January **2018**

Creating Sustainability through Public-Private Partnerships: The Future of New Primary Care Models

ISSUE BRIEF

As the U.S. health care system places a growing emphasis on improving the value of health care, many states and the federal government have increasingly invested in primary care to improve health outcomes and lower health care costs. Unlike "traditional" primary care settings, newer primary care models strengthen primary care providers' role in expanding access to care and providing comprehensive, coordinated services to help improve patients' experiences. In recent years, states have used federal funding to test new approaches to primary care through Patient-Centered Medical Home (PCMH) and other such initiatives.

Many of these efforts were originally funded through time-limited Centers for Medicare and Medicaid Services (CMS) demonstration projects that encouraged or required commitments from commercial payers and/or state Medicaid programs. As these initial demonstration grant periods end, public-private partnerships and other creative funding approaches are emerging to continue and/or expand PCMH efforts. New leadership at CMS appears poised to move the focus toward local solutions and governance that leverage private sector partnerships.

This brief, developed with support from the Commonwealth Fund, describes the major elements of PCMH initiatives and sustainability efforts in four states—Michigan, Vermont, Colorado, and Arkansas. The efforts undertaken by these four states provide valuable learnings for all states considering the future of their own initiatives.

Key Elements of Patient-Centered Medical Home Efforts

In a PCMH model, team-based primary care focuses on improving access to care and coordinating care for patients with complex medical care and social support needs. PCMH efforts often employ care coordinators to assess and coordinate patient medical care and social support needs,[1] requiring investments to increase staff size and enhance data systems.[2]

[1] E. Rich, D. Lipson, J. Libersky, et al., "Organizing Care for Complex Patients in the Patient-Centered Medical Home," *Annals of Family Medicine*, Jan. 2012, 10(1): 60–62: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3262464/ (accessed 12/14/17).
[2] M. Magill, D. Ehrenberger, D. Scammon, et al., "The Cost of Sustaining a Patient-Centered Medical Home: Experience from 2 States," *Annals of Family Medicine*, Sep. 2015, 13(5): 429-35: https://www.ncbi.nlm.nih.gov/pubmed/26371263 (accessed 12/14/17).

The Center for Healthcare Research & Transformation (CHRT) at the University of Michigan is an independent 501(c)(3) impact organization with a mission to advance evidence-based care delivery, improve population health, and expand access to care.

Visit CHRT on the Web at:
www.chrt.org

Suggested citation: Foster Friedman, M.; Malouin, J.; Marriott, D.; Ndukwe, E.; Welch Marahar, M.; and Udow-Phillips, M. *Creating Sustainability through Public-Private Partnerships: The Future of New Primary Care Models.* Jan. 2018. Center for Healthcare Research & Transformation. Ann Arbor, MI.

PCMH efforts are expected to help achieve the Quadruple Aim: improving patient experience, increasing provider satisfaction, improving population health, and reducing health care costs.[3]

Some of these initiatives have demonstrated positive health outcomes, improvements in patient satisfaction, and reduced costs for certain populations. The literature remains mixed, but the preponderance of results to date suggests some positive results, including improved health outcomes such as better control of blood glucose and blood pressure levels, and increases in screening and immunization rates.[4] Additionally, some studies show improvements in patient satisfaction and reduced costs through reduced emergency department or urgent care visits, inpatient admissions, and hospital readmissions.[5,6]

Federal Support for PCMH Initiatives

The federal government has implemented several initiatives to test the efficiency and efficacy of PCMH models through the Centers for Medicare and Medicaid Services (CMS) and the Center for Medicare and Medicaid Innovation (CMMI). Some demonstrations centered on a single national primary care model implemented locally, such as the Comprehensive Primary Care (CPC) and Comprehensive Primary Care Plus (CPC+) initiatives. Others have emphasized flexibility in design and approach, such as the Multi-Payer Advanced Primary Care Practice (MAPCP) demonstration and some State Innovation Model awards (see *Figure 1*).

CMS has also encouraged or required commercial payers and state Medicaid programs to participate in these initiatives, recognizing the importance of multi-payer alignment to achieve the goals of primary care transformation. In 2017, CMS and CMMI changed agency leadership under President Trump. CMS Administrator Seema Verma has recently signaled her intent for CMMI to pursue new strategies to promote patient-centered care.

