CHCS Center for Health Care Strategies, Inc.

Technical Assistance Brief

Key Considerations for Supporting Medicaid Accountable Care Organization Providers

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IN BRIEF

States looking to implement accountable care organizations in Medicaid understand that payment reform alone is not sufficient to transform care delivery. Primary care providers, particularly those serving the health care safety net, require resources and guidance to meet the substantial quality and cost containment aspirations of the accountable care model. This issue brief outlines the types of technical assistance supports that state Medicaid agencies can potentially offer to help providers in transforming care delivery. It also details considerations for planning, implementing, and sustaining such technical assistance.

Accountable care organizations (ACOs) embody a fundamentally different way of paying for and delivering health care services, necessitating substantial change for providers and care teams. Providers in Medicaid ACOs must build new connections across health services and social supports, while at the same time assuming unprecedented accountability for quality, utilization, and cost. To take on this new role, providers must significantly enhance information technology, workflow, communications, data analytics, quality improvement, and patient and community engagement. Perhaps more than any set of providers, those serving the safety net vary in their capacity to perform ACO functions,[1] and payment reform alone is insufficient for them to build the necessary competencies. A key challenge for Medicaid agencies is determining how to arm providers with the appropriate resources, training, and assistance to address ACO improvement aims.

States are exploring a variety of provider support vehicles, such as learning collaboratives, practice coaches, and training institutes, to help practices establish a foothold in emerging ACO models. This brief outlines the competencies that are critical for ACOs and details considerations for supporting providers with capacity-building technical assistance. It describes different kinds of support vehicles, strategies to encourage provider participation, and approaches to designing and sustaining the assistance. Since Medicaid ACOs are a relatively new model, this brief builds largely on lessons learned from states providing supports related to patient-centered medical homes (PCMH), which are foundational to ACOs.

Core ACO Provider Competencies

The goals of an ACO – to enhance quality, improve outcomes, and reduce costs – are not attainable without a transformation in the way providers deliver care. To take on these new roles, providers require care teams with diverse personal and clinical skills, high-functioning workflows, and a culture of continuous quality improvement that can guide leadership, clinicians, and staff through the transformation process.[2] Provider competencies necessary to support ACOs, organized under four broad categories, include:

1. Care Delivery Innovations
   - Enhanced primary care
   - Care coordination
   - Complex care management
   - Population management
2. Data and Quality
   - Data collection and analysis
   - Utilization and cost assessment
   - Quality measurement and reporting
   - Quality improvement
3. Stakeholder Engagement
   - Patient engagement and cultural competency
   - Community outreach and collaboration
4. Leadership
   - Vision and organizational culture
   - Change management

These new competencies may be challenging for providers to master atop existing day-to-day clinical demands, and providers can benefit significantly from structured technical assistance. States are well positioned to deliver such assistance through a variety of vehicles. In designing these supports, states will need to recognize differences in readiness across

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provider types (e.g., federally qualified health centers), demographics (e.g., rural, racially/ethnically diverse), and existing capacity (e.g., patient-centered medical home, health home) to appropriately tailor the content and engagement approach.

Provider Support Vehicles

Provider support vehicles vary in their scope and intensity. In deciding which to use, states should assess: (1) provider level of need; (2) the domains in which assistance is required; and (3) the resources available to provide assistance in those domains. Support vehicles include:

- **Tools and Resources:** Print and online materials offer a good starting point for disseminating information related to emerging ACO programs. Print and online materials can reach the broadest swath of providers, while requiring fewer state resources. States with less experience delivering technical assistance, or limited capacity, may want to start with this vehicle. Information such as quality measure specifications, rules around organizational structure and governance, and legislative regulation are well suited to this form of support.

- **Trainings:** Interactive training sessions can be delivered through conference calls, online webinars, or face-to-face sessions. They provide more hands-on opportunities for providers to master new skillsets, pose technical questions, or clarify questions about ACO implementation. Quality improvement, data analytics, payment methodology, IT infrastructure design, and population management are ripe topics for such training sessions.

