



Aligning Payers and Practices to Transform Primary Care:

A Report from the Multi-State Collaborative

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Foreword

Since 2009, the Milbank Memorial Fund (MMF) has provided support to state leaders committed to transforming primary care. Several of these states had been working on their own versions of primary care transformation initiatives and sought to share with one another the experience of their states' efforts in lowering the cost of health care and improving its quality by transforming their primary care delivery systems. The premise behind these initiatives was that providing primary care that is accessible and effective is essential to improving population health and reducing costs—but only if changes to the primary care delivery system include payment reform across all payers. The group, which took the name Multi-State Collaborative (MC) in 2010, is essentially a “collaborative of collaboratives,” bringing together state initiatives that were themselves collaborative.

Working with states on primary care transformation is the kind of work that the MMF likes to support. The evidence on the value of primary care is strong, and the projects under way in the states are beginning to generate some significant positive outcomes. An endowed operating foundation that works to improve the health of populations by connecting leaders and decision makers with the best available evidence and experience, the MMF engages in nonpartisan analysis, collaboration, and communication on significant issues in health policy.

The collaborative nature of the initiatives was also in keeping with the kind of efforts we often support. With complex problems, effective policies and programs are more likely to emerge when individuals and groups work together collaboratively. This is true of the challenge of transforming primary care—both within states and across the country. The participating states had much to gain by working together—learning and making progress faster.

The MC is now poised to make the case that primary care transformation and state-convened multi-payer efforts are vital to improving the performance of health care delivery in the United States. The purpose of this report is to document the efforts of these collaboratives as they work toward their ambitious goals, including how they have addressed fundamental questions of organization, purpose, and priorities.

The report begins with a description of the logic model and the eight components of primary care transformation that the initiatives have identified as essential for success followed by a brief history of the MC. The report then describes the methods of the study and its findings, which include the characteristics of governance structure and project management for the state collaboratives as well as details about how the responding member states have implemented the eight components of primary care transformation in their efforts to effect change. The report concludes with lessons learned from the MC experience to date.

The implementation of the Affordable Care Act has focused much attention on insurance provisions, but the real challenges and opportunities for health reform lie in improving the performance of the medical care delivery system. Such efforts must address

many challenges, including the two taken on by MC participants—the fundamental devaluing of primary care in medical care financing and the multi-payer system in the United States, both of which make it difficult to set up sufficient economic incentives for privately organized providers. The MMF believes that addressing such challenges will happen only with public policies that focus on multi-stakeholder alignment. The lessons captured here by these pioneering efforts are instructive for collective efforts to build more sustainable health care systems in the future.

I would like to thank the members of the MC for their efforts, which are the focus of this report, and for their vision of improving the health of our communities.

Christopher F. Koller
President, Milbank Memorial Fund

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Introduction

Since the mid-2000s, a number of states have developed and implemented initiatives to transform their primary care delivery systems in order to improve the health of their populations and reduce costs. These initiatives bring together health care providers and payers in collaborative efforts to implement patient-centered medical homes and promote payment reform by aligning incentives across all payers. What the states have learned from their experiences is that primary care transformation can only be achieved through change to both systems—organizing and paying for care.

This report describes how the states went about transforming primary care and the factors that shaped their efforts. It offers lessons learned that could help guide similar efforts in other states. The report is based on a 2013 survey of members of the Multi-State Collaborative (MC), a voluntary group composed of representatives of state-based primary care initiatives that are themselves collaborative. With support from the Milbank Memorial Fund (MMF) since 2009, the MC has provided a forum for its members to share data, participate in collaborative learning, and advocate for improved collaboration between the states and the federal government on primary care transformation. By the spring of 2014, the MC included 17 states, six more than when the survey that is the basis for this report was conducted. New states have joined the group each year as evidence of the effectiveness of these primary care transformation initiatives has grown and members report the benefits of sharing information with their peers.

The report begins with the principles underlying state-based primary care transformation initiatives and a brief history of the MC. It then describes the methods and findings of a 2013 observational study of MC states, based on a survey and interviews with MC leaders. The study looks at the similarities and differences in the activities of each of the state initiatives within eight categories, which are outlined in the section that follows. The report concludes with lessons learned, followed by an appendix, notes, and a list of resources.

The findings in this report have implications for primary care transformation efforts, in particular, and, more generally, for state-convened provider payment reform initiatives. The report was developed to inform many stakeholder groups—from legislators and regulatory authorities to providers and payers. It can also shed light on the process of state-convened reform initiatives for other collaborative groups, physicians, primary care practices and associations, and businesses.

STATE-BASED PRIMARY CARE TRANSFORMATION INITIATIVES

In the mid-2000s, states became interested in primary care transformation because of the growing evidence that primary care is central to a high-performing health system and the improved health of a population.¹

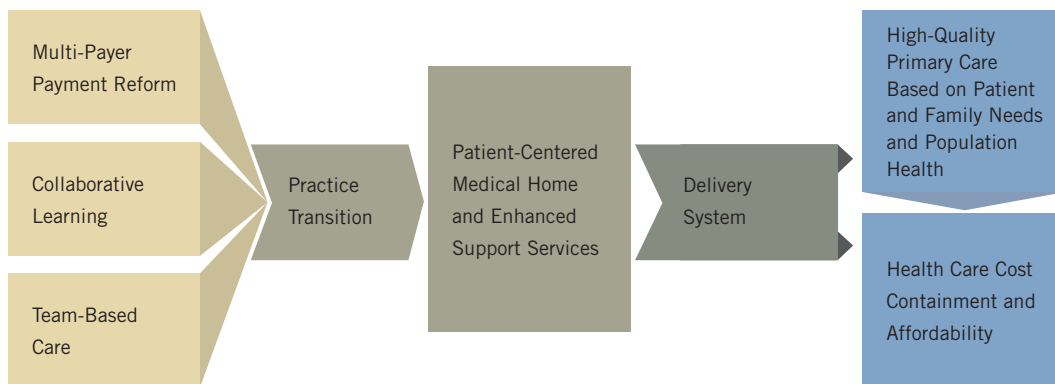
The patient-centered medical home (PCMH) was at the core of the work. First introduced by the American Academy of Pediatrics in the 1960s, the PCMH has been

adopted by providers, professional societies, and payers in the public and private sectors as a model for primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.^{2,3} With the PCMH, patients are expected to receive integrated support services in a wide range of fields, including behavioral and mental health, substance abuse and addiction treatment, nutrition guidance, health coaching, targeted disease management, links to social and economic services, self-management opportunities, and coordination of referrals and transitions of care. The PCMH also aspires to provide for the accurate and timely transfer of clinical information, promotes payment incentives aligned with quality (in sharp contrast to volume-based fee-for-service), and builds the capacity to achieve measurable outcomes that address population health within the primary care practice and community-based resources.

Beginning in about 2005, multi-payer initiatives intended to transform primary care began to take form in the states. Although the specifics of the states' collaborative initiatives differed, each initiative was based on the following principles:

- Health care cost containment (and therefore affordability) cannot be achieved without delivery system transformation across multiple aligned payers.
- Delivery system transformation is predicated upon access to high-quality primary care and supporting services.
- High-quality primary care is more likely to occur in a consistently supported and formally recognized PCMH setting.
- The creation and nurturing of primary care transformation can only be successful in a uniformly applied multi-payer model coupled with collaborative learning and team-based care.

Figure 1
Logic Model



As the state initiatives matured, they each had—in addition to a broad commitment to primary care transformation—activities in place that could be categorized as having the following eight components:

COMPONENT 1. INNOVATIVE PAYMENT REFORMS TO SUPPORT PRIMARY CARE

Much of the weakening of the US primary care infrastructure can be attributed to a fee-for-service payment structure that places a higher value on procedures and visits than the services needed to keep populations healthy.

COMPONENT 2. MULTIPLE PAYER PARTICIPATION

Coordinated multi-payer actions are far better positioned to send sufficiently strong economic signals to health care providers to change behaviors.

COMPONENT 3. STATE GOVERNMENT CONVENING ROLE

States have broad responsibilities and are in unique positions to align payers and to convene and coordinate many stakeholders, as well as to encourage their participation.

COMPONENT 4. STANDARDS FOR PCMH IDENTIFICATION

Objective, agreed-to structural and process standards for transformed primary care are critical for accountability.

COMPONENT 5. NEW STAFFING MODELS FOR TEAM-BASED PRIMARY CARE

Holding primary care practices responsible for the health of populations, not merely satisfactory patient encounters, requires supplemental staffing, greater coordination of activities, and redefined roles for each team member.

COMPONENT 6. TECHNICAL ASSISTANCE TO PRACTICE SITES

Money, staffing, and standards are not enough. To change operations in practice sites—and ultimately behavior—requires guidance, coaching, and reinforcement from experts.

COMPONENT 7. COMMON MEASUREMENT OF PERFORMANCE

Also critical for improvement are accepted measures of performance—and performance that is measured frequently, reliably, and transparently.

COMPONENT 8. COLLABORATIVE LEARNING

There is not a competitive market for primary care. Most practices are not competing for market share, and the health of individuals and populations is not a service to be bought. The goal of transformed primary care is great—improved population

health—and will not be attained with a market-driven model. Participating primary care practices in these initiatives commit to learning from one another about how to improve.

HISTORY OF THE MULTI-STATE COLLABORATIVE

The group that would become the MC began in 2009 when five New England states—Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont—sought ways to share with one another their states’ experiences in transforming their primary care delivery systems. The MMF provided support for a meeting of the group, which described itself as a “collaborative of collaboratives.” Discussion at this early meeting revealed a common set of concerns—from how to engage a broad range of partners (health care providers, payers, state government, foundations) to the need for accurate, timely, accessible, and useful data for evaluating patient care and provider effectiveness. The members were especially interested in getting the Centers for Medicare & Medicaid Services (CMS) to participate in their state-based multi-payer initiatives by sharing Medicare data—a notable gap in their efforts to align the compensation offered by all insurers to primary care providers. Following the meeting, members of the group drafted a letter to CMS requesting Medicare’s participation, which each state’s governor signed.

On September 16, 2009, Health and Human Services Secretary Kathleen Sebelius, Vermont Governor and chair of the National Governors Association James Douglas, and White House Office of Health Reform Director Nancy-Ann DeParle announced that CMS would establish a demonstration program that would enable Medicare to join Medicaid and private insurers in innovative state-based primary care initiatives. The new Medicare-Medicaid Advanced Practice Primary Care Demonstration (APC) sought applications from states that had already established Advanced Primary Care models (patient-centered medical homes) that included both their Medicaid program and private payers.⁴

Passage of the Affordable Care Act (ACA) in March 2010 reinforced and expanded opportunities for state and federal collaboration on primary care system transformation. In June, CMS announced the Multi-Payer Advanced Primary Care Practice (MAPCP) demonstration, which replaced the earlier announced APC demonstration. CMS said it would select six states that were currently conducting multi-payer reform initiatives to participate in an evaluation of the effects of advanced primary care practice on health care quality and cost.⁵ The members of the MC decided to advocate for CMS to select the MC as a single MAPCP awardee or, alternatively, to expand the number of awardees. MC members met with then CMS Administrator Donald Berwick in September and October 2010 to make the case that selecting the MC as a single awardee would help ensure the success of the demonstration in yielding useful information. CMS did not select the MC as a single entity but expanded the number of awards, with most of them going to MC member states.