[3] T. Bodenheimer and C. Sinsky, "From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider," *Annals of Family Medicine*, Nov/Dec 2014 12(6): 573-576: https://www.ncbi.nlm.nih.gov/pubmed/25384822 (accessed 12/19/17).
[4] M. Nielsen, J. Nwando Olayiwola, P. Grundy, et al., *The Patient-Centered Medical Home's Impact on Cost & Quality: An Annual Update of the Evidence, 2012-2013* (Washington, D.C.: Patient-Centered Primary Care Collaborative, Jan. 2014): https://www.pcpcc.org/sites/default/files/resources/Executive%20Summary%20Only%20with%20Evidence.pdf (accessed 12/14/17).
[5] *Ibid.*
[6] L. Lebrun-Harris, L. Shi, J. Zhu, et al., "Effects of Patient-Centered Medical Home Attributes on Patients' Perceptions of Quality in Federally Supported Health Centers," *Annals of Family Medicine*, Nov. 2013, 11(6): 508–516: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3823721/ (accessed 12/14/17).

Figure 1: Elements of CMS PCMH Initiatives

	Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration	Comprehensive Primary Care (CPC) Initiative	Comprehensive Primary Care Plus (CPC+) Initiative		State Innovation Model (SIM) Awards
			Round 1	*Round 2*	
Timeline	2011-2014; extended through 2016 in 5 states	2012-2016	2017-2021	2018-2022	2013-2019
Regions	8 states	4 states, 3 metro regions	10 states, 4 metro regions	3 states, 1 metro region	34 states, 3 territories, and the District of Columbia
Participating Practices and Providers	Over 800 practices, over 6,000 providers	442 practices, 2,188 providers	2,816 practices, 13,090 providers	1,000 practices (expected)	Varies by state
Number of Participating Payers	4 to 9 payers per state	38	54	7	Varies by state
Types of Payers	Medicare, Medicaid, commercial payers	Medicare, Medicaid, commercial payers	Medicare, Medicaid, commercial payers		Medicaid, state employee plans, commercial payers (in some states)
Funding Structure	Per-member per-month (PMPM) payments or other equivalent funding models made to practices to support the delivery of patient-centered care.	Medicare: PMPM care management fee, opportunity for shared savings. Other payers: PMPM payments for care management.	Medicare: PMPM care management payments; payment incentives that must be repaid to CMS if certain quality metrics are not met. Other payers: PMPM payments for care management		Grants to states to implement and accelerate multi-payer, statewide health care delivery reforms, including PCMH models.

Impact of PCMH Initiatives

Initial evaluations of these multi-payer PCMH programs have shown some positive impacts. For example, the CPC Initiative showed improvements in delivering risk-stratified care management and expanding Medicare beneficiaries' access to care, as well as reducing hospitalizations and emergency department visits.[7] In the CPC Initiative, practices in Arkansas, Colorado, Oklahoma, and Oregon generated substantial Medicare cost-savings; in the MAPCP demonstration, Michigan and Vermont experienced statistically significant Medicare cost-savings.[8,9] However, the MAPCP demonstration also revealed the considerable time between transforming practices to implement PCMH elements to generating results. By the end of the initial three-year demonstration, many practices had only recently completed implementation and begun the actual work with patients that would demonstrate impact.[10] Given these positive outcomes but also recognizing that practice transformation takes time, many states have elected to continue their state-based, multi-payer primary care initiatives beyond the CMS-funded demonstration period.

Examples of State Approaches to PCMH Sustainability Beyond Demonstration Periods

States have explored different strategies to sustain primary care innovations beyond their initial demonstration. CHRT conducted interviews with leaders in four states—Michigan, Vermont, Colorado, and Arkansas—to understand the varying approaches to achieve PCMH sustainability. These states differ in terms of geography, population density, primary care workforce, and commercial insurance markets—factors that shape PCMH efforts in each state. While these states have pursued PCMH program sustainability in different ways, all four have found ways to continue funding PCMH initiatives. State summaries are below and more detailed descriptions of each state are included in *Appendix A*.