- **Learning Collaboratives:** Participation in a peer learning collaborative can be extremely valuable for providers looking to take on significant improvement goals. To maximize benefits to providers, states should be thoughtful about the mix of provider types, needs, and readiness among collaborative participants. Learning collaborative formats are conducive for topics that are more nuanced (less didactic in nature) and that lend themselves to meaningful discussion or peer sharing. This may include issues for which there is no established evidence base, or those for which best practices are just emerging. Care coordination, high-utilizer care management, team-based care delivery, cultural competency, stakeholder engagement, alignment with managed care, leadership development, and patient engagement are some issue areas that can be explored through this format. Given the time and resource intensity of this work, states can benefit from using contracted partners to assist with learning collaborative administration and content development.

- **Direct Assistance:** Personalized 1:1 technical assistance can be provided by practice facilitators or coaches, who support the transformation needs of a provider through hands-on training at the practice site. While there may be a time lag for providers to apply lessons derived through a learning collaborative, direct technical assistance can facilitate real-time implementation. Direct assistance can also be provided to multiple members in a provider organization – leadership, clinicians, front-line staff – and facilitate a team approach to rapidly develop and test solutions. Implementing this model requires states to identify eligible providers upfront; recruit and train practice facilitators; monitor training effectiveness; and importantly, fund the direct assistance. Direct assistance can be ideal for providers that need significant ramp-up in areas such as workflow efficiency; care team composition and processes; data and health IT infrastructure; quality improvement; and high-risk patient management. Contracted partners can help states greatly in coordinating such support.

Since each type of provider support vehicle offers relative advantages, states typically use a mix of approaches. States investing in new ACO-specific efforts may want to start with existing support programs, such as those developed for quality improvement initiatives or patient-centered medical homes, and build from there. States should also prioritize building provider capacity in ACO skill sets that are essential, but missing. To assist with planning, Figure 1 details types of assistance and the relative merits of each.

Figure 1: **Provider Support Vehicles: Features and Examples**

Vehicle	Key Features and Advantages	Key Challenges	Examples
Tools & Resources ▪ *Print (e.g., notices, letters)* ▪ *Electronic (e.g., video, email announcement)* ▪ *Web-based (e.g., websites, social media)*	▪ Broadly available ▪ Provider-driven uptake ▪ Easy dissemination ▪ Distills existing, well-defined technical expertise ▪ Best suited for less complex topics	▪ Identifying the right topic and content ▪ Structuring in an engaging, easily digestible manner ▪ Fostering widespread uptake ▪ Finding the subject matter expertise ▪ Keeping information up–to-date	▪ Vermont BluePrint's *Healthier Living Workshop* materials for providers and patients http://hcr.vermont.gov/blueprint ▪ New York Health Home Functional Assessment tools http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/index.htm ▪ Oregon's Patient-Centered Primary Care Institute's resources http://www.pcpci.org
Trainings ▪ *In-person seminars and workshops* ▪ *Webinars* ▪ *Online courses*	▪ Suitable for complex skills best acquired through interactive methods ▪ Distills existing, well-defined technical expertise ▪ Didactic in nature ▪ Broad spread and easy dissemination via technology	▪ Encouraging audience participation ▪ Engaging participants effectively ▪ Ensuring participant readiness and preparation ▪ Developing supporting tools and resources ▪ Potentially time-intensive for participants and state	▪ New York Health Home implementation bi-weekly webinars http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/meetings_webinars.htm ▪ Johns Hopkins' Guided Care online nursing course sponsored by the Rhode Island Beacon Community for nurse care managers in participating practices http://www.ijhn.jhmi.edu ▪ Oregon's Patient-Centered Primary Care Institute's trainings http://www.pcpci.org
Learning Collaboratives ▪ *In-person and virtual convenings* ▪ *Learning Series* ▪ *Institutes*	▪ Allows for peer sharing among participants ▪ Variety in content and medium of transmission (e.g., in person, web, print, guest speakers) ▪ Facilitates a "learn as you go" approach ▪ Encourages team-building	▪ Moderately-to-highly time intensive for participants and state ▪ Ensuring sustained participation ▪ Requires subsequent follow-up and implementation for participants	▪ Maine PCMH Pilot - Learning Collaborative http://www.mainequalitycounts.org/page/2-714/pcmh-learning-sessions-and-webinars ▪ Rhode Island Beacon Community program http://www.riqi.org/matriarch/MultiPiecePage.asp_Q_PageID_E_133_A_PageName_E_ServicesBeacon ▪ Oregon's Patient-Centered Primary Care Institute's learning collaboratives http://www.pcpci.org
Direct Assistance ▪ *Quality improvement specialist* ▪ *IT/data or workflow consultant* ▪ *Community health worker* ▪ *Practice Coach/Facilitator*	▪ Highly tailored to meet providers "where they are" ▪ Provides immediate assistance/action without need for provider "translation" ▪ Involves a limited number of participants	▪ Highly time intensive for participants and state ▪ Relies on successful integration of the direct assistance staff with the provider team ▪ Requires direct assistance staff with multiple complex skill sets and technical expertise	▪ AHRQ Practice Facilitation Guide, used by Maine's Quality Counts www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/pcmh_implementing_the_pcmh___practice_facilitation_v2 ▪ SoonerCare Health Management Program's practice facilitation program http://www.okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=14481&libID=13464 ▪ Oregon's Patient-Centered Primary Care Institute's practice coaches http://www.pcpci.org