In 2011, CMS began a different demonstration project, the Comprehensive Primary Care (CPC) initiative. The MC's membership grew in 2011 with the addition of Colorado, a state engaged in the CPC initiative.

With staff and financial support from the MMF, the MC has continued to share data and learning on issues related to primary care transformation and to advocate with CMS about improving collaboration between the states and federal government. By the spring of 2014, the MC included 17 states. New states have joined the group each year as evidence of the effectiveness of these primary care transformation initiatives has grown and members report the benefits of sharing information with their peers.

At an MMF-convened meeting in April 2014, MC members shared their state's data and the challenges of data collection and discussed ways to gain early access to data from federally funded evaluations of the demonstration projects. Members of the MC continue to share information on data benchmarking, sustainability models, and best practices.

Federal Programs That Support States Working on Primary Care Transformation and Payment Reform

Following passage of the Affordable Care Act (ACA) in March 2010, the Centers for Medicare & Medicaid Services (CMS) announced new initiatives for working with states on primary care transformation.

CMS INNOVATION CENTER

Created by the ACA, the Center for Medicare & Medicaid Innovation (the Innovation Center) (formerly CMMI) supports the development and testing of innovative health care payment and service delivery models that save money for Medicare, Medicaid, and Children's Health Insurance Program beneficiaries while improving coordination of care and health outcomes.

MULTI-PAYER ADVANCED PRIMARY CARE PRACTICE (MAPCP) DEMONSTRATION

One of the first initiatives to be announced as part of the ACA in 2010 was the Multi-Payer Advanced Primary Care Practice (MAPCP) demonstration, which replaced the earlier APC demonstration. The MAPCP demonstration was a three-year project conducted with eight states (ME, VT, RI, NY, PA, NC, MI, and MN) that tested the impact of providing broad-based financial support from all major payers to facilitate the transformation of primary care practices into "medical homes." Medicare participation started in state programs in VT, NY, RI, NC, and MI in 2011, followed by ME, PA, and MN in 2012.

STATE INNOVATION MODELS (SIM) INITIATIVE

The State Innovation Models (SIM) Initiative, an initiative of the CMS Innovation Center, provides support to states for the development and testing of state-based models for multi-payer payment and health care delivery system transformation with the aim of improving health system performance. States that receive funding are referred to as SIM states. In 2013, CMS awarded funding to 25 states to design or test improvements to their payment or delivery system. In May 2014, CMS announced it would fund an additional 15 “model design” and 12 “model test” projects.

COMPREHENSIVE PRIMARY CARE (CPC) INITIATIVE

In 2011, the CMS Innovation Center began its Comprehensive Primary Care (CPC) initiative, a multi-payer initiative that fosters collaboration between public and private health care payers to strengthen primary care. As part of the initiative, Medicare works with commercial and state health insurance plans and provides participating primary care practices with resources to better coordinate primary care for their Medicare patients. There were 497 participating sites across the country in 2014.

Table 1 lists the MC members as of December 2013 and their participation in CMS multi-payer demonstrations.⁶

Table 1
MC Members as of December 2013

MC Member	MAPCP Multi-Payer Advanced Primary Care Practice Demonstration Participant	CPC Comprehensive Primary Care Initiative Demonstration Participant
Colorado		○
Maine	○	
Massachusetts		
Michigan	○	
Minnesota	○	
New Hampshire (no initiative yet)		
New York (Adirondack region)	○	
(Mid-Hudson region)		○
North Carolina	○	
Pennsylvania	○	
Rhode Island	○	
Vermont	○	

Study Methods

This descriptive study of the work of the MC is based on information gathered through an electronic survey conducted during the summer of 2013 and through structured interviews with leaders and implementation directors of the MC initiatives conducted during the fall of 2013. The aggregated results and additional comments are presented in a combined format in this report to give a fuller picture of these complex and often unique programs.

ELECTRONIC SURVEY: Representatives of several lead MC state initiatives designed the survey, which was completed by 10 of 11 MC members, a 91% response rate. It is important to note that the participating staff members were in some cases appointed state officials. With a change in administration following elections came a change (and sometimes absence) in representation to the MC, resulting in a decreased capacity to participate.

The members of the MC provided ongoing input into the areas of highest interest to survey, as well as into the interpretation and display of the aggregate results. Discussions occurred at MMF-supported meetings, through electronic correspondence, and on multiple conference calls.

The electronic survey elements fell into the following categories:

1. GOVERNANCE AND POLICY LEVERS

- a. Origin of initiative
- b. Lead conveners
 - i. Outreach
 - ii. Accountability

2. FUNDING

- a. Participating insurers in the initiative
- b. Populations with access to PCMH through the initiative
- c. Percentage of initiative population covered by each insurer
- d. Provider payment mechanism in the initiative
 - i. Additional financial incentives
- e. Funding for additional activities, program support, and infrastructure
 - i. Support services linked to payment reform
 - (1). Services provided
 - (2). Staffing structure and payment mechanisms
 - ii. Health information exchange (HIE) development or expansion
 - iii. Practice transformation through facilitation and coaching
 - iv. Implementation team and program operations

3. EVALUATION AND QUALITY IMPROVEMENT

STRUCTURED INTERVIEWS: Information about the MC initiatives also came from interviews with leaders of the member states. More than 30 individuals were interviewed,

representing state agencies including Medicaid and Departments of Public Health and Human Services, health reform implementation officials, primary care practitioners, commercial insurers, academics, and private consultants. Information gathered through this approach complemented and expanded on the data collected in the electronic survey. The complete interview questions are in the Appendix.

The interview topic areas included the following:

INTERNAL PROGRAM ATTRIBUTES

- Engagement strategies
- Payment “transparency”
- “Transformation” activity support
- Internal challenges
- Availability and reliability of outcomes data
- Governance summary

EXTERNAL INTERACTIONS

- CMS (MAPCP or CPC demonstrations)
- The MC

Study Findings

This report provides a unique opportunity to observe primary care transformation across a wide range of settings. While MC initiatives were early in their implementation at the time of the survey, general conclusions can be drawn about the efficacy of certain programmatic decisions. Preliminary assessments—using the electronic survey data as the vehicle and enhanced information from individual interviews as descriptors—are summarized in this section. In addition, several of the MC programs have been written about in industry and peer-reviewed literature in recent years, and these publications are cited in this section.

GOVERNANCE STRUCTURE AND PROJECT MANAGEMENT

OVERVIEW

Governance, defined for the purpose of this report, is how institutions conduct public affairs and manage resources. It can apply to corporate, national, state, and local entities, or to the interactions between them and other stakeholders. The United Nations defines good governance as having the following major characteristics: it is “participatory, consensus oriented, accountable, transparent, responsive, effective and efficient, equitable and inclusive and follows the rule of law.”⁷ The MC members generally used these principles as they developed and implemented their programs.

The trigger for implementation varied. Some states, like Minnesota with its Health Care Home legislation, passed health reform requiring the development of the PCMH and payment reform. For others, such as Rhode Island, a regulatory authority authorized the PCMH and payment reform. Respondents were equally divided between legislative and regulatory implementation.

An examination of the development, leadership, and maintenance of primary care transformation initiatives led to an understanding of the effect that governance had on the success of individual programs. The survey delineated sites of origin, implementation, support, and accountability.

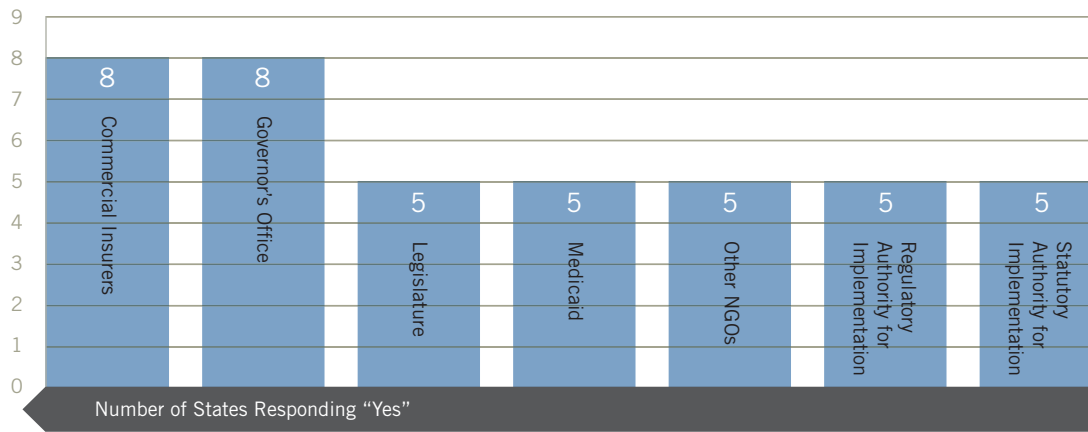
Interviews with leaders and published reports about member states’ experiences underscored the need for clear and central leadership in state government. While commercial insurers often played a large role in the pilot phase, there was a consistent case made for centralized state leadership over the long term.

ORIGIN OF INITIATIVE

In many of the MC state initiatives, multiple efforts to establish payment reform and the PCMH were in place when these initiatives first developed, only later to become more centrally organized. While 80% of initiatives began with the governor’s office, creating

credibility from the highest level of state governmental authority, there were multiple centers of origin (Figure 2). The identification of one or more commercial insurers reflected the innovation and perhaps nimbleness that private entities brought to a new program.

Figure 2
Origin of Initiative



Lead Conveners—Outreach

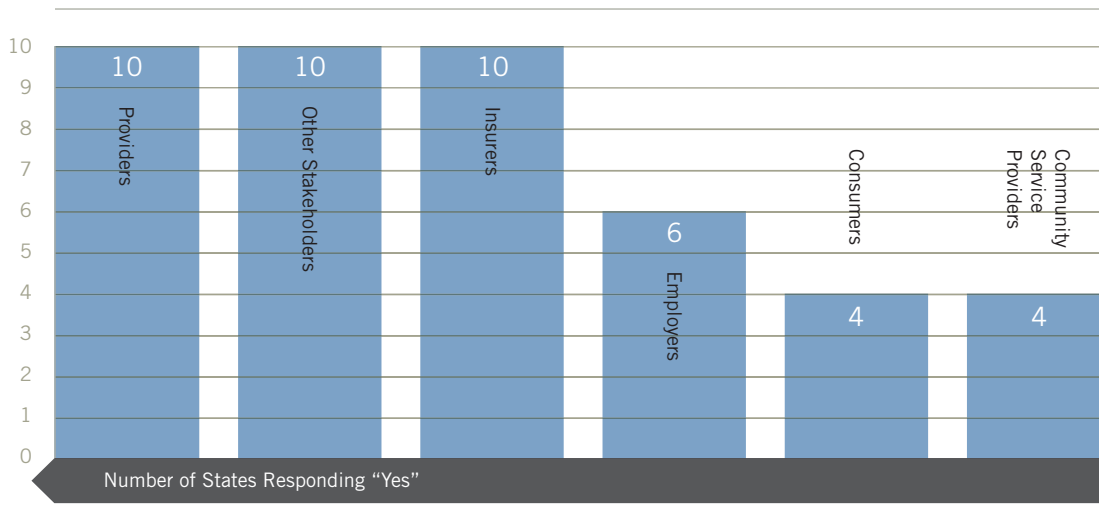
In all 10 states, the lead convening entity reliably brought together multiple stakeholders, specifically insurers and health care providers. Employers, community service providers, and health care consumers were identified as targets of this outreach in some states. The survey did not identify the express purpose of the outreach, but interviews suggested that coalition building was important to establishing a successful program, even in situations where there was more than a single convener. State leaders stressed the time-consuming but essential business of “setting the stage” for collaboration, building relationships with potential partners. This was not something that could be rushed or predicted.