Michigan

Initial Pilot, Year and Funding Source	The **Michigan Primary Care Transformation Project (MiPCT)** launched in **2011**, funded as a MAPCP demonstration project. MAPCP was seen as an opportunity to bring commercial payers together to fund a common model of team-based care. Originally funded through 2014, MI extended MAPCP for 2 years, through 2016.
Payer Engagement	MiPCT leaders partnered closely with the Michigan Department of Health and Human Services (MDHHS), helping payers feel more committed to the program. MiPCT convinced commercial payers that MiPCT's efforts aligned with what payers were already funding, and promoted the additional federal funding available for PCMH through MAPCP.
Provider Engagement	Physician organizations played a convening role, participating in governance and decision-making. MiPCT held regional town hall meetings with physicians and care team members, and provided forums for physicians and care managers to train and to learn from other practices.
Current Status	MI received a **SIM Model Testing Award**, providing Medicaid support through 2019 of the SIM PCMH Initiative. Michigan also participates in the **CPC+ Initiative**. Two commercial payers fund the MiPCT care management model through a monthly billing code. Physician organizations in Michigan have continued to have leadership roles in PCMH efforts through CPC+ and SIM.

[7] D. Peikes, E. Fries Taylor, S. Dale, et al., *Evaluation of the Comprehensive Primary Care Initiative: Second Annual Report* (Washington, DC: Mathematica Policy Research, Apr. 2016): https://innovation.cms.gov/Files/reports/cpci-evalrpt2.pdf (accessed 12/14/17).
[8] *Ibid.*
[9] D. Nichols, S. Haber, M. Romaire, et al., *Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration: Final Report* (Research Triangle Park, NC and Washington, DC: RTI International, Urban Institute, and National Academy for State Health Policy, Jun. 2017): https://downloads.cms.gov/files/cmmi/mapcp-finalevalrpt.pdf (accessed 12/14/17).
[10] Nichols et al., 2017.

Vermont

Initial Pilot, Year and Funding Source	The **Blueprint for Health** launched in **2006**. The VT Legislature codified the Blueprint's framework in statute and mandated commercial payer participation. VT and several other states negotiated Medicare participation in PCMH initiatives, culminating in the creation of the MAPCP demonstration project.
Payer Engagement	Commercial payers were engaged at the outset, and recognized that health care cost growth was unsustainable. Commercial payer participation in the Blueprint is mandatory. Strong leadership and commitment from Blueprint staff, the State Legislature, and the state's executive branch held payers accountable.
Provider Engagement	The Blueprint's payment model enticed providers to join the program, and as the program evolved, additional support was given to practices in order to maintain provider participation. The Blueprint continually solicited feedback from providers and evolved program elements accordingly.
Current Status	After the end of the MAPCP demonstration in 2016, Vermont has opted to continue and expand its PCMH initiatives through a new **All-Payer ACO Model**. Accountable Care Organizations (ACOs) will receive risk-based payments from Medicare, Medicaid, and participating commercial payers to carry out the practice transformation and population health functions created by the Blueprint.

Colorado

Initial Pilot, Year and Funding Source	The **Colorado Multi-Payer Patient-Centered Medical Home Pilot**, launched in **2009**, was a three-year program with seven participating payers and sixteen primary care practices. HealthTeamWorks served as a convening partner.
Payer Engagement	HealthTeamWorks built on existing relationships with local payers to convince national payers of the value of the pilot. Framed the effort as a multi-payer approach. The role of the convening partner was key to build relationships, establish common goals, and induce collaboration. Leaders in CO recognized that payers needed to be supportive of the pilot before providers would agree to participate.
Provider Engagement	PMPM payments were provided to practices to build infrastructure, hire care managers and care coordinators, and invest in electronic health records (EHRs), reporting, and behavioral health requirements). Practices could earn bonus payments by reaching certain clinical and cost measures.
Current Status	CO participated in the **CPC Initiative**, allowing the state to build the infrastructure to produce better cost data and develop common metrics to reduce reporting burdens for practices. CO currently participates in the **CPC+ Initiative**. CO has also continued to advance PCMH efforts for its Medicaid population through the Colorado Medicaid **Accountable Care Collaborative (ACC)**. The ACC works to enroll Medicaid clients in a PCMH and provide more coordinated care for these clients. In its next phase, the ACC will integrate behavioral health and physical health benefits for its members.

