Multi-Payer Investments in Primary Care: Policy and Measurement Strategies

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Table of Contents

Introduction **2**

Section 1. Levers to Boost Multi-Payer Primary Care Infrastructure Investment **3**

1.1 Legislation 3

1.2 Establishing a Multi-Payer Workgroup 5

1.3 Health Plan Regulation 7

1.4 Engaging Self-Insured Employers 8

Section 2. Primary Care Revenue Enhancement Strategies **8**

2.1 Increase the Percentage of Health Payments Spent on Primary Care 9

2.2 More Comprehensive Capitation Rate 9

2.3 New Billing Codes for Primary Care Services 10

2.4 Higher Primary Care Rates 10

2.5 Pay for Performance Incentives 11

2.6 Shared Savings 12

Section 3. Practice Transformation Supports **13**

3.1 Multi-Payer Financial Investment in Practice Transformation 13

3.2 Health Information Technology 14

3.3 Practice Facilitation 15

3.4 Primary Care Extension Program 15

Section 4. Measurement Strategies **16**

4.1 Monitoring the Impacts of Policies to Enhance Primary Care Infrastructure 16

4.2 Monitoring Primary Care System Performance 18

Conclusion **22**

Introduction

Rapid transformation in health care coverage and financing is taking place in many U.S. states, with extensive implications for the primary care system and primary care infrastructure. By 2016, the Affordable Care Act is expected to increase the number of people with insurance by 25 million.[1] Simultaneously, there is a major shift in how health care is paid for and delivered in Medicare, Medicaid, public employee groups, and commercial health plans.

Investing in primary care is a central strategy for transforming the delivery and financing of care. Research suggests access to a regular primary care physician is associated with higher rates of preventive care and lower rates of preventable emergency department visits, hospital admissions, and specialist utilization.[2,3,4] Greater investment in primary care can also lead to lower total health care costs, better patient outcomes, and fewer population health disparities.[5,6] Many states are implementing strategies to improve the accessibility, quality, and cost effectiveness of primary care, including: promoting patient-centered medical home (PCMH) programs; raising payment rates for Medicaid primary care providers; investing in primary care-based health information technology; and supporting practice-level knowledge-sharing and technical assistance. Specific examples of state primary care investments include:

- *Vermont*: The multi-payer Blueprint for Health establishes a new primary care-focused health services model for Vermont, centered on the creation of PCMHs and multidisciplinary community health teams (CHTs), which support PCMHs and provide a range of health services. An integrated information technology infrastructure supports the primary care delivery system. A 2012 analysis published by Vermont demonstrated that people who received primary care in the PCMH and CHT setting had more favorable outcomes than comparison groups, including: lower total health expenditures; lower rates of medical and surgical specialty care; higher rates of primary care; and higher rates of some preventive services. Commercial insurer and Medicaid investments were more than offset by reductions in health care expenditures.[7]
- *North Carolina*: Community Care of North Carolina (CCNC), a statewide network of primary care providers, established multi-payer medical homes for more than a million residents across the state. In collaboration with the North Carolina Area Health Education Center, CCNC provides physicians with resources to better manage enrolled populations; links providers to local health systems, hospitals and health departments; and trains a multidisciplinary health care workforce
- *Rhode Island:* Under the Chronic Care Sustainability Initiative (CSI), a multi-payer PCMH initiative, Medicaid and commercial payers use a common contract that specifies uniform practice requirements and performance metrics. Under CSI, payers also jointly fund nurse care managers. The state further supports primary care through a set of affordability standards that require commercial insurers to invest an increasing percentage of their total spend on primary care services and non-fee-for-service (FFS) payment models.

The purpose of this paper is to help states develop or refine a multi-payer primary care investment strategy. It presents a range of options for advancing and measuring investments in state-based primary care systems, with an emphasis on enhancing the engagement of commercial payers and aligning public

and private payment and care delivery models. This paper begins by exploring the levers states can use to advance multi-payer primary care programs and policies. It then highlights the policy approaches some states have used to stimulate multi-payer investment in primary care, via revenue enhancement strategies and practice supports. The paper concludes with a review of metrics that could be used to monitor the impacts of primary care investment policies and track primary care system performance.

Section 1. Levers to Boost Multi-Payer Primary Care Infrastructure Investment

Primary care transformation becomes increasingly viable as more payers invest in infrastructure development and pay providers through non-FFS arrangements. Building a coordinated strategy across multiple payers has the following benefits:

- Providing consistent messaging and incentives to primary care practices;
- Reducing the administrative burden associated with different payment methodologies and expectations;
- Avoiding the economic "free rider" problem of some entities benefiting from others' investments; and
- More widely distributing costs and risks.

States can assume a variety of roles to promote multi-payer primary care investment: policymaker, payer, regulator, convener, and grant maker. They should consider the different roles they can assume at different times—as well as the levers they can use to promote commercial insurers' meaningful investment in the state's primary care infrastructure. Four core strategies are highlighted below: (1) legislation; (2) establishing a multi-payer workgroup or collaborative; (3) health plan regulation; and (4) engaging self-insured employers. States can consider applying any of these levers to implement the primary care investments described in more detail in Sections 2 and 3 of this paper.

1.1 Legislation

Passing legislation to boost primary care infrastructure investment can be a high-cost/high-reward lever. The legislative process can be slow and unpredictable, but a policy successfully enacted through legislation will likely have legitimacy and staying power. That being said, there is no guarantee that a legislatively mandated policy will be any more successful than a voluntary policy. A number of states—including Maryland, New York, Minnesota, and Vermont—have relied on legislation to secure multi-payer participation in state-based PCMH pilots. Legislation can also be used to require insurance companies to invest in primary care. States could use legislation to require aligned commercial participation in a medical home program or establish a new statewide entity focused specifically on creating and enforcing primary care payment and investment policies.

One limitation with using legislation to enact primary care policy changes is that it does not have influence over self-insured employers due to the ERISA preemption, which prohibits state laws from regulating ERISA plans (this also holds true for health plan regulation, discussed in Section 1.3 below).