In North Carolina, the “whole first year was dedicated” to relationship building, with officials saying that it “takes a lot of nurturance” and is “not done yet” even four years into the process. In Michigan, multiple engagement strategies aimed at a wide group of stakeholders were implemented all at once, successfully bringing Michigan Medicaid into the already established program convened by the dominant commercial carrier. The MAPCP was described as a “big enabler,” lending further credibility, especially helpful to beleaguered providers seeking a unified and aligned initiative. In addition, Michigan leaders stated that demonstration of success was most persuasive when coming from recognized professional peers. For example, self-insured employers needed to see similar organizations fruitfully participating before they were willing to sign on.

There was wide variability regarding patient and consumer engagement, from “nothing” to truly foundational partnerships. While several states expressed concern that they had not yet made inroads into general public awareness, several had accomplished a great deal in this area. In Maine, patients and parents served on practice and community care team councils for many years. In June 2013, a formal Consumer Advisory Council was established, which met monthly to support consumer leadership in health system transformation, to promote quality and effective messaging to Maine’s citizens to improve health and health care, and to provide guidance for the work of the initiative, including contributing to the development of patient experience survey tools and public presentations. Maine Quality Counts, the convening organization for Maine’s initiative, offered primary care practices patient guide development tools, complimentary webinars open to providers and consumers, and broad access to many health improvement tools for both providers and consumers on its user-friendly and robust website.

The Michigan Primary Care Transformation (MiPCT) Demonstration Project had a statewide Patient Advisory Council with seven members of varying age and gender who geographically represented both peninsulas of the state. The MiPCT director facilitated their monthly meetings. These volunteers, all of whom have either been served by care managers or have family members who have been, advised the steering committee in order to ensure that the patient voice and experience was incorporated into decision making. This was such a success that plans were under way to create local Patient Advisory Councils for the participating provider organizations and practices.

Figure 3
Convening Entity—Outreach Targets



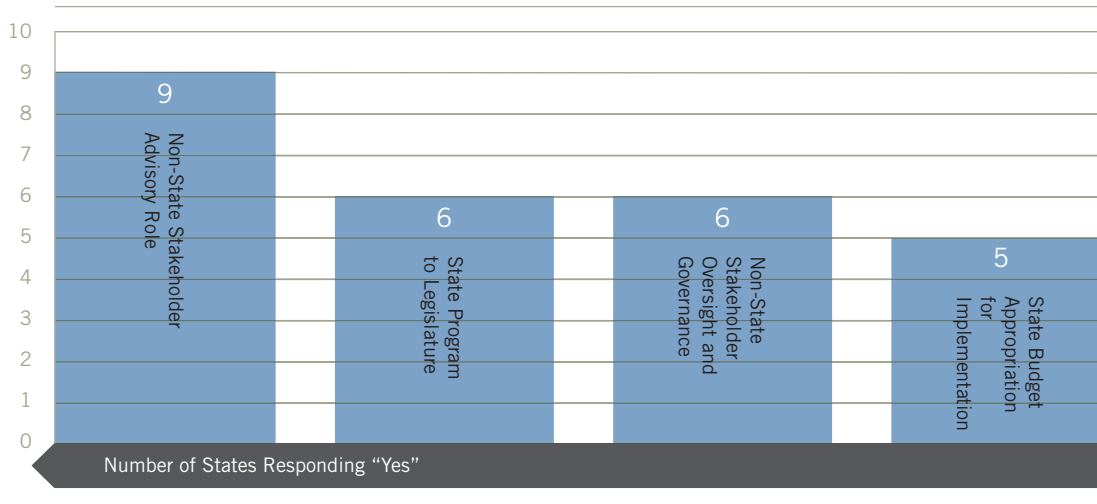
Lead Conveners—Accountability

Accountability has a sentinel effect important to any initiative, as people and organizations are more apt to make an effort when they have to report on their actions. While the need for a government-led convener was consistently observed, non-state government partners who were engaged (and, in some cases, provided leadership) gave the process broad reach and credibility. Ninety percent of programs were accountable to an advisory group outside of the government, and 60% of those groups exerted oversight and governance.

Vermont’s legislation called for participation from a very broad advisory group (the Blueprint Expansion, Design and Evaluation Committee). This group had to have key multi-stakeholder representation, with specific public and private organizations named in statute, and it was subject to the state’s open meeting laws.

Sixty percent of programs had required reporting to their state legislatures, while 50% had dedicated state appropriations.

Figure 4
Accountability



PROJECT MANAGEMENT—IMPLEMENTATION TEAMS AND OPERATIONS

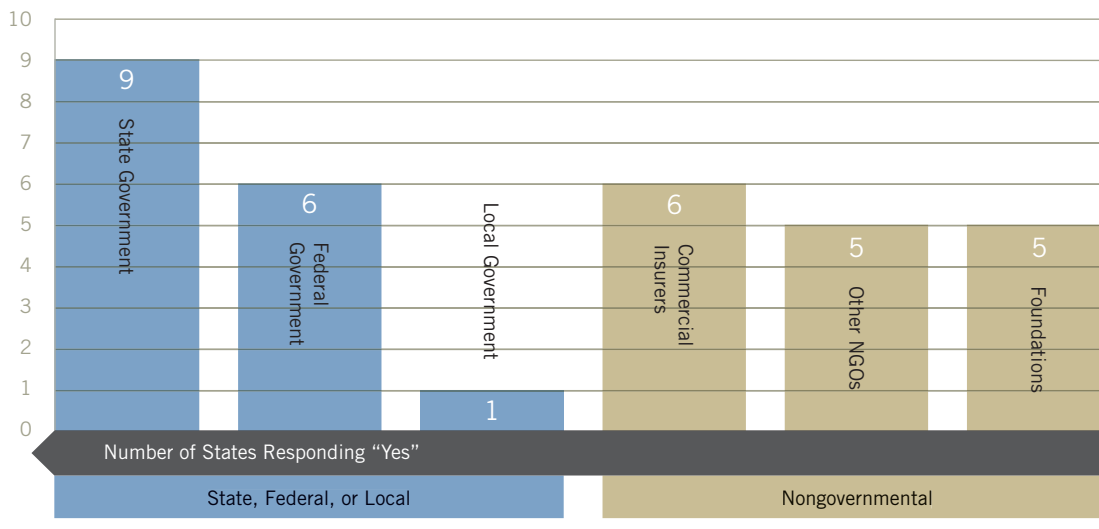
At the time of the survey in 2013, the number of patients in primary care practices targeted in the state initiatives ranged from 54,000 in Rhode Island to over a million in Michigan. As could be predicted, the startup and rollout of initiatives of this size and scale required significant administrative capacity. Resources were needed to fund these new functions, and 90% of responses identified state government as a

primary funder of implementation and program operations. This was consistent with the observation that the state often was the lead convener. Sixty percent of programs had federal support (outside of the MAPCP, which specifically funded the practices and care coordinators/teams) and support from commercial insurers that funded some portion of administrative and implementation efforts. Fifty percent of the initiatives received other NGO (nongovernmental organization) and/or foundation support. The MC state initiatives were known as being “early adopters” of the PCMH and payment reform and might have received planning or pilot support as a result.

Through a Global Commitment Medicaid (Section 1115) waiver, Vermont funded a small central administrative implementation team in its Medicaid office as well as grants to local communities to achieve its innovation goals. This program, the Blueprint for Health, was written into state statute as a building block of health care reform, and has sustainable funding unless the legislation is revoked.

With the exception of North Carolina, all the MC state initiatives received funding from CMS under its SIM program either as a “design,” “pre-testing,” or “testing” grant and used these funds to support the work of their initiatives.

Figure 5
Funding for Implementation Team/Program Operations



SUMMARY

Governance in a multi-stakeholder effort had to incorporate explicit support from a recognized neutral entity. Specifically, most of the MC programs had demonstrable state

governmental genesis and support, which sparked the subsequent path towards health care system transformation.

COMPONENTS OF PRIMARY CARE TRANSFORMATION INITIATIVES AND THEIR FUNDING MECHANISMS

OVERVIEW

This section details the attributes of the primary care transformation initiatives in the MC and their financing mechanisms. It is organized by the eight key components of these transformation initiatives identified earlier in this report.

COMPONENT ONE: INNOVATIVE PAYMENT REFORMS TO SUPPORT PRIMARY CARE

Payments to Primary Care PCMHs

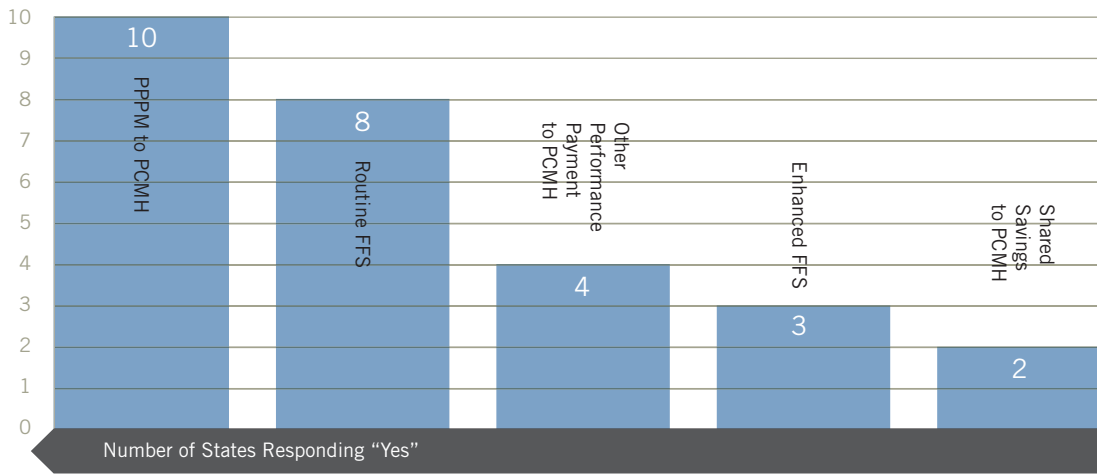
State initiatives tended to have a mix of payment mechanisms to participating practices (Figure 6). A dependable revenue stream is necessary to keep a primary care practice in business and to make needed investments in primary care practices that have historically been underfunded. The payment models tested were in addition to those mechanisms that were typically fee-for-service (FFS). FFS was preserved in 80% of the initiatives, reflecting the reality of the current insurance market and the pilot-type nature of the initiatives. All programs had a per-patient-per-month (PPPM) payment that went directly to the primary care practice or to the parent provider organization, triggered by meeting specific standards.