Arkansas

Initial Pilot, Year and Funding Source	The **Arkansas Patient-Centered Medical Home Program** launched in **2013**. Arkansas set overall goals for improving primary care, and then applied for both CPC and SIM, receiving awards under both programs. The Arkansas Center for Health Improvement served as convening partner.
Payer Engagement	Major payers took a leadership role, encouraging commitment from other payers. Payer familiarity due to AR's relatively small size facilitated collaboration. The Arkansas Center for Health Improvement brought payers and providers together through learning sessions, aligning measures as much as possible. Standing meetings among payers keep lines of communication open.
Provider Engagement	Providers appeared to understand that new payment models were necessary for sustainability. AR engaged providers prior to the implementation of CPC by holding town halls that helped providers understand the need for this new approach, soliciting input on the PCMH model, and changing the model based on that feedback. AR's PCMH model received support from the Legislature, which was an important endorsement early in the model development process.
Current Status	Arkansas demonstrated cost-savings through the **CPC Initiative**, leading providers and payers to want to continue the program beyond its initial project period. Arkansas is currently participating in the **CPC+ Initiative**, continuing the PCMH initiatives it launched under CPC. This strategy allowed the state to avoid some of the challenges related to time-limited funding. By aligning multiple "puzzle pieces" to advance their overall strategy, the state has been able to transition relatively smoothly between CPC and CPC+.

New Directions for CMMI: What Does the Future Hold for PCMH?

Under the Trump Administration, CMS' new leadership has signaled significant changes in the agency's direction, including its approach to testing innovations in care delivery. In September 2017, CMS Administrator Seema Verma issued a request for information (RFI) to solicit input on CMMI's direction. In an accompanying op-ed, Verma spoke of the need to evaluate current CMMI programs "to determine what is working and should continue, and what isn't and shouldn't."[11] CMS intends to pursue eight areas of focus for CMMI moving forward: Advanced Alternative Payment Models (APMs), consumer and market-driven innovations, physician specialty models, prescription drug models, Medicare Advantage innovations, state and local innovations, mental and behavioral health models, and program integrity.[12] While the RFI did not explicitly mention PCMH models, the inclusion of a state and local area of focus may indicate CMS' ongoing interest in testing PCMH models.

As CMS considers CMMI's future direction, Medicare will likely continue to play a role in promoting primary care innovations. As the U.S. population ages and the number of Medicare beneficiaries grow, Medicare will face increasing demographic pressures over time. CMS will need to consider innovative avenues to address the needs and costs of these beneficiaries. Ongoing improvements in primary care, including elements of PCMH, are good policy levers for Medicare to produce greater value within primary care. While states must remain

[11] S. Verma, "Medicare and Medicaid Need Innovation," *Wall Street Journal,* September 19, 2017: https://www.wsj.com/articles/medicare-and-medicaid-need-innovation-1505862017 (accessed 12/14/17).
[12] Centers for Medicare & Medicaid Services: Innovation Center New Direction (Centers for Medicare and Medicaid Services request for information, Sep. 2017): https://innovation.cms.gov/Files/x/newdirection-rfi.pdf (accessed 12/14/17).

attuned to the rapidly changing political and policy environment, PCMH programs should remain focused on their mission, vision, and return on investment.

That said, the recent changes in CMS' leadership and approach to payment and delivery reforms may be creating some uncertainty among states, payers, and providers regarding the future direction of delivery system reform at the federal level. That uncertainty may already be impacting stakeholders' willingness to continue participating in PCMH initiatives. One interviewee discussed the substantial effort spent moving payers and providers from fee-for-service to new primary care models, noting that continued uncertainty could lead to burnout among payers and providers.

In the meantime, stakeholders across states have expressed a desire for CMMI to continue supporting state-led payment and delivery system reform efforts. In September 2016, CMMI released an RFI seeking input on potential future directions for the State Innovation Model. RFI responses indicated a need for CMMI to continue investing in state-driven innovations in care delivery and payment. As states move toward adopting alternative primary care payment models, CMMI can provide states with technical assistance to bolster data collection, analysis, measurement, and payment infrastructure. CMMI can also help states align existing multi-payer efforts with newer federal initiatives, such as the Quality Payment Program created under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), helping ensure that state-led multi-payer efforts meet these initiatives' criteria.

Next Steps: Lessons in Sustainability

Interviews with leaders in the four study states uncovered several key lessons that may be instructive to other states seeking to sustain new primary care models.

1. Timely, accessible and credible data at all levels is essential for sustainability.

States must demonstrate tangible, quantifiable, and reputable results of their PCMH efforts to encourage payers' continued support. While quality and satisfaction data are useful, payers rely on data showing financial sustainability. This means states must invest in building the data infrastructure necessary to obtain and use all the data needed to sustain PCMH programs.