EXAMPLES OF LEGISLATION TO ESTABLISH MULTI-PAYER MEDICAL HOME PROGRAMS AND NEW STATE ENTITIES

Legislation Establishing Multi-Payer Medical Home Programs

- In 2010, the **Maryland** legislature passed SB855/HB929 requiring all payers with premium revenues of more than $90 million to participate in the **Multi-Payer Patient Centered Medical Home Program** (MMPP). Legislation was used to compel participation and provide the antitrust protection Maryland payers needed to participate. Results to date:
  - In comparing results of MMPP with comparison sites between 2010 and 2011, MMPP was associated with substantial improvements ($p < 0.10$) in three of 13 quality measures (young adult hospital admissions due to asthma, adolescent well-care visits, and cervical cancer screenings), two of 12 utilization measures (office visits to an attributed primary care physician, office visits to specialty physicians), and four of 12 cost measures (total outpatient payments, primary care office visit payments, total other costs, and total laboratory payments).[8]
- Chapter 58 of the Laws of 2009 (the 2009-2010 state budget) created **New York's Adirondack Multi-Payer Demonstration**. Legislation provided antitrust protection for payers to collaborate and specified terms of the demonstration, though did not mandate payer participation. All seven of the region's commercial payers, Medicare, and Medicaid joined the demonstration, in part due to providers' strong advocacy efforts. Payer concerns included:
  - Issues around time, capacity and coordination, as some payers were already participating in other pilots;
  - Insufficient data on the model's return for payers; and
  - Finding a mutually acceptable PMPM payment level was difficult. (This issue was solved when the providers hired an outside accounting firm to estimate the PMPM cost of the demonstration's requirements. The estimate of $8.40 PMPM was ultimately negotiated down to $7 PMPM.)

Legislation Establishing New State Entities*

- **Massachusetts'** Chapter 224, passed in 2012, created the **Health Policy Commission** (HPC), an independent state agency charged with reducing overall health care cost growth; improving access to quality, accountable care; and reforming the way health care is delivered and paid for. HPC is funded through the state's Healthcare Payment Reform Fund until June 30, 2016; after that date, HPC will be funded through assessments on hospitals, ambulatory surgical centers, and surcharge payers. Its activities include:
  - Establishing an annual cost growth benchmark and monitoring whether spending has exceeded the target; the benchmark for 2013 is 3.6 percent;
  - Conducting cost trends hearings and publishing a cost trends report (the only explicit primary care measure included in the 2013 report is "ED visits that are preventable or avoidable with timely and effective primary care");
  - Analyzing the performance of provider organizations with revenues of $25 million or more and requiring provider groups with above-target spending to submit plans for corrective action;
  - Reviewing provider changes, including consolidations and alignments; and
  - Developing and implementing standards for Massachusetts PCMHs.
- The **Rhode Island** Health Care Reform Act of 2004 (Chapter 42-14.5) established the nation's first Office of the **Health Insurance Commissioner**, separating health insurance regulation from the Department of Business Regulation. The decision to pursue this legislation came from the realization that the state did not have the information or authority needed to affect the relationship between insurers and providers in the large- and small-group insurance markets. The legislation added two new standards to the traditional roles of a health insurance regulator: (1) to hold health insurers accountable for fair treatment of providers; and (2) to direct insurers to promote improved accessibility, quality, and affordability.

** These examples are not specific to primary care, but describe entities states could use as models to promote primary care investment*

1.2 Establishing a Multi-Payer Workgroup

Another possible lever states can use to address primary care infrastructure needs is to establish a workgroup (e.g., advisory group or voluntary multi-payer partnership) to foster shared goals and strategies across payers. States may choose to serve as convener, given existing relationships with payers and purchasers and the fact that states can provide anti-trust protection for payers to establish aligned payment strategies. High-profile leadership from the governor, legislature, or insurance commissioner can also lend credibility to the initiative and the need for change. On the other hand, a state-run collaborative may seem overly political and may survive only as long as the current administration. A non-state convener, such as a statewide health improvement collaborative, may appear less politically motivated and thus offer more staying power.

In establishing a workgroup, states should consider the following:

- *Purpose*: What should the workgroup focus on and what is its ultimate objective? Should it only work on a specific initiative (such as implementing a medical home program) or should it address multiple issues related to primary care infrastructure? How might the workgroup incorporate existing multi-payer primary care efforts such as the Comprehensive Primary Care Initiative?
- *Authority:* Should the workgroup have any decision-making or enforcement authority regarding new policies?
- *Governance*: Should the workgroup be governed by a formal charter or memorandum of understanding? How should the workgroup be structured to facilitate consensus building and informed decision-making?
- *Members*: What stakeholders should be invited to participate in the group?
- *Convener:* Who is the right convener for the workgroup? Neutrality, the ability to develop consensus, and trust among commercial payers will be critical for a successful convener.
- *Meeting requirements*: What type of meeting schedule would facilitate progress while not being too burdensome? How will the meetings be structured?
- *Reporting requirements*: Should the workgroup be required to submit reports or updates, and if so, for what audience?

EXAMPLES OF MULTI-PAYER WORKGROUPS AND GOVERNANCE STRUCTURES

State-Based

- The **Idaho** Medical Home Collaborative (IMHC) includes four large payers, state officials, physician groups, and patient and employer representatives. Each member signed a charter, which included five sections:[9]
    - *Purpose*: Describes the purpose of IMHC as making "recommendations on the development, promotion and implementation of a Patient-Centered Medical Home model of care statewide."
    - *Authority/Reporting*: Asserts that members shall be assigned by the Governor and overseen by the Department of Insurance.
    - *Membership*: Lists all current members.
    - *Member Responsibilities*: Contends that members are to attend all meetings, actively participate and commit to follow-through on assignments.

- *Meetings and Structure*: Notes that the group will meet on a monthly basis.

- **Montana**'s Commissioner of Securities and Insurance was charged with planning and convening a multi-payer medical home effort in 2010. In 2013, the commissioner published a set of rules relating to the PCMH program, including rules around the establishment and duties of the Patient-Centered Medical Homes Stakeholder Council. The following rules were included:[10]
  - The stakeholder council consists of 15 members appointed by the Commissioner to serve 12-month terms.
  - The Commissioner shall consult with the Stakeholder Council before proposing new PCMH rules.
  - The Council shall advise the Commissioner regarding PCMH activities.
  - The Council shall meet at least twice a year (since November 2013, the Council has met every month).
- **Rhode Island**'s multi-payer CSI is convened by the Rhode Island Office of the Health Insurance Commissioner (OHIC) and the Executive Office of Health and Human Services. CSI has the following governance structure:
  - *Steering Committee***:** Responsible for the strategic direction and overall governance of the project.
  - *Executive Committee***:** Makes recommendations to the Steering Committee regarding the strategic direction and overall governance of the project, including two subcommittees:
    - *Marketing and Communications Subcommittee***:** Increases awareness and demand for PCMH. Target audiences include employers and labor unions.
    - *Patient Advisory Subcommittee*: Serves as the voice of the patient and family.
  - *Working Committees*: Includes subcommittees on Practice Training Support and Transformation; Practice Reporting, Data and Evaluation; Payment Reform and Contracts; and Service Expansion.
  - Current governance considerations include: developing by-laws to address electing co-chairs, committee membership, and term limits; monitoring project as it grows for risk of scalability; and assessing and identifying ways to formalize CSI structure as an entity.
- In 2013, insurers and providers in **Nebraska** signed a Participation Agreement to recognize and reform payment structures to support PCMHs. The agreement includes the following information:[11]
  - *Effective dates*: January 2014 – January 2016.
  - *Goals*: Insurers will have active PCMH contracts with approximately 10 clinics by the end of 2014 and approximately 20 clinics by the end of 2015.
  - *Definitions*: Provides a definition of a PCMH in Nebraska.
  - *Payment*: Insurers must utilize payment mechanisms that recognize value beyond the FFS payment. The design and details of the payment mechanism will be left up to each individual health plan.
  - *Progress Reports*: Participating payers are asked to report annually, by letter, successes realized and challenges faced in their efforts to comply with this agreement. The report should include the number of PCMH contracts signed.
- **Colorado**'s multi-payer PCMH pilot—which included five private and two public health plans—was convened by HealthTeamWorks, a nonprofit, multi-stakeholder collaborative. While each health plan developed its own contract with practices, HealthTeamWorks reduced fragmentation between plans by writing suggested contract language. Plans used this language as a starting place and then adapted it to best meet their needs.