Capacity-type payments such as the PPPM were novel mechanisms and a significant departure from FFS, requiring administrative organization and a willingness to observe their impacts over time. For a PPPM payment to be made in insurance benefit plans that did not require patients to declare their primary care physician—the majority of those in place in most markets—the relationship between patient and physician had to be inferred and the patient attributed to a particular practice, based on claims activity. The accuracy of these attribution models was inherently limited, creating challenges for efforts that aligned payments with a population focus. In the state initiatives, the administrative changes required to support PPPM payments were in the midst of implementation and evaluation.

Less than half of the MC state initiatives chose to incorporate a pay-for-performance component. In the early years of their initiatives, interviewees revealed a common frustration with ready access to accurate, valid, and usable collated data on which to base a performance-related reward.

Figure 6

Type of PCMH Payment



PCMH Financial Incentives Linked to Outcome Measures

Responses to this survey section demonstrated a wide spectrum of options used by states for aligning fiscal incentives with process and outcome measures. At a minimum, most initiatives had incorporated recognition standards for PCMH, including those developed by the National Committee for Quality Assurance (NCQA), as a condition for any payment or for enhanced payment (Figure 7). Beyond this there was no evidence of consensus on the nature or size of incentive (Figure 8). Most states used process and utilization measures to incentivize practices and providers. There was a lack of consensus nationally on common quality or health outcome metrics for this work, including how performance on them should be incentivized.

There was limited experimentation with adopting utilization measures and/or cost measures as a form of provider payment incentive (Figure 8). These were not broadly adopted and were hampered, respondents said, by a lack of evidence demonstrating which incentives were effective, claims measurement credibility and frequency issues, and a lack of consensus within the initiatives themselves regarding which performance metrics were truly controlled by the PCMH.

In the future, it will be important for the MC to understand not just the range of financial incentives used, but also whether some incentives can be more credibly linked to improved performance relative to others.

Figure 7
Financial Incentives Linked to PCMH Recognition

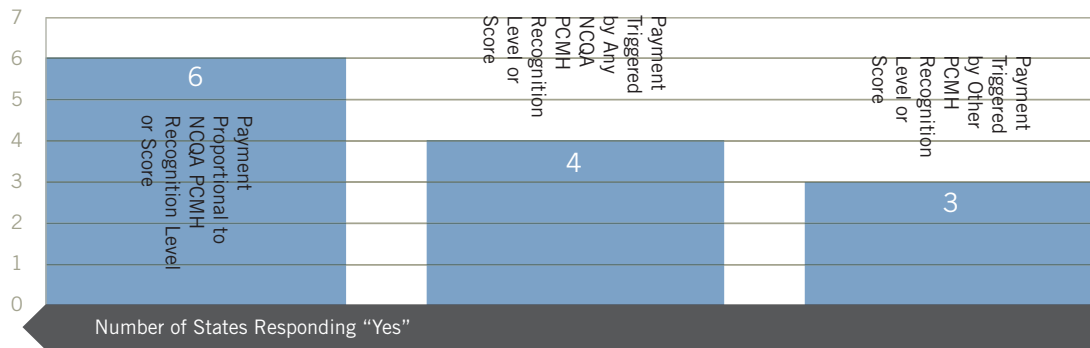
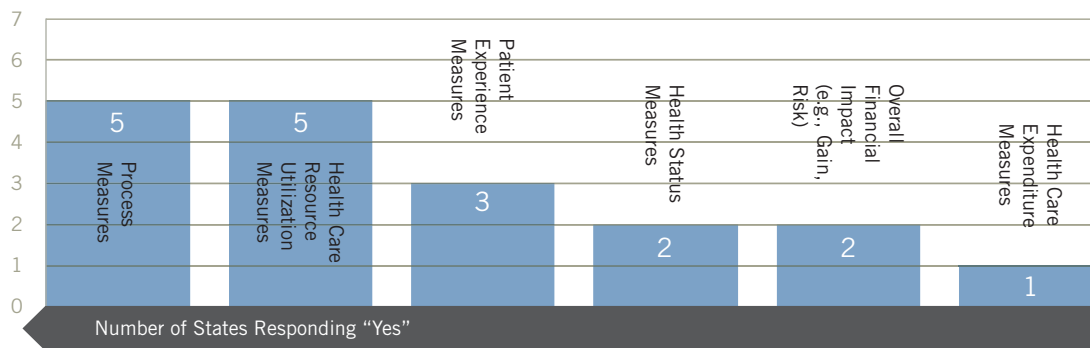


Figure 8
PCMH Financial Incentives Linked to Outcomes



COMPONENT TWO: MULTIPLE PAYER PARTICIPATION

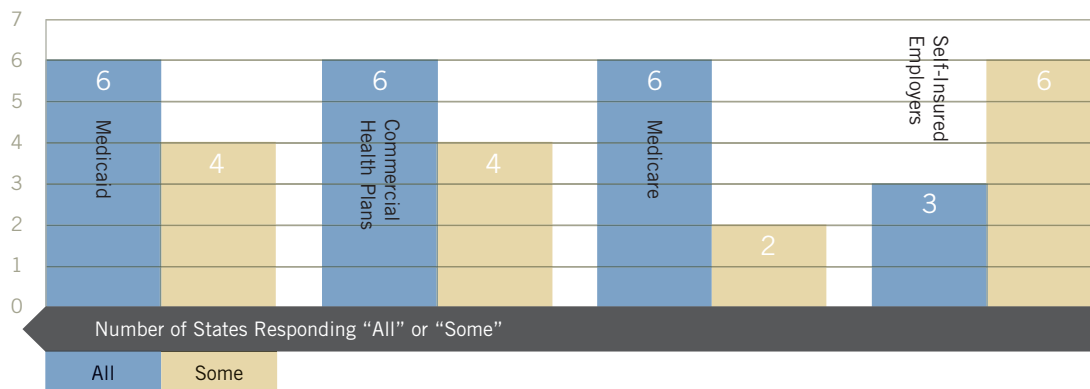
Interviews with state leaders confirmed that primary care practices have expressed an ongoing concern about the fractured nature of the payment system as it exists today. This system forces them to meet increasingly burdensome, conflicting, and/or redundant requirements of the many payers with whom they interact.⁸ These requirements included, but were not limited to, documentation, payment policies, coverage, utilization review, prior authorization, and care delivery elements. While not addressing all the “pain points” of providers, effective multi-payer PCMH program planning and

implementation ameliorated many of them by requiring adoption of consistent approaches to attribution (assigning patients to primary care practices) and payment methodologies, a major step forward.

For this report, states were asked to name all of the types of health insurers involved with their PCMH payment reforms (Figure 9). Medicare was only participating with the eight MAPCP demonstration states.

The definition of a “participating” insurer varied—particularly for commercial payers. At one end, Rhode Island required complete consistency among commercial insurers, resulting in common contract language that was publicly shared. In Vermont, participation was legislatively defined. However, in Colorado and in Maine, payers sat at the table and agreed to general direction but negotiated separate terms privately with each provider. These variations reflected different levels of government engagement, different statutory authority, and local culture and policies. Respondents reported that wide levels of variation in payer participation could be a significant impediment to building collective trust and momentum. It was also observed that insistence on absolute consistency slowed down the process with protracted negotiations and could result in less innovative contracting. It remains to be seen if any type of participation affected initiative performance.

Figure 9
Participating Insurers for PCMH Programs

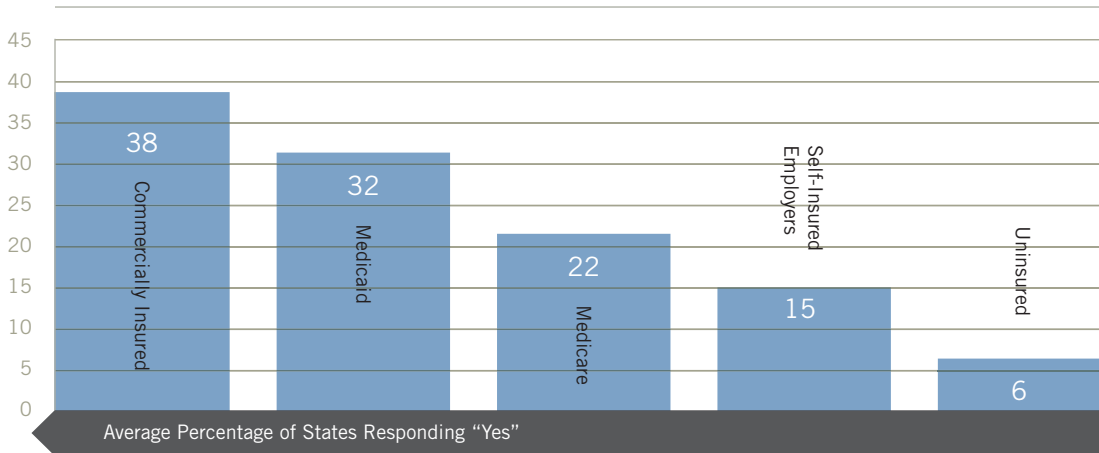


Percentage of Population Covered by Each Insurer

States were asked to estimate the percentage of their attributed PCMH populations that were covered by each insurer (Figure 10). Only the MAPCP demonstration states included their Medicare beneficiaries. Two of the 10 responding states did not answer this question.

Figure 10

Percentage of Population Covered by Each Insurer



Populations with Access

States were asked to identify which populations had access to the participating PCMH practices and programs. In a true all-payer initiative, all patients would have access to new programs developed as part of the initiative. Even though multiple payers were involved in these initiatives, not all patients in the participating practices had access to all programs (Figure 11).

In interviews, participation of Medicare through the MAPCP demonstration was described as absolutely essential for those states where it occurred, creating a critical mass of aligned payments and patients for providers and eliminating the perception of a potential “free rider.”