Some states began discussing how to sustain PCMH efforts even in the absence of robust cost data. In Michigan, the MiPCT program had yet to obtain robust cost results as it planned for sustainability beyond MAPCP. Instead, MiPCT relied on utilization data and surveys of patients and providers to demonstrate value. MiPCT also presented payers with anecdotal success stories that illustrated large decreases in utilization and increases in patients' quality of life. However, securing payers and providers' commitment to sustainability was difficult until both felt comfortable that the model was financially sustainable. For commercial payers and CMS alike, financial results are important to commit to continued PCMH funding.

2. Ability to leverage time-limited funding opportunities is crucial to further overall goals.

States' willingness to actively partner with the federal government and continually demonstrate the value of PCMH models to both commercial and public payers has allowed states to piece together various funding sources to sustain PCMH efforts. For example, Vermont—which participated in the MAPCP demonstration—has continued actively engaging the federal government, and also successfully negotiated the All-Payer ACO Model to continue Medicare's participation in their PCMH efforts. Following MAPCP's end, Michigan leveraged funding through the SIM to continue Medicaid payments for PCMH, used CPC+ to continue Medicare payments, and secured continued commercial payer participation through billing codes to fund care management payments to practices. In the states studied, different demonstration projects fit

within an overall strategy for primary care transformation. This approach allowed states to use federal dollars provided by MAPCP, SIM, and CPC/CPC+ to advance their existing efforts. Diversifying funding streams can help states progress on PCMH concepts even as the specific funding sources change over time.

3. Robust, ongoing stakeholder engagement is vital to advance states' PCMH efforts.

For the four states in CHRT's analysis, a clear contributing factor to program success was early and ongoing input from those impacted by the program. Stakeholders need to both be involved in shaping PCMH programs and granted decision-making ability to generate and sustain their support. States should be willing to adapt their models based on this feedback, and should hold themselves accountable to stakeholders on issues important to them. In addition, PCMH initiatives in these states were successful in part because a convening entity united commercial payers around a common goal, convincing each to set aside individual interests for those of the broader initiative.

Securing stakeholder support early in the program development process and maintaining that support throughout implementation helped states make successful cases for sustaining their PCMH initiatives. In Arkansas, health care providers supported their PCMH model, in part because the state implemented the program using substantial provider feedback, and in part because the program demonstrated some cost savings. Had providers not already been supportive of the PCMH model that Arkansas built, there may have been less of a desire to continue the program past its initial pilot phase. While there is a recognized need to engage stakeholders meaningfully as PCMH programs are designed and implemented, these strategies can also help lay a strong foundation for sustainability.

4. Leadership of neutral convening entities and state partners is essential to PCMH sustainability.

A strong, neutral convening partner helps bring and keep everyone at the table. Those interviewed in each state noted the importance of a strong, dedicated, neutral entity to keep stakeholders engaged and supportive of the process, and to keep them "at the table" when they might have otherwise walked away. Colorado did not have a dominant insurer in the market, and needed buy-in from all payers in the state (including several national carriers) for their PCMH program to be successful. Colorado's convening organization had already developed partnerships with local carriers, but had to build relationships with national carriers to obtain their participation in the PCMH initiative. In this instance, the role of a convening partner was key to ensuring all major payers were participating in negotiations and committed to the model.

In addition, support from state legislatures and executive branches have contributed to PCMH sustainability. In Vermont, the Legislature's support for primary care transformation, as well as enshrining the Blueprint for Health framework in state statute,[13] has allowed Vermont's PCMH model to endure and evolve over time and has kept payers and providers participating in the program. Furthermore, state executive leadership has been essential in securing federal support for testing PCMH models. Governors in multiple states banded together to negotiate Medicare PCMH payments with the federal government and signed a common letter calling for Medicare participation in PCMH efforts, a crucial step in the creation of the MAPCP demonstration.

[13] H.861: An Act Relating to Health Care Affordability for Vermonters. Vermont General Assembly, Reg. Sess., 2005-2006. http://www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2006/acts/ACT191.htm

Conclusion

Recognizing the role of primary care in improving health outcomes, increasing patient satisfaction, and constraining health care costs, states have pursued various strategies to continue PCMH efforts that launched under time-limited demonstration projects. States have used a combination of public and private partnerships for sustainability. While states used federal funding opportunities such as the MAPCP demonstration and the CPC Initiative to launch PCMH programs, newer funding opportunities such as SIM and CPC+ are also promising vehicles for program sustainability. States continue to engage commercial payers, thus securing their continued financial support for PCMH initiatives as well. Factors critical to PCMH programs' overall success—such as strong, neutral program leadership, intensive stakeholder involvement, and the use of data to advance practice transformation—have also contributed to states' success in sustaining PCMH initiatives.