Independent

- **California's Integrated Healthcare Association**, a multi-stakeholder nonprofit group, serves as the neutral administrator of the California Pay for Performance Program, the largest non-governmental physician incentive program in the United States. IHA board members include health plans, physician groups, and hospital systems, as well as academic, consumer, purchaser, and technology representatives. IHA began its pay for performance program with a statement of vision, goals, core principles and project objectives. It also established ground rules that defined the scope and operation of the program. IHA has a set of core committees:[12]
  - *Technical Efficiency Committee*: Develops cost-efficiency and resource use measures;
  - *Technical Quality Committee*: Develops quality measures;
  - *Steering Committee*: Reviews Technical Committees' recommendations and responsible for making final decisions and overseeing the program;
  - *Executive Committee*: Handles long-term planning and provides direction to program staff; and
  - *Payment Committee*: Explores and recommends common incentive payment methodologies.

1.3 Health Plan Regulation

States can influence commercial insurers' investment in primary care through the rate review process, authority over the certification of marketplace carriers, and regulation of qualified health plans (QHPs).

Rate Review and Financial Reporting

States can use the rate review process—or an alternative financial reporting process—to monitor commercial health plans' primary care investment patterns and mandate enhanced payer contributions to primary care services (see Table 1 in Section 4.1 for measures to use in assessing changes in payment policies). Specifically, states can use this lever to:

- *Gather information on primary care spending:* States can use rate review to require commercial insurers to disclose information about: (1) annual spending on primary care services; (2) incentives to increase primary care activities (both the direct provision of services and investment in transformation activities and infrastructure supports); (3) any assumptions about primary care usage and cost that are included in premium calculations; and (4) hospital and provider pricing, contract terms, and spending trends.
- *Set standards or goals at the insurer level:* States can encourage or require insurance companies to incorporate best practices in contracts with providers and then report on the results. Potential standards include:
    - Increasing the percentage of total spend on primary care;
    - Engaging in primary care-based quality improvement efforts;
    - Adopting the medical home care model and/or investing in medical home practices;
    - Tying outcomes to payment and reimbursement; and
    - Requiring public and standardized provider contract terms.
- *Use investment in primary care as a factor in approving/denying rate increases:* States can adjust rate review methodology to account for the total percentage of spend insurers invest in primary care (with insurers who invest more in primary care being "rewarded" with slightly higher rate increases).

EXAMPLES OF LEVERAGING THE RATE REVIEW PROCESS

- In 2007, the **Rhode Island** Insurance Commissioner's office updated its rate review process to make rate filings annual, consistent across lines of business and insurers, and transparent. The next year the state began to require insurers to report how they were addressing affordability with their rate filings—yet these descriptions tended to be nonspecific lists of activities around disease management, wellness programs, and benefit design. To obtain more specific information and set clearer expectations for insurers, the insurance commissioner then developed four formal affordability standards, using the annual rate review process "as the point of leverage" (see Section 2.1 for more information about Rhode Island's affordability standards).

Authority over Marketplace Plans

States running state-based health insurance marketplaces can use their administrative authority over these entities to promote primary care goals in QHPs. States can seek to:

- *Establish primary care standards for QHPs or marketplace carriers*: States can consider setting specific primary care standards for participation on the marketplace, related to plans' benefits package or carriers' primary care spending or investment in primary care transformation.
- *Steer consumers toward "high value" plans*: States can help steer consumers toward plans that invest more in primary care by establishing a favorable rating or designation system for plans that meet certain primary care criteria, or by displaying these plans more prominently on marketplace website.

1.4 Engaging Self-Insured Employers

Engaging self-insured employers in primary care transformation efforts can be challenging, as these employers are not subject to state payment and delivery system reform polices because of the ERISA exemption. States' only option to secure employer participation may therefore be to educate and engage them about why primary care investment benefits them. To engage employers in primary care programs, states can:

- *Make the business case for primary care*: Employers want to know about the anticipated return-on-investment for any new investment. States must therefore rigorously measure a primary care program's progress and outcomes, using key data points to compute the program's return-on-investment and craft a business case for why employers should join the effort.
- *Identify a key employer champion*: Some companies have publicly supported the medical home model and other primary care investment strategies. IBM, for example, is currently participating in six multi-payer medical home pilot projects in New York and Vermont. In Cincinnati, GE is leading a group of employers and payers in delivery system reform efforts. GE took charge of calling meetings to discuss new payment strategies and set up an Executive Stakeholder Council; other employers, health plans, and provider groups then joined the effort. If states can find one champion like IBM or GE—a large company that is willing to be out in front—other employers may be more likely to follow their lead.

EXAMPLES OF ENGAGING SELF-INSURED EMPLOYERS

- **Maryland** created a Frequently Asked Questions document for self-funded employers around participating in the state's multi-payer PCMH pilot.[13] The state also created a list of "Incentives for Self-Insured Employers who Participate in the Program" on its website.[14] Self-insured employers voluntarily choosing to participate in the pilot include Maryland hospital systems.
- The **Minnesota** state government is working with employers to provide education and develop strategies to encourage the integration of medical home payments into insurance products (medical homes are known as health care homes in the state). In its health care home demonstration application, the state estimated that 15 percent of the self-insured market will voluntarily participate in the program by the end of the demonstration period.[15]

Section 2. Primary Care Revenue Enhancement Strategies

Nationwide, the percentage of total health care expenditures devoted to primary care is between five and six percent.[16] Some experts have advocated for payers to increase this share to 10 to 12 percent of

expenditures, based on the hypothesis that greater investment in primary care could reduce long-term costs and improve the quality of care if invested in more efficient and evidence-based processes.[17] Below are strategies that would increase the amount or percentage of health care funding invested in primary care services.

