CHCS Center for Health Care Strategies, Inc.

Practice Transformation in Medicaid: Five Levers to Strengthen Small, "High-Volume, High-Opportunity" Practices

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While the majority of practice improvement efforts in the U.S. have supported community health centers and larger practice settings, there is increasing investment by federal and state government, philanthropies, professional societies, and non-profit organizations in quality improvement and redesign for small practices. This shift is not surprising. The challenges of engaging providers who are generally less equipped with the technology and infrastructure needed for effective chronic care are real, as are the difficulties of developing a scalable and sustainable practice improvement model to address their needs. Small practices likely will face greater hurdles to use of important but complex frameworks of care such as the patient-centered medical home (PCMH) and Chronic Care Model.

Approximately 60 percent of physicians work in practice settings with only one to four providers.[1] Yet small practices are apt to remain an important piece of the current health care delivery system for years to come, playing a substantial role in caring for low-income and racially and ethnically diverse Medicaid beneficiaries. Unfortunately, these practices include physicians who are likely to retire before they adapt to a new primary care environment. They are also often under-resourced, disenfranchised from the larger health care system, and isolated from other providers and quality improvement initiatives. In the absence of external support, small practices risk falling further behind in chronic care management, health information technology (HIT), and quality of care, compared to their larger, more integrated peers.

Medicaid Levers for Quality Improvement

This brief presents how Medicaid can leverage its resources to facilitate and sustain improvements in care and reduce disparities in small, under-resourced practices with high-volume Medicaid panels. It describes the experiences of the four states participating in the Center for Health Care Strategies' (CHCS) *Reducing Disparities at the Practice Site* initiative, which is testing five Medicaid levers for supporting these practices. As described below, state Medicaid agencies can:

1. Serve as a neutral convener and create alignment across payers and practice improvement activities;
2. Use Medicaid data to identify and target high-volume, high-opportunity practices for transformation;
3. Use Medicaid's leadership to shift care management and quality improvement resources to the point of care;
4. Use Medicaid's purchasing power to support adoption and meaningful use of HIT; and
5. Serve as a laboratory to test financial incentives and payment reform approaches.

Lever #1: Serve as a neutral convener and create alignment across payers and practice improvement activities.

Primary care practices typically contract with multiple health plans, each with its own quality improvement requirements, performance measures, clinical guidelines, incentive programs, and staff. These payers typically have no compelling reason to collaborate and align quality improvement activities. Given that each payer

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represents only a fraction of a physician's panel, practices often discount the myriad of performance messages they receive — a lost opportunity to improve quality of care.

Through its purchasing leverage, Medicaid can provide that compelling reason and convene payers to adopt an aligned quality improvement approach and drive quality at the point of care. Medicaid agencies can encourage practice improvement initiatives through related projects, payment or incentive programs (at the plan and practice levels), and contracts. Given their regulatory role, Medicaid agencies with managed care delivery systems are especially well-positioned to bring competing health plans together.

Medicaid can lead stakeholder discussions about developing a common vision, adopting uniform performance measures, engaging a shared set of primary care practices, and adopting a common set of practice improvement interventions. Within *Reducing Disparities at the Practice Site*, for example, Michigan Medicaid is convening six plans and a local university to leverage data and data-mining, quality improvement expertise, financial incentives, and HIT resources. In addition, the Greater Detroit Area Health Council, a multi-stakeholder regional coalition, is contributing commercial payer data.

About *Reducing Disparities at the Practice Site*

CHCS developed *Reducing Disparities at the Practice Site* to support quality improvement in small practices serving a high volume of racially and ethnically diverse Medicaid beneficiaries. The three-year initiative, launched in October 2008 with funding from the Robert Wood Johnson Foundation, is testing the leverage that Medicaid agencies, health plans, primary care case management programs, and other community-based organizations have to improve chronic care in small practices serving this population. State-led teams in Michigan, North Carolina, Oklahoma, and Pennsylvania are building the quality infrastructure of 40 high-volume primary care practices that together serve 53,000 Medicaid patients. The teams are supporting practice efforts to improve chronic care by:

- Assessing each practice's needs and priorities for improving care delivery;
- Identifying and tracking the care of diabetic patients through electronic registries;
- Deploying practice-based quality improvement coaches and/or nurse care managers to support practices in redesign and care management; and
- Providing financial support for each practice's time and effort.

Pennsylvania Medicaid is aligning its three Philadelphia-area health plans around shared small practices, uniform performance measures, and coordinated care management. The agency has plan- and practice-level pay-for-performance programs to incent alignment around quality improvement efforts, and is leveraging its relationship with its quality improvement organization (QIO) and the larger Pennsylvania Chronic Care Initiative[2] for additional resources.