As CMS evaluates the success of CMMI primary care investments to date, the federal government's future role in primary care initiatives may shift to a greater focus on state- and locally-driven innovations. In this environment, some states are building public-private partnerships based on primary care interventions that produce demonstrable, quantifiable successes. Building durable partnerships with private and public payers is an important strategy for states to maintain new primary care models in changing political and policy climates.

Appendix A: Detail on State Approaches to PCMH Sustainability

Michigan

The Michigan Primary Care Transformation Project (MiPCT) launched in 2011 when CMS selected Michigan to participate in the MAPCP demonstration project. Prior to MiPCT's inception, some commercial payers in the state (e.g., Blue Cross Blue Shield of Michigan, Priority Health) had implemented PCMH pilots. Having already piloted care management efforts, leaders in Michigan viewed MAPCP as an opportunity to bring commercial payers together to fund a common model of team-based care.

From the outset, MiPCT worked with commercial payers in the state to articulate a vision for transformed primary care that included participation of all payers. As the state prepared its MAPCP application, they highlighted the additional federal funding that would come to the state to fund PCMH efforts. MiPCT leaders partnered closely with leaders within Michigan Department of Health and Human Services (MDHHS), which helped payers feel the need to be responsive to the program. MiPCT also worked to convince commercial payers that their efforts aligned with what payers were already funding. Ultimately, three of the largest commercial payers in the state joined Medicaid and Medicare as participating payers in MiPCT: Blue Cross Blue Shield of Michigan, Blue Care Network, and Priority Health.

MiPCT's provider engagement efforts were facilitated by a general understanding among providers of the value of multi-payer transformation. MiPCT held regional town hall meetings with physicians and care team members across the state to discuss the program and obtain their support. MiPCT focused heavily on engagement at the practice level in the program's early stages. At the time, few practices were familiar with embedded care managers, so MiPCT provided forums for physicians and their care managers that provided training and opportunities to learn from other practices. In addition, physician organizations played an important convening role and participated in MiPCT governance and decision-making, an arrangement that is somewhat unique to Michigan. Physician organizations in Michigan have continued to have leadership roles in PCMH efforts through CPC+ and SIM.

The state of Michigan has leveraged funding from other federal programs to continue the PCMH efforts launched under the MAPCP. However, while leaders in Michigan recognized the value of the activities launched in MiPCT, continued funding was uncertain until shortly before the MAPCP demonstration ended. CMS initially agreed to extend MAPCP funding for an additional two years beyond its initial three-year period. During this time, MiPCT worked to secure commitments from commercial payers to continue to fund the MiPCT care management model through a series of encounter-based billing codes. Two of MiPCT's three commercial payers (BCBSM and Priority Health) agreed to continue funding PCMH-designated practices through these billing codes.

Michigan has secured several federal grants to continue Medicare and Medicaid support for PCMH initiatives. Toward the end of the extended MAPCP project period, MDHHS received a SIM Model Testing Award, which provides the state $70 million in federal funding from 2016 to 2019. The SIM PCMH Initiative is one of the three pillars of Michigan's State Innovation Model. Practices that participated in MiPCT were invited to participate in the SIM PCMH Initiative, along with PCMH practices in the state's five SIM Community Health Innovation Regions. The SIM PCMH Initiative continues many of the elements present in MiPCT, such as 24/7 access to a clinical decision-maker. This is an intentional feature, as early in the state's SIM application process, MiPCT and MDHHS determined which MiPCT program elements to carry over into the SIM PCMH Initiative. This provides continuity from program to program for participating practices, making the transition between initiatives somewhat easier to manage. The SIM PCMH Initiative extends Medicaid's participation in

PCMH efforts in the state, with the state providing participating practices PMPM payments for practice transformation, and care management and coordination. Eleven Medicaid health plans participate in the initiative.

In addition, Michigan participates in the CPC+ Initiative, which has created an additional cohort of practices engaged in PCMH efforts. Though leaders had originally hoped there would be a greater number of practices participating in both programs, only about 100 practices are currently part of both. State leaders had hoped that the two programs would contain similar participation requirements, but there is variation MDHHS's approach to administering the SIM PCMH Initiative and CMS' approach to administering CPC+.