2.1 Increase the Percentage of Health Payments Spent on Primary Care

States can use one or more of the levers discussed in Section 1 to require or encourage health plans to gradually increase the proportion of total payments made to primary care services. States would first need to determine a current baseline for each major insurance carrier and then propose reasonable future standards.

EXAMPLE OF INCREASING THE PROPORTION OF PAYMENTS MADE TO PRIMARY CARE SERVICES

- Beginning in 2010, **Rhode Island**'s OHIC has enforced a set of four criteria, collectively termed the Affordability Standards, among the state's commercial insurance companies. One of the Standards requires the state's main commercial insurers to increase the share of total medical payments made to primary care by one percentage point per year from 2010 to 2014. This spending cannot result in higher premiums and cannot increase overall medical expenses; rather, it must reflect a shift in issuers' primary care payment strategies away from the dominant FFS system.
    - *RESULTS*: In 2012, insurers spent 9.1 cents of every fully insured commercial medical dollar on primary care services, an increase of nearly 3.5 cents from 2008. Insurers also continue to invest in non-FFS methods, particularly PCMHs, to drive primary care spending. From 2008 to 2012, spending on primary care in Rhode Island grew 37 percent, and in 2012, the market spent $7 million more on primary care than it did in 2011. While overall medical spending declined during this time period, the state does not attribute this change to higher primary care spending, but rather to a variety of other factors—such as the recession, benefit changes, and a shift to self-insurance. Since Rhode Island's Affordability Standards went into place, insurers have met their primary care spending requirements and have greatly increased investments in non-FFS projects, with 34 percent of all primary care costs attributed to non-FFS spending.[18]

2.2 More Comprehensive Capitation Rate

Payers participating in medical home programs can consider offering practices an all-inclusive per member per month (PMPM) payment for clinical services and other medical home activities. A more comprehensive capitation rate could cover all practice expenses, essential infrastructures and systems, and salaries,[19] or more minimally, cover behavioral health services, care coordination, and case management, similar to the Massachusetts model highlighted below.

EXAMPLE OF A MORE COMPREHENSIVE CAPITATION RATE

- As part of **Massachusetts'** Primary Care Payment Reform Initiative, MassHealth (Medicaid) will pay participating practices a Comprehensive Primary Care Payment (CPCP), a risk-adjusted per member per month payment for a defined set of primary care and behavioral health services to include evaluation and management, case management, care coordination, and behavioral health coordination. MassHealth plans to base the CPCP on Medicare rates, at least until December 31, 2014.

2.3 New Billing Codes for Primary Care Services

Payers can begin reimbursing primary care providers for services that are not currently designated with a primary care procedure code. Such services could include care coordination, telemedicine, phone-based visits, and certain disability examinations. States can also work to align Medicaid primary care procedure codes and provider types with those in Medicare, public employee plans, and commercial plans. Finally, states can provide additional or extra payments for care delivered during extended hours. A potential drawback to this strategy is the continued reliance on a FFS-based payment methodology.

EXAMPLES OF NEW BILLING CODES FOR PRIMARY CARE SERVICES

- **WellPoint**, a private, for-profit health plan, announced in 2012 that it will begin paying doctors for certain services that are not currently reimbursed for, including developing treatment plans for patients with chronic diseases. The company stated that it believes this strategy, coupled with paying primary care providers higher rates, will improve overall patient health and reduce expensive medical services like emergency room visits and hospital stays.
- BlueCross BlueShield of **Michigan**, Horizon BCBS of **New Jersey**, and **Texas** Medicaid began paying for traditionally non-reimbursed care management services through new procedure codes.
- The **Oklahoma** Health Care Authority provides additional reimbursement to SoonerCare Choice (Medicaid) primary care providers for care provided outside of normally scheduled office hours. Providers use standard evaluation and management codes with additional CPT Codes 99050 ($19.30) or 99051 ($6.97).
- Starting in 2013, **Medicare** began reimbursing for five new codes related to care coordination. Three of the codes are used for reporting complex care coordination services, while two reimburse for post-discharge transitional care coordination.

2.4 Higher Primary Care Rates

Increasing Rates Based on Medical Home Recognition

Many examples exist for how commercial and public insurers can reward primary care practices for increasing their levels of "medical home-ness," though these examples may increase existing FFS or PMPM payments, rather than promote innovative payment methodologies.

EXAMPLES OF HIGHER PAYMENT RATES BASED ON MEDICAL HOME RECOGNITION

Multi-Payer

- Under the **New York** Statewide Patient-Centered Medical Home Program, National Committee for Quality Assurance (NCQA)-recognized hospital outpatient clinics and office-based practitioners are eligible to receive enhanced service rates for certain evaluation and management and preventive medicine codes for participating enrollees. The payments vary by NCQA recognition level. **Oklahoma**, **Nebraska**, and **Maryland** also tier medical home payments, rewarding practices that achieve higher levels of recognition with higher PMPM payments.

Medicaid

- **Colorado** increased evaluation and management codes for primary care visits to 90 percent of the Medicare rates. Practices receive a significantly higher bump for Medicaid preventive visits (120 to 130 percent of the Medicare rate),

if they complete a medical home index questionnaire and meet medical home standards developed by the state.

Commercial

- **Blue Cross and Blue Shield of North Carolina** (BCBSNC) pays an enhanced FFS amount for evaluation and management codes billed to BCBSNC practices that apply for NCQA PCMH recognition.

Increasing Rates for all Primary Care Providers

States can consider extending the Affordable Care Act's (ACA) Medicaid primary care rate increase past 2014 or otherwise work to align Medicaid primary care reimbursement levels with Medicare and commercial levels. States can also support legislation to extend equal pay for primary care nurse practitioners and physician assistants outside independent practices. Additionally, commercial insurers can choose to raise reimbursement rates to all primary care providers.

EXAMPLES OF HIGHER PAYMENT RATES FOR ALL PRIMARY CARE PROVIDERS

Medicaid

- Both **Colorado** and **Maryland** have proposed maintaining the ACA Medicaid primary care rate increase past 2014. Colorado's governor has included the rate bump in his proposed 2015 state budget.

Commercial

- In early 2012, **WellPoint** announced plans to spend $1 billion or more to increase primary care doctors' fees by roughly 10 percent within its network of 100,000 primary care providers. The insurer estimates the new payment approach could result in a 20 percent reduction in projected medical costs by 2015.