Oklahoma Medicaid contracted with the Iowa Foundation for Medical Care (IFMC) to provide practice facilitators to work one-on-one with small practices on registries, performance measurement and quality improvement. The state is also exploring various reimbursement and payment incentive approaches.

One of Community Care of North Carolina's (CCNC)[3] networks, Carolina Collaborative Community Care (4C), is partnering with *Improving Performance in Practice* (*IPIP*), a state-based, nationally led initiative that deploys quality improvement coaches to work directly with practices on implementing and using registries.[4] The state's 4C initiative provides a dedicated case manager to each practice, while *IPIP* offers a quality improvement coach to support the implementation and use of registries. The initiative leverages its well-established relationships with its provider network to gain the attention, trust and engagement of practices.

Lever #2: Use data to identify and target high-volume, high-opportunity practices for transformation.

Medicaid agencies and health plans need to target their limited quality improvement resources strategically. This includes focusing on providers with large Medicaid patient panels and wide, measureable gaps in quality,

as well as those (e.g., small practices) without access to quality improvement resources. Fortunately, Medicaid agencies and plans have the data required for this.

In states with primary care case management programs (e.g., North Carolina and Oklahoma), performance data are located centrally, making such analysis relatively easy. Oklahoma, for example, uses a predictive modeling tool to identify practices at risk for poorer quality outcomes and inappropriate utilization, for intervention opportunities.

In states with managed care delivery systems (e.g., Michigan and Pennsylvania), provider performance data are often decentralized — held by contracting plans. These data must be aggregated to: (1) identify high-volume practices that contract with multiple Medicaid plans; and (2) calculate more complete performance rates at the physician or practice level. Targeting practices that contract with multiple Medicaid plans increases the portion of a physician's panel that will be impacted by a quality improvement effort. In such instances, the state or a state contractor (e.g., a QIO or a university) can be the data aggregator across the managed care delivery system.[5]

Lever #3: Use Medicaid's leadership to shift care management and quality improvement resources to the point of care.

As primary care practices, particularly small ones, struggle with the "hamster wheel" of 15-minute visits and perverse incentives created by fee-for-service reimbursement, providers typically do not have the time or resources to effectively manage care for patients with complex needs. Given that care management and coordination are not reimbursable under Medicaid, primary care practices have few incentives to provide these services.

Although states and health plans often provide care management staff and resources, these services are not coordinated. Furthermore, practices often perceive payers' care management networks to be confusing and burdensome, requiring contact with different care managers, care coordinators, or disease managers, depending on a patient's insurer. To reduce this confusion, Medicaid can lead efforts to test new models of shared care management.

Pennsylvania, for example, is using a shared nurse care manager who represents three managed care plans, but is employed by the state. She reaches out to practices, helps implement the electronic patient registry, identifies care gaps, and engages patients to address those gaps.

In Michigan, each health plan deploys a quality improvement coach to work with a practice on population management and workflow redesign as the practice strives to achieve the National Committee on Quality Assurance's Level 1 or 2 PCMH designation.[6] The coaches have standardized approaches across the practices — e.g., using consistent registry tools, medical home standards, and financial incentives for achieving specified milestones. Although there is a uniform goal across practices, the coaches tailor their strategies around the unique needs and priorities of each practice.

Despite their differences, all states are shifting care management and quality improvement supports to the point of care. Many are also creating peer groups of practices that are undergoing the challenge of transformation at the same time.

Lever #4: Use Medicaid's purchasing power to support adoption and meaningful use of HIT.

Small practices need automated tools to manage their patient populations efficiently. Medicaid can play a critical role in helping practices obtain access, training, and ongoing technical support for HIT, such as registries or electronic health records (EHRs). Given funding available to states and providers through the American Recovery and Reinvestment Act, Medicaid has unprecedented leverage to support providers in effective adoption of EHRs to transform the quality of care throughout its delivery system.

Medicaid and its partners can use aggregated claims and other data to identify high-volume Medicaid practices that may be eligible for federal incentives. For example, Medicaid can: (1) develop a strategy to help practices vet the multitude of HIT products; (2) leverage its purchasing power to back EHR products that meet Medicaid's unique needs; (3) create alignment across performance measures; (4) engage and educate the provider community in a coordinated and strategic manner; and (5) ensure that small practices use EHRs in tandem with quality improvement strategies to transform care delivery.

When *Reducing Disparities at the Practice Site* began, state teams developed strategies to provide registries to their practices. The states believe that these registries are helping to teach small practices the culture of quality and meaningful use of performance data and population management, positioning them for the EHR incentive program.