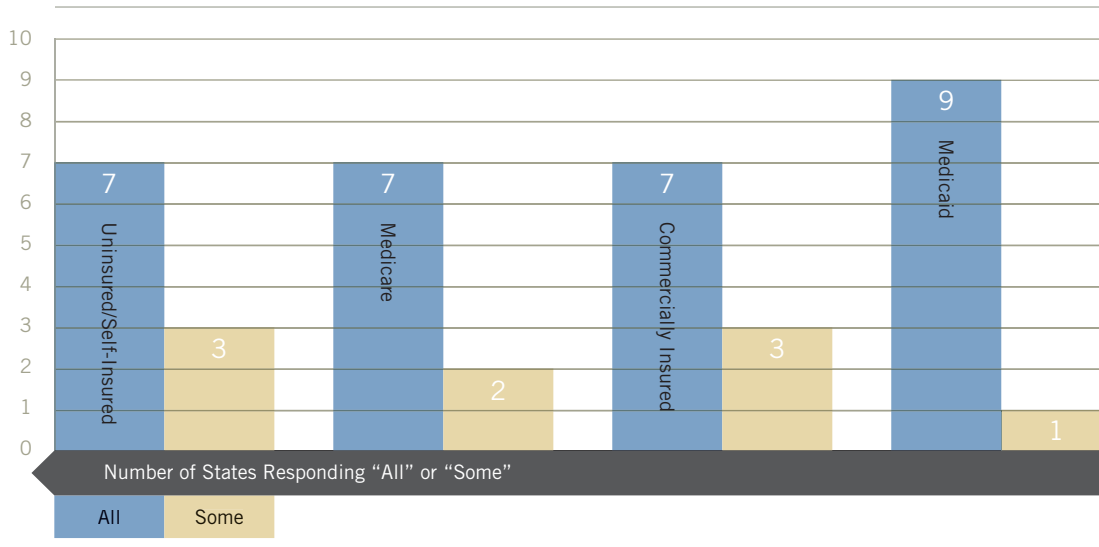
COMPONENT THREE: STATE GOVERNMENT CONVENING ROLE

Lead Conveners

The lead conveners provided the central leadership, leveraging and distribution of funding, and networking connections for the developing programs. In particular, the role of the state as the lead convener was critical to generating collaborative work, which could then more readily proceed because of decreased competitive business tensions. Specifically noted as important was the ability of the state to provide antitrust protection⁹ and credibility as a strong source of political and economic capital. While the actual office that holds this responsibility varied by state, in most instances the Departments of Health and Human Services (including Medicaid) were centrally involved (Figure 12).

Figure 11

Populations with Access to PCMH Programs by Insurer



Interviews revealed a universal assertion that active engagement of high-level state authority was key to the successful implementation of the initiatives. State officials in New York and Vermont went as far as to say that any large-scale effort was doomed to failure without the strength of the state administration behind it. In a published report in *Health Affairs* in 2012,¹⁰ Colorado leaders cited a set of problems they felt stemmed from state government not acting as the neutral convener—antitrust issues, uneven commitment of health plans affecting payments to practices, and lack of access to data—that presented implementation challenges.

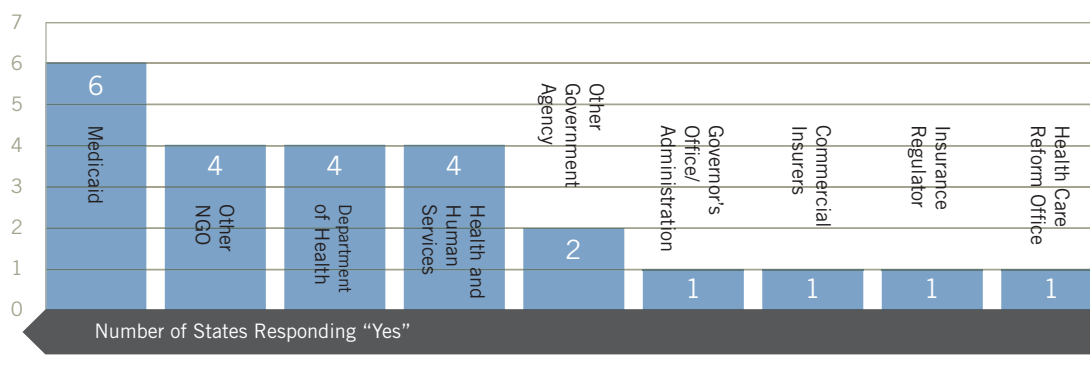
Community Care of North Carolina (CCNC), a Medicaid-only program with a focus on pediatric and adult care coordination, had Medicaid support from the start, providing a strong foundation for multi-payer activity. With a long and successful history in all 14 regions of the state, and care managers often well-known to the local practices, CCNC offered the extremely attractive opportunity of helping more patients (by increasing the care managers’ panel size).

In Pennsylvania, administrative turnover caused a change in the ability of the state to act as convener, as it had done initially. From the perspective of the practices, the initiative was unaffected—data feedback, payment, and learning sessions all continued—but support from the new administration was “without the same ardor.” As a consequence, there was “spotty” payer support, with several large insurers leaving the demonstration.

Rhode Island officials explained that their most effective outreach and partnering were with their commercial payers.¹¹ Transformation activity there was funded primarily through the support of the health plans.

Michigan’s leaders stated unequivocally that the “state needs to be the convener” even with strong and effective private partners.

Figure 12
Lead Conveners



COMPONENT FOUR: STANDARDS FOR PCMH IDENTIFICATION

Eight of the ten responding states used the NCQA Patient-Centered Medical Home (PCMH) recognition,¹² by far the dominant formal recognition program in the United States and the standard for PCMH recognition. Receiving NCQA recognition meant a state was meeting a basic national standard for excellence in the delivery of primary care, which many states found useful in negotiating with their payer collaborators. Of those eight, six had commensurate levels of payment linked to specific levels of NCQA recognition.

Minnesota and Michigan developed and implemented their own comprehensive and independently audited recognition standards for practice transformation.

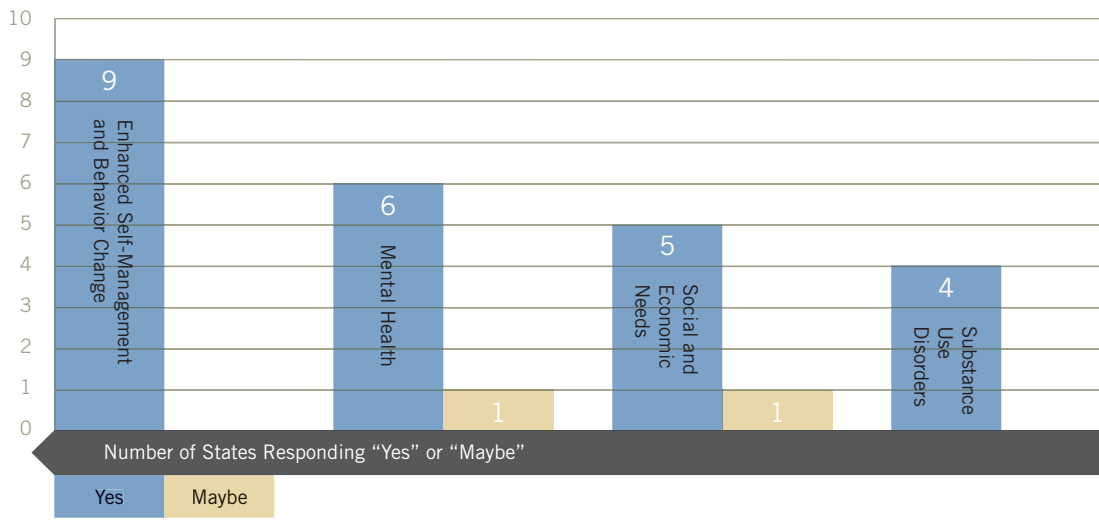
COMPONENT FIVE: NEW STAFFING MODELS FOR TEAM-BASED PRIMARY CARE

Critical to primary care transformation was the introduction of health care provider teams to treat populations within the practice and coordinate with community resources. Developing these teams and the additional care-support services they provide involved the introduction of new staff roles to coordinate and manage care. The provider teams also used new tools such as electronic health records, centralized data repositories, and health

information exchanges (HIEs). These enhanced support services varied by initiative in terms of new staff roles and specific activities performed.

Edward Wagner introduced the concept of the Chronic Care Model in 1998,¹³ contributing to the common understanding of the need for access to services not traditionally available in the primary care setting. The Chronic Care Model has been extensively implemented and modified with well-documented positive effects.¹⁴ MC respondents said it greatly influenced their work—specifically, programs offering such resources as improved patient self-management support, increased access to mental health and substance abuse treatment, and the appropriate referral and tracking of services for social and economic needs.

Figure 13
Types of Additional Care-Support Services Provided



Additional Care-Support Services: Target Populations and Activities

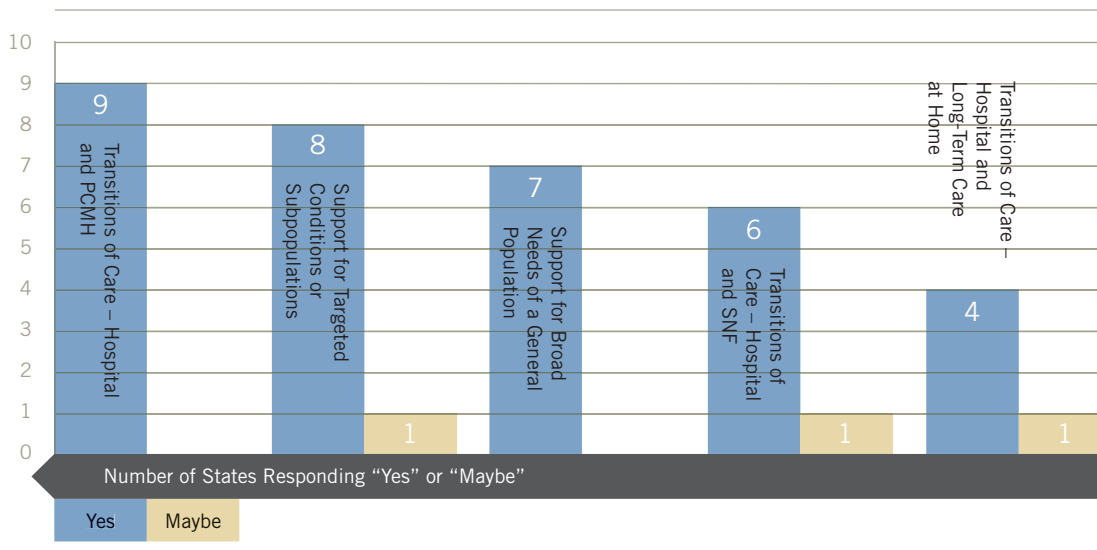
Whether it is a patient’s transition from hospital to home or from hospital to skilled nursing facility (SNF), health care professionals are aware that discharge planning and outpatient care transitions could use improvement in terms of communication and care delivery. The gaps identified in transitions of care from inpatient hospitalizations to outpatient settings were a high priority for 90% of respondents (Figure 14). The associated quality improvement and cost-savings potential in resolving these gaps naturally drove this—and was demonstrated in the literature starting with the work by Mary Naylor and her colleagues in 1994.¹⁵

Vermont leaders emphatically stated that their multi-disciplinary, locally based care teams (Community Health Teams) were viewed by many clinicians as the most crucial aspect of the program, far more important than enhanced payment directly to the practice (the PPPM), which was viewed as modest.

The targeted (segmented populations) and broader (preventive) approaches were both in use by the MC programs. The broadest definition was in Vermont, which had steadfastly kept universal access to support services through the Community Health Teams. There were no eligibility requirements of any kind, and the services were free to all Vermont citizens who were patients at participating practices.