2.5 Pay for Performance Incentives

States can considering establishing a multi-payer pay for performance (P4P) program at the practice or individual provider level, rewarding providers directly for meeting primary care targets, including successful primary care transformation. States could couple a P4P program with a medical home program to establish a greater connection between medical home investments and quality outcomes and create a stronger business case for commercial plans. Payers can offer extra payments as a reward for certain processes (establishing EHRs and registries, after-hours care, meeting medical home standards) or outcomes (reducing ED visits, hospitalizations, total cost of care, etc.).

EXAMPLES OF PAY FOR PERFORMANCE INCENTIVES

Multi-Payer

- In **Rhode Island's** multi-payer CSI, the PMPM payment increases or decreases based on achievement of performance targets related to utilization, quality and member satisfaction, and process improvement. Practices receive: $5.00 PMPM if 0-1 of the three performance targets is achieved; $5.50 if the utilization target and one other performance target are achieved; or $6.00 if all three performance targets are achieved.
    - *RESULTS*: After two years, CSI was associated with substantial improvements in medical home recognition

scores and a significant reduction in ambulatory care sensitive emergency department visits. Although not achieving significance, there were downward trends in emergency department visits and inpatient admissions.[20]

Medicaid

- In **Colorado's** Accountable Care Collaborative, a $20 PMPM is divided among three entities: PCPs, Regional Care Collaborative Organizations (RCCO), and a Statewide Data and Analytics Contractor. $1 PMPM is withheld from both the PCP and the RCCO, creating a shared quarterly incentive payment pool. The $1 PMPM can be recouped by each entity by meeting key performance indicators, including: reduced ED utilization, reduced hospital readmissions, reduced utilization of medical imaging, and well-child visits.
- **Connecticut** Medicaid's Husky Health PCMH program provides incentive payments for practices in the top 10 percent for performance (fractions of the incentive payment begin phasing in at the 25th percentile) and improvement payments (practices in the top 10 percent for improvement will receive 100 percent of the possible improvement payment).
- **Oklahoma's** SoonerExcel program (Medicaid) makes quarterly payments to PCPs who meet or exceed expectations in: inpatient admitting and visits, breast and cervical cancer screenings, ED utilization and EPSDT and immunization targets.

2.6 Shared Savings

Payers can implement a shared savings component within a medical home model, with accrued savings awarded based on primary care performance and reinvested in primary care infrastructure and staff. Shared savings programs could incorporate the following components to promote primary care investment:

- *Award savings based on providers' performance on primary care indicators*: The shared savings program can be structured to reward primary care practices that meet pre-determined primary care quality goals and/or save money by reducing acute care utilization.
- *Require practices to invest shared savings in primary care infrastructure or PCP incentives*: In addition to suggesting *who* is awarded savings accrued in a shared shavings payment design, the state could consider being more prescriptive about *how* savings are re-invested at the practice level. Requiring providers to reinvest all or a portion of accrued savings in primary care infrastructure (such as upgraded or enhanced health information system technology and additional care coordinators and support staff) could help practices quickly develop into higher-functioning medical homes.

EXAMPLES OF SHARED SAVINGS PROGRAMS

Multi-Payer

- **Maryland's** Multi-payer PCMH Program includes a shared savings payment in which primary care practices can earn a percentage of the savings they generate through improved care and better patient outcomes. Practices that meet performance and measurement criteria and achieve savings relative to their own baseline will receive a percentage of cost savings. These shared savings calculations comprise all patient costs, including approximately 94 percent of costs that occur outside the primary care practice (e.g., in hospitals, specialist physicians, laboratories, etc.). The first of

these payments was made in the fall of 2012, and payments were based on performance during 2010 and 2011; 23 of 52 participating practices received shared savings payments from private insurers. Total incentive payments, based on 2011 performance metrics and savings, were $815,670.[21]

- **Northeastern Pennsylvania's** Chronic Care Initiative has a shared savings program that pays providers "value reimbursement payments" if: (1) they have met a certain number of performance criteria; and (2) the savings generated exceed the annual value of the other ongoing medical home payments.

Commercial

- **California**'s Integrated Healthcare Association (IHA) added a shared savings provision to its P4P program to reward practices for performance on a series of resource use measures (including inpatient utilization and emergency department visits). IHA calculates risk-adjusted rates using data from all of the IHA-participating health plans, and the health plans calculate savings using their own unit cost data. Savings are shared based on a formula that allocates savings between the provider organization, the health plan, and employers (in the form of future premium trend reduction).
- In 2009, BCBS of **Massachusetts** instituted global budgets coupled with financial risk and performance bonuses with seven provider organizations under its Alternative Quality Contract (AQC). Sixteen provider organizations (most with a mix of primary care providers and specialists) are now participating in the contract. The AQC rewards provider groups with up to 10 percent of their global budget for meeting 64 quality measures. Researchers found that AQC providers reduced the rate of increase in health spending by 3.3 percent in the second year, up from 1.9 percent in the first year. Quality of care also improved compared to control organizations, with chronic care management, adult preventive care, and pediatric care within the contracting groups improving more in year two than in year one.[22]

Medicaid

- **Massachusetts** Medicaid's Primary Care Payment Reform, implemented in 2013, includes a shared savings payment (in addition to a risk-adjusted capitation payment and quality incentives). Providers share in savings on non-primary care spending, including hospital and specialist services. There are also options for shared risk terms.
- **Arkansas'** Medicaid Patient Centered Medical Home program includes shared savings incentives for providers. Practices are eligible for shared savings if the practice: (1) completes all scheduled practice support activities through the ConnectCare Primary Care Case Management Program and meets a majority of practice support metrics; and (2) meets 2/3 or more of quality metrics.

Section 3. Practice Transformation Supports

Another strategy to boost states' primary care infrastructure is for both public and private payers to provide financial and/or non-financial supports to assist primary care practices in transforming into medical homes. Investment in practice transformation supports can address a number of barriers to medical home implementation, including: (1) cost and lack of resources; (2) staffing and training; (3) time; and (4) administrative burdens.

3.1 Multi-Payer Financial Investment in Practice Transformation

States can develop medical home payer requirements in which all participating plans contribute a portion of costs to fund transformation services—or, alternatively, to directly fund a centralized state resource hub to provide technical assistance to practice sites. The examples highlighted below describe how public and private payers have jointly contributed to transformation or infrastructure supports within multi-payer medical home programs.