States may also consider delivering some or all of these supports through a centralized entity. Oregon has created a Patient-Centered Primary Care Institute (PCPCI) to provide a broad array of technical assistance to primary care practices in various stages of patient-centered primary care home (PCPCH) transformation. The institute brings together subject matter experts, providers, patient advisors, policymakers, health plans, academic health centers, and other stakeholders to maximize the quality of technical assistance services across the state. Oregon is also providing customized supports through a team of Innovator Agents that serve as a single point of contact between Coordinated Care Organizations (CCOs) – the central entity in Oregon's ACO structure – and the state. The agents will help CCOs, their providers, and their Community Advisory Councils develop strategies to support adoption of care innovations. For states that do not have the resources to support such broad-based capacity building, more targeted outreach, such as solicitations of applications or requests for proposal, may help identify a self-selecting set of providers that are ready for transformation and receptive to support.

Key Considerations for Deploying Provider Supports

In addition to identifying the type(s) of vehicle(s) to use, states may want to address the following considerations related to the planning, design, and implementation of ACO provider supports.

Understand what providers need. States will benefit by identifying the types of assistance providers need early on in the support process. In 2010, the Oregon Health Authority partnered with an independent non-profit entity, the North West Health Foundation, to conduct a needs assessment of providers seeking to transform into patient-centered primary care homes. The assessment consisted of surveys, key informant interviews, and focus groups. By partnering with an independent entity, the state was able to garner objective feedback from providers, and providers were happy to provide input, given the rising expectations placed on them through the statewide delivery system transformation. This kind of evaluation can be particularly useful to states in identifying practices that may require additional resources, e.g., community-based, behavioral health, rural, high-volume Medicaid, small, and/or independent providers. For example, in 2008, Oklahoma targeted practices facing the highest burden of chronic disease to receive practice facilitation services through its SoonerCare Health Management Program.