Other states directed their attention to patients with multiple or specific chronic conditions. Maine's Community Care Teams focused on "super-utilizers" of health care, as did Pennsylvania's Chronic Care Initiative. North Carolina's multi-payer program was an extension of its well-established CCNC program. It also had special emphasis on targeted services for patients with asthma, congestive heart failure, and diabetes and for those in need of mental health and primary care integration. Rhode Island's initiative measured and documented performance improvements in a small number of chronic conditions. MC participants from that state reported that, in their initiative, practice-based care coordination nurses work with patients with complex problems regardless of their diagnosis.

Figure 14
Additional Care-Support Services: Target Populations and Activities



Although the escalating costs of health care are not primarily based at the primary care outpatient setting, the practices strived to reduce costs with efforts and services

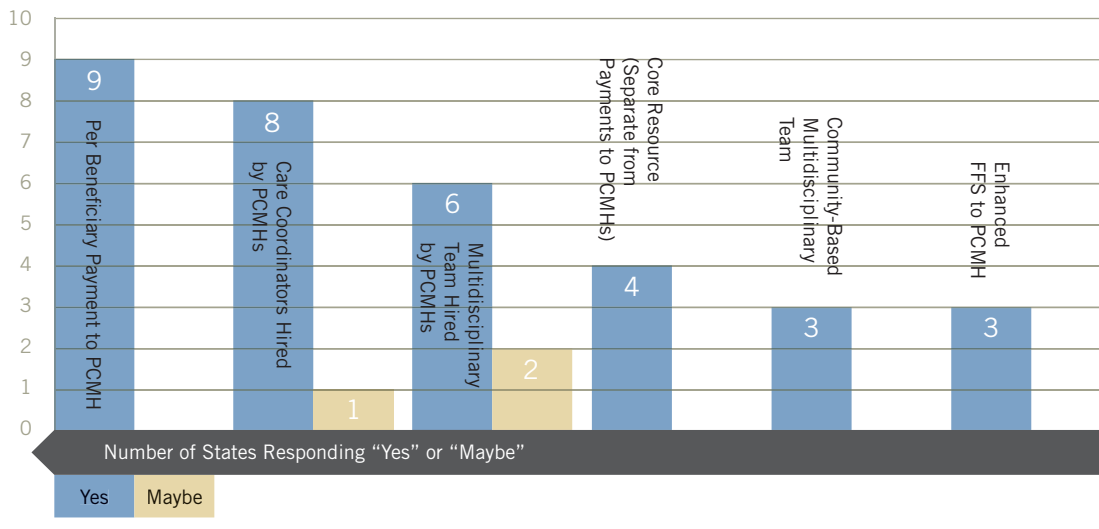
directed at ambulatory-sensitive conditions and events. A key challenge for many initiatives was developing systematic approaches to better patient care, approaches that could have an impact on skyrocketing costs in other areas of the health care system.

Additional Care-Support Services: Staffing Structure, Payment Mechanisms, and Funding Sources

Historically, payers relied on contracted disease management services despite mixed experience with their efficacy.¹⁶ CMS demonstrated that traditional centralized and/or remote disease management programs not connected to the health care delivery system were less likely to be effective.¹⁷ The multi-payer primary care transformation initiatives, including the MAPCP, supported a test of care coordination and delivery services embedded in primary care and widely available to patients regardless of eligibility requirements. This was in contrast to targeted disease management programs, which were still widely used in the MC state initiatives by commercial payers and Medicaid programs.

Figure 15

Additional Care-Support Services: Staffing Structure and Payment Mechanisms



The team-based model of care moved these services closer to the practice. The Rhode Island Chronic Care Sustainability Initiative (CSI-RI) placed nurse care coordinators in their participating primary care practices. These skilled nurses were overwhelmed by the need for essential non-nursing services (behavioral health, social services), and a team approach was therefore under development. CSI-RI held a learning collaborative in

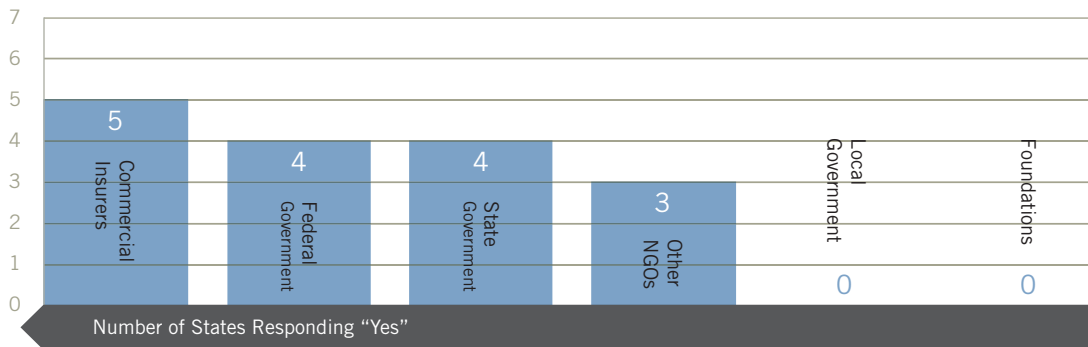
October 2013, where leaders from other MC state initiatives (Maine’s Community Care Teams and Vermont’s Community Health Teams) shared their strategies and experiences with the Rhode Island stakeholders and practices.

New York had locally based governance and support service access through its three “pods” in the Adirondack region. This structure strengthened the team approach and made the services more accessible to patients and families.

Vermont kept access to Community Health Teams open to all patients empanelled by the participating practices. This “utility” or “core resource” approach had no eligibility requirements for patient access to services and intentionally erred on the side of inclusion. Funding for these teams was a shared fiduciary responsibility, creating in effect a public utility available to all patients in a geographic area.

Maine combined public and private funding for Community Care Teams, which focused on targeted populations with more complex illness and/or high health care resource utilization. This hybrid approach was instrumental in the creation of “health homes” for chronically ill Medicaid enrollees by combining Community Care Teams with recognized PCMH practices. The convening coalition took this opportunity to leverage its primary care transformation initiative infrastructure to win recognition under the ACA’s Section 2703, which provided funding for such health homes targeting specific, chronically ill Medicaid-enrolled populations.¹⁸

Figure 16
Funding Sources for Additional Care-Support Services



In light of mounting evidence of the lack of effectiveness of the dominant models of care and case management programs^{19,20,21}—payer-specific and usually implemented telephonically by payer or sub-contracted staff—New York and Vermont leaders reported that some participating insurers considered redirecting funding for current disease management contracts to the locally based care-support teams.

COMPONENT SIX: TECHNICAL ASSISTANCE TO PRACTICE SITES

Technical Assistance to Practice Sites: Practice Transformation

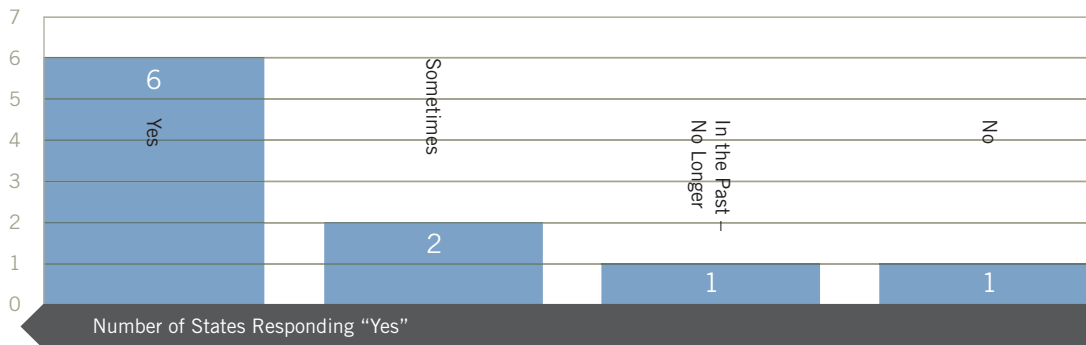
The Agency for Healthcare Research and Quality (AHRQ) defined practice facilitation as “a supportive service provided to a primary care practice by a trained individual or team of individuals. These individuals use a range of organizational development, project management, quality improvement, and practice improvement approaches and methods to build the internal capacity of a practice to help it engage in improvement activities over time and support it in reaching incremental and transformative improvement goals.”²²

MC respondents used a variety of practice facilitation (also called “coaching”) models, and most attested to their importance. Vermont’s Expansion and Quality Improvement Program (EQuIP) consisted of a team of practice facilitators who assisted primary care practices with PCMH recognition preparation and continuous quality improvement efforts. The EQuIP team members came from disciplines such as social work, nursing, and patient advocacy, and were all highly skilled in change management and process improvement. Facilitators were trained to develop relationships and work on-site in practices with the providers they supported, consistently working with the same practice-based teams as much as possible in a busy clinical setting.

Colorado had an extensive and well-respected nonprofit multi-stakeholder quality improvement organization, HealthTeamWorks.²³ Services offered included transformation (PCMH recognition preparation, electronic health record [EHR] adoption, and “meaningful use” attestation), coaching and change management, and other consulting services. Other transformation-focused organizations participated in the Colorado practices, such as TransforMED, Qualis, and the Primary Care Development Corporation.

Figure 17

Use of Practice Facilitators/Coaches for Primary Care Practice Transformation

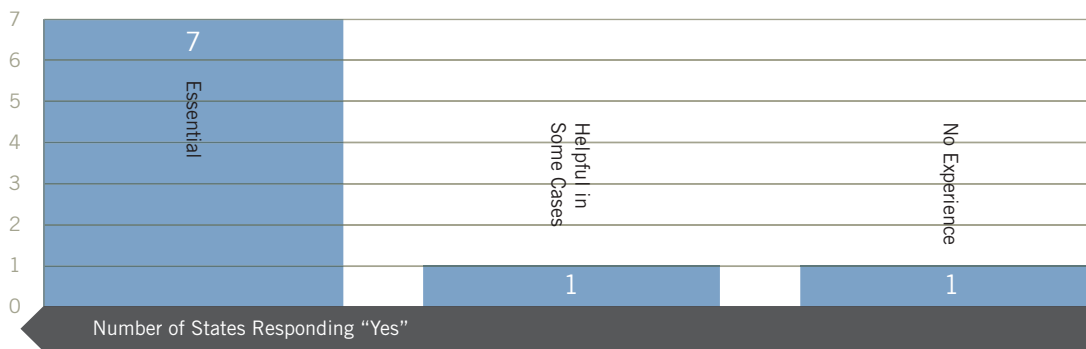


Two-thirds of MC state initiatives described practice facilitators or coaches as “essential” and a key ingredient to achieving and sustaining practice transformation.

Practice facilitators or coaches were an important example of a type of new support that required funding, since they were critical to the effective transformation of primary care practices.