EXAMPLES OF MULTI-PAYER INVESTMENT IN PRACTICE TRANSFORMATION

Multi-Payer

- In **Massachusetts**' multi-payer Patient-Centered Medical Home Initiative, participating commercial, state employee, and public programs provide practices with start-up payments that range up to $15,000 in the first year and $3,500 in the second year.
- All payers in the **Michigan** Primary Care Transformation (MiPCT) Project contribute $1.50 PMPM for practice transformation.
- In the Southeast **Pennsylvania** PCMH, each payer pays its share of the $21,000 payment in proportion to the share of the practice's revenue that comes from the payer.
- Practices in **Washington** State's multi-payer Patient Centered Medical Home Pilot **r**eceived $6,400 stipends to attend eight days of learning sessions.
- In **Rhode Island**'s Chronic Care Sustainability Initiative, Medicaid health plans partner with commercial payers to cover the salary and benefits of an on-site nurse care manager for each practice in the pilot program. The nurse care managers work on-site as an employee of each practice and see patients of all insurers.

3.2 Health Information Technology

States can promote multi-payer investment in statewide health information technology to enhance primary care functioning, such as electronic health records, health information exchanges, access to web portals, and referral tracking systems.

EXAMPLES OF HEALTH INFORMATION TECHNOLOGY INVESTMENTS

- In 2005, **Vermont** authorized and funded a single statewide Regional Health Information Organization (RHIO) called Vermont Information Technology Leaders (VITL), which operates as a private 501(c)3. VITL is both the state's designated health information exchange and a federally designated regional extension center. This statewide information exchange infrastructure enables data transmission to and from the state's web-based registry called DocSite, which produces reports on measures to enhance clinical operations, population management, and program evaluation. Providers without an EMR can also use the registry for electronic prescribing. VITL is supported in part by the Vermont Health IT Fund, which was created via legislation in 2007 and became operational in 2008. It is funded by a fee of 2/10ths of one percent of the dollars paid on commercial health insurance claims.
- **Ohio's** PCMH Education Pilot Project requires the patient-centered medical home education advisory group to reimburse up to 75 percent of a practice's health information technology investments for participating primary care practices (including training and technical support). The pilot was created through legislation and is leveraging meaningful use incentives from the HITECH Act.
- **Iowa** is directing practices to use a portion of their PMPM payments from the state to establish and maintain a registry for tracking key patient information and developing a system for sharing clinical information with hospitals.
- **Colorado's** Regional Extension Center (CO-REC) services helped eligible primary care providers in Colorado qualify for Medicaid and Medicare incentive payments through 2012. CO-REC assists primary care providers in adopting, implementing, and becoming meaningful users of electronic health record systems to qualify for federal stimulus funds. Nearly 1,800 providers and 24 hospitals are actively engaged with a CO-REC partner today to meet the Stage 1 Meaningful Use criteria.

3.3 Practice Facilitation

States can explore launching or enhancing a practice facilitation program to help practices meet primary care home recognition standards and maintain improvements. Research on practice facilitation is mixed, but generally positive: primary care practices are more likely to adopt evidence-based guidelines using practice facilitation when compared with control practices.[23]

EXAMPLES OF PRACTICE FACILITATION PROGRAMS

- **Oklahoma's** SoonerCare Health Management Program used a contractor to employ, train, and deploy eight nurses to serve as practice facilitators statewide. The practice facilitators supported practice transformation by engaging in: team development; workflow redesign; creation of a registry, resource library, and educational materials; and quality improvement projects. An independent evaluation of 62 Health Management Program practices conducted between 2008 and 2009 found $2.8 million in aggregate savings and a 16.5 percent improvement of on disease management quality measures.[24]
- The **Oklahoma** Physicians Resource/Research Network (OKPRN), developed and tested a quality improvement method that includes performance feedback with benchmarking, academic detailing, practice facilitation, HIT support, and learning collaboratives. Four full-time practice enhancement assistants provide practices with audits and feedback, staff training, "cross-fertilization" of ideas, coordination of quality improvement initiatives, and facilitation of practice-based research network projects. Its activities have produced improvements in preventive services and diabetes care by sharing approaches to common challenges.[25]
- **North Carolina**'s AHEC Practice Support Program employs 49 facilitators to work in teams based in each of the state's nine regional AHEC centers. Each center has three to nine individuals with skills in quality improvement, EHR implementation, and EHR optimization. Each team works with 25-30 practices at a time and serves 1,100 practices statewide (generally 12 – 18 months at a time, onsite).
- The **Vermont** Equip Program, begun in 2008, uses Practice Facilitators (PF) to assist practices in becoming PCMHs and implementing and using HIT supports. PFs build practice quality improvement capacity and help practices achieve other self-identified goals. The program's 13 practice facilitators make twice monthly visits to practices, with one PF to every 8-10 practices.

3.4 Primary Care Extension Program

States can consider establishing a primary care extension program to deploy community-based agents or coaches to support practices as they transform into medical homes. The states listed below received funding from the Agency for Healthcare Research and Quality under the Infrastructure for Maintaining Primary Care Transformation (IMPaCT) program to employ primary care extension agents in small- and mid-sized independent primary care practices to assist with primary care redesign.

EXAMPLES OF PRIMARY CARE EXTENSION PROGRAMS

- The **New Mexico** Health Extension Regional Offices (HEROs) were developed to improve community health and are located in underserved rural counties. Ten Regional HERO Officers support HERO agents, who link providers and communities to resources and offer provider education, research, and services like case management, practice support, and community health assessments. HERO agents help train community health workers, who provide case management services for patients with high urgent or emergent care utilization.
- The Public Health Institute of **Oklahoma** (PHIO) acts as the state hub for Oklahoma's extension system. PHIO directs a certification process for county health improvement organizations, which contract with the four regional Area Health

Education Centers (AHECs) to provide quality improvement support for primary care practices. Each AHEC has around 18 practice facilitators who perform practice audits, conduct patient surveys, train staff, and coordinate quality improvement initiatives.

- In 1998, **North Carolina**'s Medicaid program began Community Care of North Carolina (CCNC), which consists of 14 provider networks. These networks include the state's nine regional Area Health Education Centers (AHECs), which employ Quality Improvement Consultants to support practices in process improvements. CCNC Networks return a portion of their PMPM for each enrollee to support the central AHEC office. Studies on CCNC suggest it has improved quality of care and yielded Medicaid a return of $2 in savings for every $1 invested.[26]
- The **Pennsylvania** Spreading Primary Care Enhanced Delivery Infrastructure (PA SPREAD) is a public-private partnership that is working to coordinate the development of a statewide Primary Care Extension Service with a variety of partners. PA SPREAD and many of its partners (including PA AHEC Regional offices) offer practice facilitators to assist practices in transforming into medical homes. PA SPREAD has also formed a Practice Facilitator Forum to bring together facilitators from across the state to learn from and support one another.

