CHCS Center for Health Care Strategies, Inc.

FACT SHEET | December 2015

Fostering Provider Participation in Payment Reform Efforts

Early Lessons from SIM Round One Test States

The State Innovation Model (SIM) initiative is ambitiously seeking to create statewide multi-payer care delivery and payment reform for roughly 80 percent of the population's care within participating states. Developing effective strategies to encourage provider involvement in new payment models is essential for reaching this goal. This fact sheet, based on experiences of SIM Round One Test States, outlines strategies to maximize provider participation in Medicaid payment reform programs, such as patient centered medical homes (PCMH) and accountable care organizations (ACOs). It offers insights on how states can encourage provider participation gleaned from Oregon's Coordinated Care Organizations (CCOs) and Patient Centered Primary Care Home (PCPCH) and Minnesota's Integrated Health Partnerships (IHP), as well as other SIM Round One Test state programs.

1. ***Minimizing barriers to entry*** can help increase the willingness of providers to participate in Medicaid reform efforts. Oregon noted that its decision not to restrict PCMH program participation to only "top tier medical homes" resulted in many more practices joining the initiative – 578 across the state as of August 2015. This broad provider uptake contributed to more expansive change to the delivery system statewide. Maine partnered with an external organization, Maine Quality Counts, to run learning collaboratives to help providers in the state attain the required National Committee for Quality Assurance certification, thereby allowing them to participate in initiatives.

2. ***Fostering flexibility*** is an important driver for provider participation. Minnesota's IHP governance and program requirements permit a wide range of provider organizations to participate. The IHP program has two tracks for provider partnerships, one for integrated systems and another for primary care or multi-specialty groups not affiliated with a hospital. This flexibility to participate in an upside-only IHP program enabled 10 Minnesota-based federally qualified health centers (FQHCs) to form the FQHC Urban Health Network (FUHN), one of the nation's FQHC-centered ACOs. Minnesota's flexibility also encouraged a number of rural providers to participate. The number of participating organizations grew from six in the first year to 16 IHPs in the third year.

3. ***Supporting active, ongoing recruiting, training and support*** is critical to provider outreach. Minnesota provides clear information about preliminary attribution, Total Cost of Care (TCOC), and risk to providers before they form IHPs to help them understand the IHP payment model and provide insight on current cost patterns as well as risks for their anticipated attributed population. The state also manages a web portal for data analytics so providers can easily access and work with IHP program data. Oregon targeted areas of the state with low provider participation by hosting community meetings and informational sessions to educate providers about PCPCH and the benefits of participation. Oregon also sent mailings to clinics that were not part of the program to help boost enrollment.

4. ***Ensuring leadership engagement*** can help increase provider buy-in and participation in reform initiatives. Minnesota's Commissioner of the Department of Human Services is a prominent and highly visible advocate of the IHP program within the provider community, as well as a trusted source of information. Her engagement helped providers feel confident that the state's reform efforts took their perspectives into account. Oregon also noted that cooperation from provider associations in the development and promotion of its reform agenda was important for garnering provider support. In addition, endorsement from provider organizations helped convey that the initiative was not simply being imposed by the state, but had provider support as well.

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5. ***Establishing financial incentives*** for participation is a valuable tool to encourage provider buy-in. Beyond the incentives embedded within the payment model, states have used supplemental incentives to encourage participation. For example, Oregon bases part of its CCO incentive payments on PCPCH participation, which directly resulted in increased involvement of primary care practices in CCO networks. Minnesota made participating in the IHP program a requirement for providers to receive certain SIM cooperative agreement money. Minnesota also promoted the savings realized by the IHP program – $14M in the first year and roughly $60M in year two – to help entice new participants. Vermont's ACO and PCMH programs are multi-payer, and the alignment across payers has reduced the costs for providers to participate in the program.

The SIM initiative has created an opportunity for states to address health care issues in a multitude of ways, all of which need the engagement of providers to succeed. These five strategies implemented by some of the states that received SIM test cooperative agreements can inform additional state efforts to improve provider participation in reform initiatives.

About this Resource

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