and to make a business case for the practices, the PSE, and the payers."
>
> ***Dennis Weaver, MD, President and CEO, EastPoint Health***

Recommendation #8: Require MCOs to Play Ball

Medicaid programs across the country have spent the last two decades enrolling patients into MCOs to improve quality and hold down costs. MCOs have improved access, enhanced customer service, provided value-added services, and improved quality as measured by HEDIS. However, in many markets, MCOs have not focused on changing local care delivery. As one Medicaid official noted, "We should let the plans do what they do well, but force them to play ball and change the delivery of care at the provider/patient level."

States can use their contracts to require plans to support PSEs, including supporting alternative payment models for both PSEs and primary care practices. Some Medicaid MCOs have already begun to provide supports to primary care practices, while many others have yet to embrace such transformative change at the practice site. States that are eager to test new primary care delivery models can require MCOs to support PSEs and discuss the optimal location of patient care coordination within a market (e.g., care management supports provided within a practice or at the health plan level).

> "Managed care organizations vary, and thus their ability to lead practice transformation depends on whether they have experience and a niche for this work."
>
> ***Richard Seidman, MD, Medical Director, LA Care Health Plan***

Conclusion

A high performance health system relies on a highly functioning primary care community that can increase preventive care services, better manage chronic care needs, reduce avoidable emergency department and hospital admissions, and decrease unnecessary specialty services. PSEs are emerging vehicles that can help primary care practices enhance access, better manage chronic care, and coordinate community linkages. Medicaid agencies can help redesign primary care by catalyzing the creation of PSEs and working with other payers to do so.

Traditional tools that Medicaid uses to control state budgets, including eligibility, benefit and provider rate cuts, do not address the underlying costs related to sub-optimal delivery of care. Until Medicaid uses its purchasing leverage to redesign care delivery at the provider level, health care costs will continue to rise. Medicaid can capitalize on its purchasing influence, its state leadership role, and its contracting vehicles to drive the creation of PSEs. This new entity can support practices, redesign care, establish the foundation for ACOs and other innovative provider care models, and, ultimately, help to transform Medicaid primary care delivery.

Resources from the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. For a wealth of information and resources, visit **www.chcs.org**.

Endnotes

[1] M. Abrams et al. "How Physician Practices Could Share Personnel and Resources to Support Medical Homes." *Health Affairs*. 29, no.6 (2010): 1194-1199.

[2] J. Reschovsky and A. O'Malley. "Do Primary Care Physicians Treating Minority Patients Report Problems in Delivering High-Quality Care?" *Health Affairs*, 27, no.3 (2008): w222-w231.