Section 4. Measurement Strategies

Monitoring the primary care system and primary care infrastructure is necessary for understanding the impacts of ongoing changes in health care coverage and financing, as well as what policy responses may be needed to ensure adequate access to high-quality primary care. This section provides suggestions on measurement strategies that can be used to monitor the impacts of specific policies to enhance primary care infrastructure, and performance of the primary care system more generally.

4.1 Monitoring the Impacts of Policies to Enhance Primary Care Infrastructure

In accordance with earlier sections of this paper, this section examines metrics that measure changes in payment policies and supports for primary care practice transformation. Table 1 summarizes metrics that may be useful for monitoring these aspects of policies to support and enhance primary care infrastructure. The measures focus on outcomes, rather than processes – in other words, they focus on measures of whether the policy goals are being achieved, rather than intermediate steps toward achieving them. The table also includes a list of potential data sources; since data availability varies by state, in some cases these metrics may require new data collection.

TABLE 1: MONITORING IMPACTS OF POLICIES TO SUPPORT PRIMARY CARE INFRASTRUCTURE

Measure	Level of Detail	Potential Data Sources
Changes in Payment Policies		
Primary care as a proportion of total spending	Total, Medicaid, and commercial (possibly by individual payer)	Medicaid reporting, health plan reporting, and/or All payer claims database (APCD)
Percent of enrollees in a recognized medical home model	Medicaid, commercial	Medicaid reporting, health plan reporting, and/or APCD
Adoption of innovative payment methodologies: percent of primary care spending that is not FFS	Medicaid, commercial	Medicaid reporting, health plan reporting
Supports for Primary Care Practice Transformation		
Private payer investments in primary care	By type of activity (e.g. EHR adoption,	Health plan reporting

TABLE 1: MONITORING IMPACTS OF POLICIES TO SUPPORT PRIMARY CARE INFRASTRUCTURE		
Measure	**Level of Detail**	**Potential Data Sources**
practice transformation	learning collaboratives)	
Proportion of primary care providers participating in medical home program	Provider types: Physicians, physician assistants, nurse practitioners	Medical home program, provider licensing surveys
Distribution of medical home providers by certification tier (if applicable)		Medical home program
Proportion of medical homes meeting EHR meaningful use standards		Medical home program
Proportion of medical homes participating in clinical information exchange		Medical home program

Changes in Payment Policies

As detailed in the discussion of policy options, a range of payment strategies is available to shift health care resources toward primary care and strengthen the primary care infrastructure. These include strategies such as increasing primary care payment rates, along with more fundamental payment reforms such as care coordination payments for patients receiving care in medical home models or shared savings models that emphasize better access to high-quality primary care services to reduce the need for high-cost, urgent services.

The measure for *primary care as a proportion of total spending* illustrates in a relatively simple way the growth in primary care spending compared to total spending, and serves as an overall measure of the resources being devoted to primary care vs. other types of services. Ideally, the numerator of this measure should include all payments to primary care providers, even those that may not be reported through an all-payer claims database (APCD) (e.g., quality performance payments). Although the denominator of this measure can be affected by factors unrelated to policies that promote primary care, nonetheless the measure provides a good "big picture" view of relative resources devoted to primary care. If the state chooses to pursue an approach similar to Rhode Island's model for holding commercial payers responsible for increasing their primary care spending, then the metric should be reported by individual commercial payers.[27] In addition to understanding the proportion of total spending that is primary care, measuring primary care spending that is taking place under innovative payment mechanisms will be of significant value to understanding system trends *(percent of primary care spending that is not FFS)*.

Supports for Primary Care Practice Transformation

Numerous strategies to support primary care practice transformation are being used by states, including the use of practice management consultants and practice facilitators, incentives, and support for adoption of electronic health records, learning collaboratives, and other strategies. The measures listed in Table 1 could be used to monitor the level of support for primary care practice transformation among

private payers, and more broadly progress toward achieving greater ability to provide care in a coordinated, efficient manner.

If states wish to monitor the degree to which private payers are investing in primary care practice transformation supports, a measure of resources devoted to this activity will be needed (*private payer investments in primary care practice transformation)*. States could also include separate measures by type of investment, such as support for EHRs, clinical information exchange, learning collaboratives, and other practice transformation activities. Another important policy goal is for clinics to build on and enhance their capabilities to provide medical home services to their populations over time; the *distribution of medical home providers by certification tier* measure would track the percentage of medical homes certified at various levels over time, to monitor progress toward enhanced primary care practice capabilities. Measures tracking the *proportion of medical homes meeting EHR meaningful use standards* and *proportion of medical homes participating in clinical information exchange* would assess progress toward making better use of health information technology to improve care.

4.2 Monitoring Primary Care System Performance

In addition to monitoring the impact of investments to strengthen states' primary care systems, state officials have an interest in monitoring the performance of the primary care system generally. Table 2 below summarizes potential metrics for monitoring primary care system performance. For most if not all of these measures, states can choose to monitor by region within the state. States that have APCDs may be particularly well-positioned to implement this type of monitoring.

TABLE 2: MONITORING PRIMARY CARE SYSTEM PERFORMANCE

Measure	Level of Detail	Potential Data Sources
Utilization		
Primary care visits / 1,000 population	Payer: Total, Medicare, Medicaid, commercial	APCD
New patient primary care visits/1,000 population	Payer: Total, Medicare, Medicaid, commercial	APCD
Primary care visits for those with chronic conditions / 1,000 population	Payer: Total, Medicare, Medicaid, commercial	APCD
Distribution of primary care services by provider type	Provider type: Physician, physician assistant, nurse practitioner Payer: Total, Medicare, Medicaid, commercial	APCD
Utilization per 1,000 population by type of service	Service type: Primary care, specialty care, inpatient hospital, ED, outpatient, and total utilization Payer: Total, Medicare, Medicaid, commercial	APCD

TABLE 2: MONITORING PRIMARY CARE SYSTEM PERFORMANCE		
Measure	**Level of Detail**	**Potential Data Sources**
Utilization for enrollees in medical homes compared to non-medical homes	Service type: Primary care, specialty care, inpatient hospital, ED, outpatient, and total utilization Payer: Total, Medicaid, and commercial	APCD
Cost		
Primary care as a proportion of total spending	Payer: Total, Medicare, Medicaid, commercial	APCD, possibly supplemented with new/existing reporting on non-FFS spending for Medicaid and commercial payers
PMPM spending by type of service	Service type: Total spending, primary care, specialty care, inpatient hospital, ED, outpatient hospital Payer: Total, Medicare, Medicaid, commercial	APCD, possibly supplemented with new/existing reporting on non-FFS spending
Distribution of primary care spending by provider type	Provider type: Physician, physician assistant, nurse practitioner Payer: Total, Medicare, Medicaid, commercial	APCD
Spending for enrollees in medical homes vs non-medical homes	Service type: Primary care, specialty care, inpatient hospital, ED, outpatient, and total spending Payer: Total, Medicare, Medicaid, commercial	APCD
Cost of potentially avoidable hospital admissions and ED visits	Payer: Total, Medicare, Medicaid, commercial	APCD
Access/Workforce		
Proportion of primary care providers accepting new patients	Provider type: Physicians, physician assistants, and nurse practitioners Payer: Medicare, Medicaid, Commercial	Provider licensing surveys
Percent of individuals with a usual source of care	Total population and by type of insurance	Household survey (state survey or federal survey such as National Health Interview Survey)
Type of place for usual source of care	Total population and by type of insurance	Household survey (state survey or federal survey such as National Health Interview Survey)