The work of practice facilitators or coaches, which is individualized and therefore labor-intensive, was a resource allocation that was not consistently supported in all MC programs (Figure 18). While some MC programs received state cooperation and support for practice facilitators and coaches, others did not (Figure 19). Having to pay a fee for this service could be a barrier to participation for some initiatives. In Vermont, the state’s Blueprint budget paid for the EQuIP staff salaries, which meant these services were free of charge to practices undergoing transformation and quality improvement.

Figure 18
Importance of Practice Facilitators/Coaches



Technical Assistance to Practice Sites: Health Information Technology

The quest for accurate, timely, and accessible health information was a common goal and challenge for the MC state initiatives. Respondents reported that they looked for ways to leverage resources for health information technology to support their primary care transformation efforts. The thinking was that better exchange of health information would enhance care coordination by PCMHs and reduce unnecessary utilization. State governments provided support for a centralized HIE, reported 90% of responding initiatives, with federal funding a source in 70% (Figure 20). Many of the MC state initiatives (Colorado, Michigan, Minnesota, Pennsylvania, and Rhode Island) were also recipients of the competitive Beacon Community grants.²⁴ This combined high level of commitment and coordination was notable.

Before health information can be exchanged digitally, it must be obtained digitally. The cost of the purchase, implementation, and maintenance of an electronic medical

record could be prohibitively expensive for practices—especially smaller ones. Significant public resources were invested for EHR adoption (Figure 21), primarily through the HITECH Act and resulting “meaningful use” standards promulgated by the Office of the National Coordinator for Health Information Technology, incentivized in Medicaid and Medicare payments, and facilitated by Regional Extension Centers (RECs). MC respondents indicated that their initiatives focused less on providing funding for EHRs and more on coordinating their efforts with the federally driven EHR strategy.

Figure 19
Funding for Practice Facilitators/Coaches

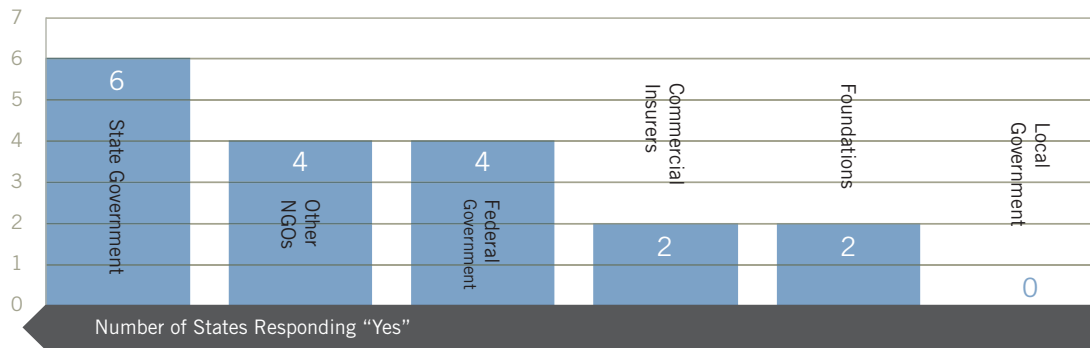
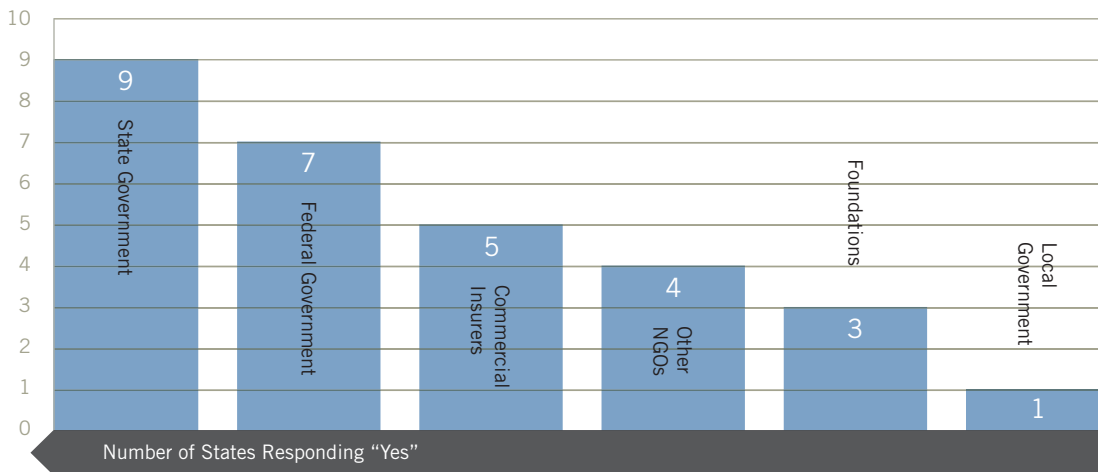


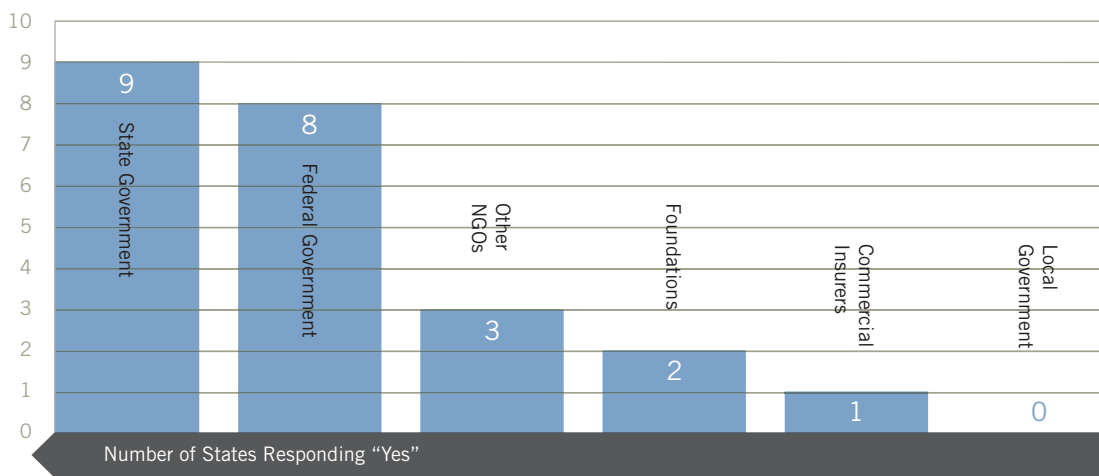
Figure 20
Funding Sources for HIE



Technical Assistance to Practice Sites: Data Systems

Aggregate data systems such as multi-payer claims databases and centralized clinical registries provided clinical data that could feed HIEs and administrative information for performance measurement and evaluation.

Figure 21
Funding Sources for EHR Adoption



Like all information technology, these aggregated data systems were costly and complex to develop, implement, and maintain. Leaders in North Carolina saw great potential in mapping their robust and mature Medicaid data systems to CMS for the purpose of MAPCP participation and observed that this was worth the effort since it yielded greater discipline and therefore consistency.

Other interviewed leaders expressed both frustration with the protracted timelines for satisfactory development and implementation and pride in (or hope for) the improved accessibility, communication, and quality of care delivered. All 10 surveyed MC members reported some support from their state governments, without which the pace would be even slower.

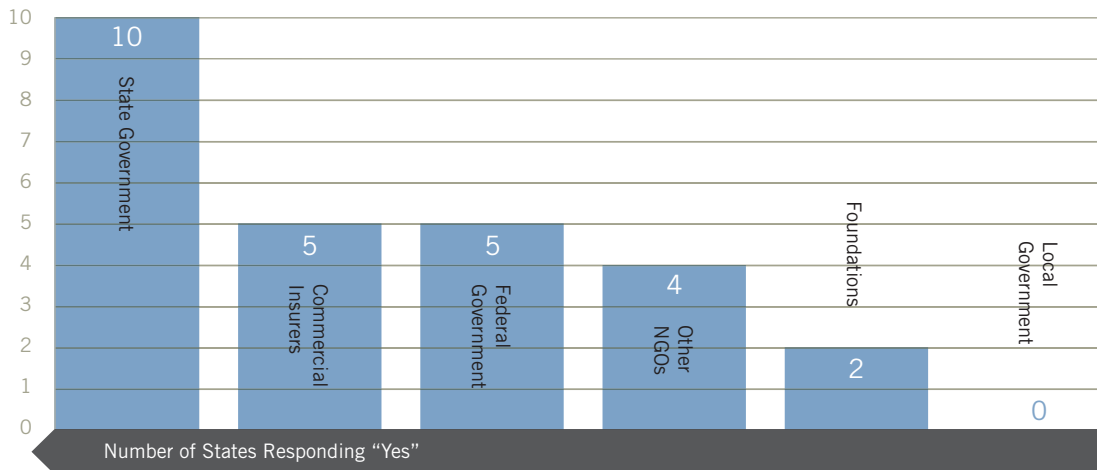
COMPONENT SEVEN: COMMON MEASUREMENT OF PERFORMANCE

Uniform measures to assess initiative performance, identify needed improvements, and convey progress are essential to the success and sustainability of any collaboration, even though they are not always easy to achieve.

As with any government-convened process, the MC state initiatives reported that they strived to be transparent and consistent in their planning, implementation, and measure

Figure 22

Funding Sources for Data Systems



ment. This transparency generated trust and acceptance of a new way of doing business.

Each MC state took stock of its own performance and measurements for the purpose of system improvement and had its own ongoing evaluation plan. The MAPCP demonstration states were evaluated by a third party contracted by CMS. Neither the survey for this report nor the interviews assessed outcomes, but information about program efficacy has started to emerge. In the first two months of 2014, Vermont²⁵ and Minnesota^{26,27} released state-specific reports with statistically significant health care utilization and cost savings measured over multiple years of intervention.

- After five years of development and implementation, Vermont's Blueprint for Health had clearly demonstrated reductions in health care utilization, a shift from specialty care to primary care services, and a trend toward better preventive care. In 2012, commercial insurers and Medicaid spent 11% and 7% less respectively on their adult intervention groups than on comparison groups.
- Minnesota's Health Care Homes (a PCMH program in its third year of implementation) demonstrated a 9.2% overall reduction in expenditures for Medicaid enrollees in 2012. While this was a single-payer initiative, Minnesota used the same practice transformation infrastructure in its multi-payer program.