Use external partners. States pursuing significant delivery and payment reform efforts such as ACO implementation may not have the capacity to lead large-scale technical assistance activities. States can, however, work with other entities – universities, quality improvement organizations, health policy institutes, research organizations – that have the staff knowledge, time, resources, and subject matter expertise to plan and implement such supports. These entities can use unique tools, such as online learning communities, and have the advantage of being a neutral third party. States may prefer to coordinate "low-intensity" assistance such as the provision of administrative tools or programmatic notices themselves, and arrange for external support for efforts that require more capacity, such as topical trainings, learning collaboratives, or practice coaching programs. For example, Oklahoma used a competitive bid process to find a vendor, Telligen (formally Iowa Foundation for Medical Care), to deploy and manage its practice facilitator program. Maine contracted with Maine Quality Counts, a leading statewide quality organization, to provide support to practices in its multi-payer PCMH pilot and run a learning collaborative. The Rhode Island Quality Institute is one of many organizations in the state of Rhode Island that provides technical assistance to PCMHs in the state. The Rhode Island Quality Institute contracts with TransforMED to provide practice transformation services for practices in its Rhode Island Beacon Community collaborative.

Solicit input and be transparent. States can build more responsive programs by incorporating stakeholder feedback into the design of technical assistance. Oregon held a pre-proposal conference before releasing an RFP to find a neutral convener that could lead practice technical assistance activities through its Patient-Centered Primary Care Institute. Oregon found that the public was very engaged during this process, identifying important considerations, and contributing to a stronger pool of applications. Prior to the solicitation, the state also used stakeholder input processes to create diverse advisory committees, including advocates, to help guide larger delivery transformation efforts. Being transparent and open to public feedback has helped Oregon gain considerable buy-in from various parts of its health sector across many of its broad, statewide reform initiatives.

Prepare providers for meaningful participation. States need to demonstrate the value of technical assistance to providers. Providers will want a clear sense for "what they get out of it" and in turn, states will need to be clear about their expectations. To incent participation, it may help to identify mutually agreed upon milestones, particularly those that link explicitly to existing provider goals such as ACO certification, quality reporting requirements, or achievement of meaningful use. This alignment may also help providers gain necessary buy-in from internal leadership and staff. Terminology can make a difference as well. The Rhode Island Quality Institute found that the term "practice transformation" did not resonate with many providers in its Beacon Community Collaborative because it was perceived as too vague and not linked concretely enough to PCMH requirements. Oregon took the approach of providing practices with scholarships to cover staff time and resources incurred through its PCPCH learning collaborative activities. Maine highlighted the business case to participants, as the providers were developing capacity and receiving payments from multiple payers through their participation in the state's pilot.

Incorporate both structure and flexibility to support provider ownership of transformation process. Successful technical assistance activities will balance a rigorous curriculum with sensitivity to the competing demands on provider time. Maine used a structured approach that moved practices in its PCMH learning collaborative through 10 discrete curriculum areas, or PCMH "Core Expectations" (expanded from National Committee for Quality Assurance PCMH requirements[3]). The collaborative process included Plan-Do-Study-Act (PDSA) change methodology, pre-post assessments between learning collaborative meetings, and discussions with key stakeholders such as health plans and consumers. To help practices integrate lessons into practice workflow, each participating practice identified a leadership team comprised of a lead provider, administrator, and clinical team member that could direct internal change efforts. The Rhode Island Quality Institute's approach mixed didactic, instructional content, often led by providers and other practice representatives, with less formal opportunities where practices could network, share best practices, and discuss challenges with each other.

Encourage peer learning. ACO transformation can be challenging without best practices or available models for replication. Providers can benefit from peer sharing, as physicians and front-line care staff, in particular, often lack the opportunities to participate in professional networking or learning forums. When Maine conducted its PCMH learning collaborative, it found that providers were eager to learn from their colleagues. The providers reported "feeling like they were in silos," rural practices felt isolated geographically, and small, independent outpatient practices felt detached from acute and inpatient providers of integrated systems. Peer interaction can help mitigate these issues, while also creating a collegial spirit of competition that can motivate providers to attend sessions and be accountable for deliverables. Providers may also be more receptive to "instruction" from peers (i.e., other clinicians), rather than states or technical experts who lack experience on the front lines of care.