TABLE 2: MONITORING PRIMARY CARE SYSTEM PERFORMANCE		
Measure	**Level of Detail**	**Potential Data Sources**
Ability to get timely appointment	Total population and by type of insurance	Household survey (state survey or federal survey such as National Health Interview Survey)
Percent of population living in primary care shortage designation areas (HPSAs, MUAs, etc.)		Census Bureau, Health Resource and Services Administration (HRSA)
Quality		
Potentially preventable hospitalizations (PQI 90)	Payer: Total, Medicare, Medicaid, Commercial	APCD or hospital discharge data
Potentially preventable hospitalizations for certain acute conditions (PQI 91)	Payer: Total, Medicare, Medicaid, Commercial Composite measure for dehydration, bacterial pneumonia, and urinary tract infections	APCD or hospital discharge data
Potentially preventable hospitalizations for certain chronic conditions (PQI 92)	Payer: Total, Medicare, Medicaid, Commercial Composite measure for diabetes, congestive heart failure, hypertension, angina, chronic obstructive pulmonary disease, and asthma	APCD or hospital discharge data
Hospital readmissions	Payer: Total, Medicare, Medicaid, Commercial	APCD or hospital discharge data
Potentially preventable ED visits	Payer: Total, Medicare, Medicaid, Commercial	APCD or hospital discharge data
Preventive care	Payer: Total, Medicare, Medicaid, Commercial Examples: Well-child visits, immunizations, cancer screenings	APCD or HEDIS reports from individual health plans
Patient satisfaction		CAHPS surveys

Utilization of Health Services

One important aspect of monitoring primary care system performance is tracking trends in the utilization of primary care services, including trends in overall volume and by type of primary care provider. In addition to tracking primary care utilization overall *(primary care visits per 1,000 population)*, separately monitoring the rate of new patient visits *(new patient primary care visits per 1,000 population)* would be useful as a potential indicator of improved access to primary care services. Although the latter measure also captures people who change primary care providers, if this turnover is

relatively constant over time, then trends in the measure would represent shifts in access. An additional useful measure would be *primary care visits for those with chronic conditions*.

Monitoring utilization more generally by type of service *(utilization per 1,000 population by type of service)* would primarily be useful for comparing trends in primary care utilization to other types of service, and especially for understanding whether utilization of other services is increasing or decreasing with changes in primary care utilization. And finally, the measure *utilization for enrollees in medical homes compared to non-medical homes* will be useful in evaluating how the spread of the medical home model is influencing care patterns.

Cost

One goal of policies to invest in primary care infrastructure and promote greater use of primary care is to contain health care cost growth by providing services in less expensive settings when appropriate and avoiding expensive complications of conditions.

Similar to tracking utilization by type of service and in medical home vs non-medical home setting, it may be useful to track cost measures *(primary care as a proportion of total spending, PMPM spending by type of service, distribution of primary care spending by provider type* and *spending for enrollees in medical homes vs. non-medical homes)* that provide context for understanding shifts in patterns by type of service and by care delivery model. In addition, the measure for *cost of potentially avoidable hospital admissions and ED visits* provides an indicator of the potential savings from reduced rates of avoidable hospital admissions and ED visits, both of which are believed to be strongly associated with appropriate access to and use of primary care.

Access/Workforce

States working to expand access to health insurance coverage and promote care models that focus on primary care may want to measure whether the existing workforce can meet the demand for primary care services. For example, the measures for *proportion of primary care providers accepting new patients* and *ability to get timely appointment* serve as indicators of potential problems with patients' ability to access care. These measures may indicate potential capacity problems systemwide, but can also be used to monitor by payer type since access to providers is a particular concern for the Medicaid population.

Quality

The shift to a primary care-focused delivery model is intended to improve health care quality by reducing rates of unnecessary utilization and providing a more patient-centered focus on coordination and prevention.

Potentially preventable hospitalizations are hospital admissions that potentially could have been avoided with better access to high-quality outpatient care. The measures suggested in Table 2 are widely used metrics from the Agency for Healthcare Research and Quality's Prevention Quality Indicators measure set.[28] *Hospital readmissions* are frequently used to identify problems in accessing outpatient care, including primary care. The measure in Table 2 is the percentage of adult patients who had a hospital stay and were readmitted within 30 days of discharge. The measure for *potentially*

preventable ED visits in Table 2 uses a definition of avoidable ED visits developed by California's Medicaid program to identify problems that could have been managed within 24 hours at a primary care physician's office, a clinic, or other ambulatory setting.[29]

Although primary care plays a role in preventable hospitalizations, hospital readmissions, and preventable ED visits, these measures are not exclusively related to the quality of primary care. *Preventive care* measures such as rates of receipt of well-child visits, immunizations, and cancer screenings are direct measures of the degree to which primary care providers are performing recommended care. *Patient satisfaction* is also an important dimension of quality that should be monitored over time.

Conclusion

As described throughout this paper, many policy and measurement strategies exist to support greater multi-payer investment in states' primary care infrastructure. States can pursue strategies that are both compatible with existing systems and support their vision for the future. The anticipated end result is an enhanced primary care system that produces far-reaching and long-term benefits, including re-allocating dollars to more cost-effective health services and improving residents' health.

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[28] The measure for acute conditions includes dehydration, bacterial pneumonia, and urinary tract infections. The measure for chronic conditions includes diabetes, congestive heart failure, hypertension, angina, chronic obstructive pulmonary disease, and asthma.

[29] Another measure of potentially preventable ED visits that is often used is an algorithm developed at New York University that classifies visits based on degree of urgency and whether the condition was treatable in a primary care setting; however, the measure has many limitations including the fact that it is not clear whether it will be updated for the transition to ICD-10 coding later this year and therefore may not be usable in the near future. AHRQ is also testing a set of measures for potentially preventable ED visits, and so the range of methods for monitoring this utilization may expand in the future.