Vermont

Launched on a limited geographic scale in 2006, Vermont's Blueprint for Health was one of the earliest state-led PCMH initiatives in the nation. The Blueprint was conceived as a vehicle to drive broad delivery system reform and innovation in the state, beginning with patient-centered medical homes as a primary component of the program. The Vermont Legislature codified the Blueprint's framework in statute and set out the program's participation expectations; while Blueprint participation for health care providers is optional, commercial payers in the state are required to participate and fund practice transformation payments. In addition to setting the state's vision for primary care and demonstrating the state's commitment to advancing delivery system reform, the Blueprint's enabling legislation also ensured it remained a multi-payer initiative. All three commercial payers in Vermont participate in the Blueprint: Blue Cross Blue Shield of Vermont, Cigna, and MVP. Vermont Medicaid has also participated from the Blueprint's inception.

Vermont has taken a proactive approach to securing federal support for their PCMH efforts. Following its initial pilot period, Vermont worked with several other states to negotiate Medicare participation in PCMH initiatives. These negotiation efforts led to the creation of the MAPCP demonstration project, which was a transformative program for the Blueprint. Securing Medicare participation in PCMH payments to practices allowed Vermont to scale up the Blueprint from a geographically-limited pilot to a statewide program, and encouraged additional providers to join the program.

After the MAPCP demonstration ended in 2016, Vermont has opted to continue and expand its PCMH initiatives through a new All-Payer ACO Model. Vermont negotiated this model with CMS to ensure continued Medicare participation in the state's PCMH efforts. Under the All-Payer ACO Model, Accountable Care Organizations (ACOs) will receive risk-based payments from Medicare, Medicaid, and participating commercial payers to carry out the practice transformation and population health functions created by the Blueprint. While the Blueprint's major concepts will be carried out through the All-Payer ACO Model, state officials who CHRT interviewed categorized the All-Payer ACO Model as a provider-driven model, compared to the state-driven approach of the Blueprint. The state's role in leading PCMH efforts has changed as the program model has evolved in Vermont. As PCMH efforts mature, the ACO model may be one approach to ensuring providers remain engaged and committed to participation in these reforms.

In Vermont, strong leadership and commitment from Blueprint staff, the State Legislature, and the state's executive branch contributed to successful efforts to gather and maintain payer and provider participation in the Blueprint. In Vermont, commercial payers were engaged at the outset. Payers recognized that health care cost growth was unsustainable and joined the state government to discuss ideas to improve health and control costs. The Blueprint's payment model enticed providers to join the program, and as the program evolved, practices received additional support to maintain provider participation. The Blueprint continually solicited feedback from both payers and providers, and evolved the program accordingly.

In Vermont, federal funding through the MAPCP demonstration and the SIM has allowed the state to expand the reach of their PCMH initiatives and test new approaches to population health. Vermont has leveraged these time-limited funding opportunities to further their overall delivery system reform goals. The Legislature's commitment to the Blueprint's goals has been an enabling factor throughout this process, as PCMH initiatives have consistently received bipartisan support.

Colorado

Launched in 2009, the Colorado Multi-Payer Patient-Centered Medical Home Pilot was a three-year program with seven participating payers: five commercial payers, Colorado Medicaid, and the state's high-risk pool. The pilot was limited to 16 primary care practices across the state. HealthTeamWorks served as a convening partner for the pilot and provided practice transformation support, learning collaboratives, and practice coaching to participating providers. Practices received PMPM payments to build infrastructure, hire care managers and care coordinators, and invest in EHRs, reporting, and behavioral health requirements. In addition, practices who achieved certain clinical and cost measures received bonus payments.

Leaders in Colorado recognized that payers needed to be supportive of the pilot before providers would agree to participate. HealthTeamWorks had already built relationships with local payers, but had to work to convince national payers of the pilot's value. UnitedHealthcare and Anthem-Wellpoint committed to the concept early, allowing program leadership to frame the effort as a multi-payer approach. In Colorado, no one payer dominates the commercial health insurance market, so all payers in the state needed to participate for the pilot to succeed. This reinforced the importance of the convening partner in building relationships with stakeholders, developing common goals, and convincing payers to work together to achieve those goals.

Stakeholders discussed the PCMS pilot's sustainability from its inception, but obtaining useable cost data proved challenging. Ultimately, the pilot had to choose a different method to pay practices based on costs. In addition, each participating payer aggregated and reported data differently, complicating efforts to combine cost data across payers. However, the pilot was able to use quality, claims, and clinical data to track progress.