Michigan, for example, used the leverage of its six plans to vet and purchase two registry products for practices. The plans collectively identified the key "must have" functions for the registry. The state also purchased vendor time and expertise to implement, initially populate, and train practices and plans on its use. Oklahoma Medicaid contracted with IFMC to develop an online health information management tool that is free to all participating practices. IFMC quality improvement facilitators are working one-on-one with practices to set up the tool and train staff in its use.

Pennsylvania and North Carolina both used their leverage to make the *Reach*My*Doctor[7] registry available for free to participating practices. In Pennsylvania, this strategy aligned Medicaid with the state's Chronic Care Commission and created economies of scale for the practices and plans. North Carolina's strategy created alignment with the *IPIP* initiative, which has already implemented *Reach*My*Doctor in numerous practices in the state.

Lever #5: Serve as a laboratory to test financial incentives and payment reform approaches.

As noted, most small practices serving a high volume of Medicaid beneficiaries are overwhelmingly under-resourced. Many of the practices in this initiative struggle to remain open, let alone focus on transformation. Only a few practices, for example, can afford a nurse on staff. The offices predominantly consist of one or two physicians, two medical assistants, and an office manager. Taking time away from revenue-generating activities to participate in quality improvement activities is a significant challenge for small practices. Medicaid can test various financial incentives and payment approaches (up front or at project milestones) to encourage small practices to join these initiatives.

In Michigan, the six health plans are each contributing dollars that are distributed to participating practices based on panel size. The financial contribution is "plan agnostic": each plan pays the same amount, regardless of the number of its members within a practice. Funds are distributed to qualifying practices based on adult Medicaid enrollment across the six plans. The plans have agreed to common milestones (e.g., participating in collaborative meetings and using registry data meaningfully) for triggering each additional payment.

North Carolina's 4C network is working with *IPIP* to provide practices with annual financial incentives to participate in transformation activities. For the first year, practices are eligible to receive $7,000 for: (1) generating baseline data for all diabetic patients from a registry; (2) having all staff and providers attend workshops on motivational interviewing and cultural competency; (3) participating in a site visit by project leaders; and (4) demonstrating a 10% improvement in diabetes measures from the baseline. The incentive program for the second year of participation is similar.

Oklahoma has a tiered incentive program that pays for: (1) participation in quality improvement facilitation; (2) use of the CareMeasures patient registry; (3) workflow/process improvement using team-based care, flow sheets, and regular quality improvement team meetings; (4) access to a patient education library; and (5) appointment reminder calls to members.

Conclusion

As more is learned about small, high-volume Medicaid practices, it is increasingly evident that despite being critical to the nation's safety net, these practices are in danger of being further disenfranchised. The five levers described in this brief are available to any Medicaid agency; as such, states should aim to weave them throughout their health care reform strategy. Even during challenging fiscal times, Medicaid has tools and resources to strengthen the primary care infrastructure — the foundation of our nation's health care system.

Related 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. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. Its program priorities are: improving quality and reducing racial and ethnic disparities; integrating care for people with complex and special needs; and building Medicaid leadership and capacity. The following resources can be found at **www.chcs.org**.

- *Reducing Disparities at the Practice Site* state profiles
- *Supporting "Meaningful Use" of HIT in Small, High-Volume Medicaid Practices*
- *The Relationship between Practice Size and Quality of Care in Medicaid*
- *Using Data to Identify High-Volume, High-Opportunity Practice Sites: A Medicaid Primer*

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Endnotes

[1] C.K. Kane. "The Practice Arrangements of Patient Care Physicians, 2001," *American Medical Association Physician Marketplace Report*, No. 2004-02 (Chicago: AMA, 2004). Note: These include only those physicians not federally or institutionally employed.

[2] For more information about the Pennsylvania Chronic Care Initiative, visit http://www.rxforpa.com/chroniccare.html.

[3] CCNC, a program of the North Carolina Office of Rural Health and Community Care, oversees community health networks that serve Medicaid beneficiaries in the state. For more information about CCNC, visit http://www.communitycarenc.com.

[4] For more information about *IPIP*, visit http://www.ncafp.com/initiatives/ipip.

[5] For more guidance on using Medicaid data to identify high-volume, high-value Medicaid practices, visit http://www.chcs.org for *Using Data to Identify High-Volume, High-Opportunity Providers: A Medicaid Primer*.

[6] For more information about NCQA's PCMH designation, visit http://www.ncqa.org/tabid/631/Default.aspx.

[7] For more information about *ReachMy*Doctor, visit https://www.reachmydoctor.com/index.aspx.