Leverage existing investments in primary care. ACO providers have to build connectivity across the full spectrum of health services, but can achieve this only with a strong primary care infrastructure.[4] States are already striving to strengthen primary care through a number of initiatives, such as PCMH, health homes, community health teams, and pay-for-performance programs, and can build atop those efforts to create capable ACO providers. Practically, states will want to align training, requirements, and policy incentives across such initiatives to reduce constraints on provider time and capacity. Such alignment will also enhance recruitment and engagement of providers in transformation activities; reduce likelihood of duplication in technical assistance; facilitate broader uptake of support activities across multiple payer markets; and reduce provider confusion around overlapping programmatic features, such as quality measures, enrollment criteria, reporting protocol, and payment methodology.

Work with managed care organizations. To increase the likelihood of success, states should consider including managed care organizations (MCOs) in the development and deployment of provider support efforts. In general, the MCOs will likely support state efforts in this area, given the resource constraints that MCOs often face in investing in their own provider transformation programs. MCOs may be willing to share existing strategies for engaging providers in their markets to contribute to a more comprehensive, state-funded provider assistance model. This may help states facilitate effective partnerships between ACOs and MCOs in areas such as data analytics, care coordination, care management, and goal-setting, which will be increasingly critical given the shifts in

accountability required by the ACO model and the new roles that health plans and providers will assume. At a minimum, MCO involvement will help states coordinate similar technical assistance, streamline communication with providers, and avoid duplication of effort.

Be creative in finding necessary funding. Deploying assistance to providers can be a significant resource load for states. Many states participating in the Center for Medicare and Medicaid Innovation's State Innovation Model (SIM) Grants will use the grant to fund their provider support activities, but in the absence of such dollars, states may need to find a patchwork of public, private, time-limited, and/or long-term funding sources. The Rhode Island Quality Institute used funding from the Rhode Island Foundation to finance its broad PCMH support initiative following a mainly Centers for Disease Control(CDC)-funded chronic care demonstration program. After the expiration of Rhode Island Foundation support, it used federal money from the Beacon program. Oregon combined private and public funding – from the North West Health Foundation and the Health Resources and Services Administraion's State Health Access Program – to provide initial start-up funding for its Patient-Centered Primary Care Institute. As it expands its learning collaborative from 25 practices in its pilot year to 50 practices, Maine plans to charge a small fee scaled to the size of the practices ($3 per patient per year, based on total panel size) to new practices participating in its PCMH learning collaborative.

Evaluate whether the supports are working. Assessing the effectiveness of technical assistance activities can be particularly helpful for states piloting new support models and/or investing significant resources in the effort. Oklahoma has a five-year plan for annual independent review of its SoonerCare Health Management Program, which includes regular surveys of practices receiving practice facilitator services. Oklahoma also holds regional collaborative meetings with participating providers to receive in-person input on the program. Oregon plans to conduct a small evaluation of its PCPCH learning collaborative to gain specific program-level information from participants. During its Beacon Community collaborative sessions, the Rhode Island Quality Institute asked participants to fill out an evaluation survey after each learning session and has continued this dialogue since, establishing formalized committees and conducting periodic informal outreach.

Conclusion

States are exploring opportunities to improve outcomes and reduce costs in their Medicaid programs through innovative models such as ACOs. Transformation at the point of care, however, is challenging and providers, particularly those serving high-volumes of safety-net populations, have significant support needs. Opportunities such as SIM present an excellent source of funding to allow states to deploy large-scale assistance to providers. Given the nascency of the ACO model, states will be most successful if they actively seek input from providers, consumers, and other stakeholders throughout the planning, implementation, and technical assistance process. For providers – and the states – ACO transformation is a significant change from business as usual and alignment of purpose will be crucial.

About Advancing Medicaid Accountable Care Organizations: A Learning Collaborative

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About 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 access and quality for low-income Americans. 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. For more information, visit www.chcs.org.

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Endnotes

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