After the initial pilot ended, the state continued and expanded PCMH efforts through various initiatives, including the Colorado Medicaid Accountable Care Collaborative (ACC), CPC/CPC+, and the Colorado Medical Home Initiative. According to one interviewee, the state's desire to participate in the CPC Initiative and the possibility of Medicare participation helped bring stakeholders back to the negotiating table after the pilot ended. This presented challenges, as the state had to restart its stakeholder engagement process with a new set of stakeholders (and interests) that had not been engaged with the initial pilot.

CPC participants in Colorado continued to build upon the PCMH model used in the initial pilot, and stakeholders worked to apply lessons learned in the PCMH pilot to the CPC model. Because the initial pilot had experienced challenges in obtaining cost data, a large focus of Colorado's CPC work was building the infrastructure needed to produce useable data. Payers worked to develop a database that combined reports from practices with data from both Medicare and commercial payers, allowing for better cost data than in the initial pilot. In addition, payers developed common metrics in an attempt to reduce reporting burdens for participating practices. Colorado has also continued to advance PCMH efforts for its Medicaid population through the Colorado Medicaid Accountable Care Collaborative (ACC). The ACC enrolls Medicaid clients in a PCMH and provides coordinated care for these clients, including through the planned integration of behavioral health and physical health benefits.

Arkansas

Arkansas has used multiple vehicles to expand upon previous delivery system initiatives and achieve overall goals of improving the primary care workforce. Prior to the Arkansas PCMH Program's launch in 2013, Arkansas had deficiencies in its primary care workforce and a lack of access to primary care. In addition, demographic pressures revealed that the state's existing payment models were unsustainable and that new approaches to health care delivery were needed. These external pressures contributed to a general sense that it was the right time for the state to explore new approaches to primary care. Seeing a need for more primary care providers, particularly in rural areas of the state, Arkansas began holding conversations around providing financial incentives to primary care providers.

Arkansas has taken a proactive approach to securing funding for PCMH initiatives. According to state leaders, Arkansas set overall goals for improving primary care, and then used multiple funding streams to help achieve those goals. Arkansas applied for both CPC and SIM, and received awards under both programs. CPC was primarily seen as a program for the Medicare population, so the state began to build opportunities for all providers, not just those with large Medicare patient panels, to receive financial incentives. Arkansas' SIM application was the impetus for the Arkansas Center for Health Improvement to convene commercial payers to align efforts. Arkansas is currently participating in Round One of CPC+, continuing the PCMH initiatives it launched under CPC. This strategy allowed the state to avoid some of the challenges related to time-limited funding. By aligning multiple "puzzle pieces" to advance their overall strategy, the state has undergone a relatively smooth transition between CPC and CPC+.

Arkansas engaged providers before implementing CPC by holding town halls to help providers understand the need for this new approach, soliciting input on the PCMH model, and changing the model based on that feedback. Arkansas' PCMH model received broad support, including from the Legislature, which was an important endorsement early in the model development process. Providers appeared to understand that new payment models were necessary for sustainability. In 2014, the program demonstrated Medicare cost savings, and in 2015, the program was able to provide shared savings back to primary care providers. This led to an increase in participating providers in the program. Because Arkansas was able to demonstrate cost slowdowns and cost-savings, providers and payers both expressed a desire to continue the program beyond its initial project period.

In Arkansas, a multi-payer approach was natural. Arkansas Medicaid and BCBS of Arkansas assume an early leadership role, helping encourage other payers to commit to the model. Arkansas' relatively small population helped to facilitate this process, since all payers knew and worked with each other. The convening partner, the Arkansas Center for Health Improvement, focused on bringing payers and providers together through learning sessions, where the two groups could build good working relationships and providers could speak with payers directly. In addition, payers have attempted to align measures, care plans, and other requirements as much as possible. Standing meetings among payers serve as a means to keep lines of communication open.

Center for Healthcare Research & Transformation
2929 Plymouth Road, Suite 245 • Ann Arbor, MI 48105-3206
Phone: 734-998-7555 • chrt-info@umich.edu • www.chrt.org

Acknowledgments: The staff at the Center for Healthcare Research & Transformation would like to thank the Commonwealth Fund for its support of the development of this brief, as well as all the state experts interviewed for the brief.