In January 2014, the Patient-Centered Primary Care Collaborative (PCPCC), a 1,000+ member coalition of business and health care organizations, published a report²⁸ analyzing 13 peer-reviewed academic studies and seven industry studies, with encouraging outcomes on utilization, cost, quality, and patient experience. Other member states did

not have enough experience to reliably report their outcomes, but maintained websites that provided interim outcomes and program updates.^{29,30,31,32,33,34}

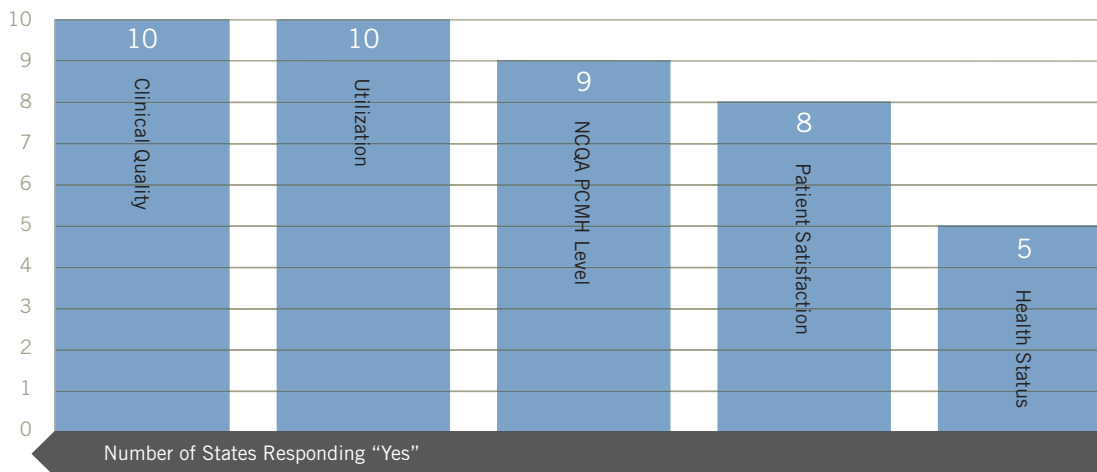
Positive external evaluations depended in part on effective internal measurement and improvement activities. State initiatives indicated a varied and comprehensive array of approaches to performance measurement. While growing in their sophistication and ability to conduct performance measurement, state initiatives were hampered by a lack of resources, standards, consensus, and credibility—issues that were particularly critical to utilization and cost measurement. The spectrum of approaches to evaluation and quality improvement used by the MC state initiatives is described in the following section.

Defined Measure Sets

Defined measure sets enabled a program to collect and assess the impact of an intervention. Universally, the programs had in place their own (state-specific) metrics to examine clinical quality and health care utilization. Ninety percent of the programs used an NCQA PCMH recognition-scoring rubric,³⁵ a national standard in wide use, to assess the “medical home-ness” of their participating practices. Michigan and Minnesota developed and fully implemented their own state-specific PCMH recognition programs.

Eighty percent of programs administered a patient satisfaction survey. The programs used standard surveys, such as a Consumer Assessment of Healthcare Providers and Systems (CAHPS)³⁶ or a Press Ganey,³⁷ as well as tools developed locally. New York conducted a structured patient experience survey by mail and found improvement in most domains from the baseline in the second round of the survey.

Figure 23
Defined Measure Sets



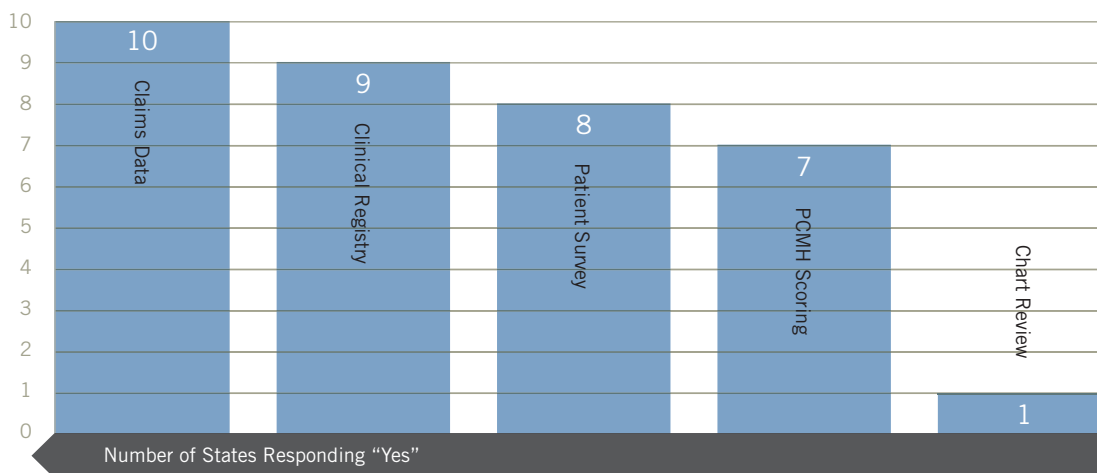
Data Sources

All MC members in this survey used claims data, and 90% had a mechanism to extract some clinical measures from registries (Figure 24). It was noteworthy that of the 10 responding states, all but two had an all-payer claims database (APCD) either in full operation or in active development.³⁸

The MAPCP demonstration states had access to robust information about Medicare beneficiaries, and in Maine this information was used to identify patients for Community Care Team services. PCMH recognition scoring, a complex set of process measures, yielded helpful information about how a practice delivered high-quality care and was seen to be in common use (70%) by MC state initiatives. Unsurprisingly, very few programs used direct chart reviews, as this was a very resource-intensive process and particularly burdensome for the practices.

North Carolina, New York, Vermont, and Pennsylvania leaders expressed concern about the supply of primary care physicians in their states. They wanted to know if primary care transformation initiatives made primary care a more rewarding field for practitioners, and could help attract more physicians to their regions.

Figure 24
Data Sources



Several states with these concerns have embarked on site-specific mechanisms that will uncover how interventions have impacted the provider experience, as in New York where a provider survey is in development. Vermont undertook a network analysis of the relationships that have been forged and modified after years of collaboration between Community Health Teams and the primary care practices they serve.

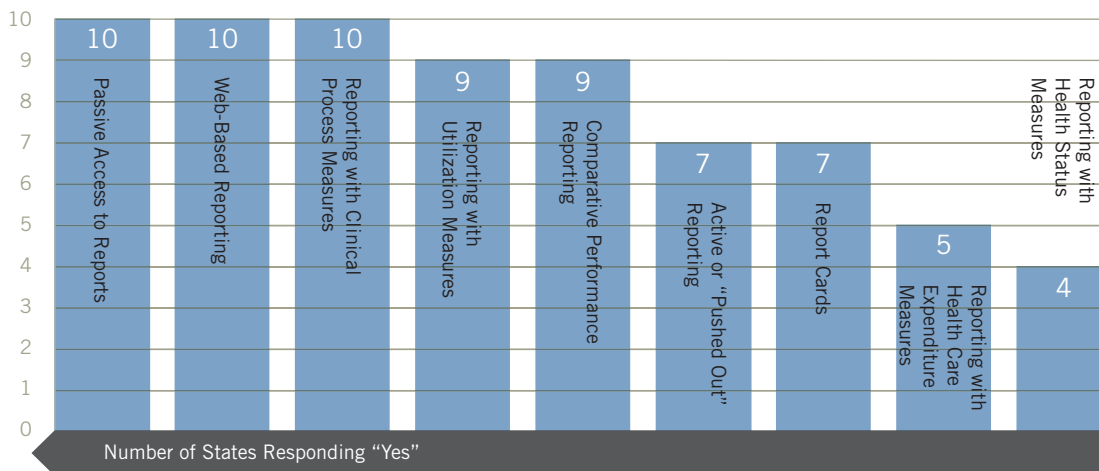
All state leaders interviewed expressed some frustration with data collection—its analysis, its use, or both. The limitations of technical capacity (interoperability of systems, evolution of HIEs), the burden on personnel (impacts on workflow or the need to hire new employees), and the costs of purchasing and maintaining information systems were all mentioned in the interviews. The need to share accurate information about the impact of the initiatives (financial and quality outcomes as well as performance reporting) with stakeholders and clinicians was clear.

Feedback to Practices

No one can improve his/her performance without feedback. In these initiatives, a feedback loop to primary care providers and practice teams was critical for performance to improve. Most programs surveyed provided data feedback, consisting of clinical and utilization measures in a retrievable format. Far fewer reported on health care expenditures at the time of the survey. All participating practices either had to seek out their own reports (“passive access”) or could access them through a web portal. In 70% of initiatives, reporting was “pushed out” to the practices on a regular basis.

Figure 25

Feedback to Practices



Clinical process metrics were always included, but utilization measures coupled with benchmarking or comparative performance rates were only sometimes included. Vermont started to send claims-based, practice-specific profiles with local and statewide benchmarking to participating primary care practices. This enabled practice staff and clinicians to see where they stood regarding resource utilization, total cost of care, and quality metrics.

In summary, performance measurement required a significant infrastructure, which MC initiatives steadily developed. The most effective and efficient allocation of performance measurement functions among providers, payers, the initiatives themselves, and outside parties remained to be determined. The initiatives were in a unique position to facilitate standards setting and a process for trusted, effective performance feedback. The actual measurement and analysis—whether of quality, expense, or patient satisfaction—required resources and technical skills that may not have been best suited for the initiatives themselves.

COMPONENT EIGHT: COLLABORATIVE LEARNING

The concept of collaborative learning—developed and popularized by the Institute for Healthcare Improvement (IHI)³⁹—has spread worldwide. All MC leaders interviewed reported that their programs had implemented some version of collaborative learning into their primary care practice transformation efforts. The opportunity to bring colleagues together to share their experiences, to engage in didactic and practical educational environments, and to take those lessons “home” to their practices was seen as invaluable.

The collaboratives took many forms, including one-on-one practice facilitation and coaching, local practice network meetings, process improvement projects at critical access hospitals, regular and frequent webinars with local and guest presenters, and annual statewide summits or conferences. Curricula came from a range of sources, such as the ABIM Foundation’s “Choosing Wisely” campaign,⁴⁰ change management in Lean⁴¹ or Clinical Microsystems,⁴² topic-specific collaboratives for asthma treatment, for medication-assisted treatment for opiate addiction, or for cancer screening; and the distribution of recent clinical guidelines and individual performance reporting for providers.

Lessons Learned

The following lessons for future work can be drawn from an analysis of the survey responses and structured interviews:

1. THE LOGIC OF A MULTI-PAYER EFFORT TO SUPPORT PRIMARY CARE TRANSFORMATION IS IRREFUTABLE.

High-performing primary care is necessary but not sufficient for a well-performing delivery system. High-quality primary care offers a way to manage the care of the chronically ill in a more cost-effective manner and provides a bridge to prevention and the nonmedical factors that drive much of the costs of medical care. A well-performing delivery system can only be attained by coordinating efforts across payers since no single payer controls enough of a practice's share of patients or revenue to fully change how it delivers care. The concept of a PCMH is a work in progress but remains an acceptable working definition of high-quality primary care. The relationship of transformed primary care to the rest of the medical care delivery system continues to evolve in the wake of the Accountable Care movement. For actuarial and systems integration reasons, MC initiative leaders agreed that even the highest performing, most transformed primary care practices needed to be nested in a larger well-integrated group of providers if they were to accept full accountability for the costs and quality care of a population of patients.

2. STATE LEADERSHIP AT THE HIGHEST LEVEL POSSIBLE IS NECESSARY FOR THE SUCCESS OF MULTI-PAYER PRIMARY CARE TRANSFORMATION.

A state can neutrally convene private and public stakeholders without undermining existing insurer-led initiatives or violating antitrust provisions.⁴³ The federal government cannot do that. A state's support can help to avoid fragmented incentives and measures, as well as aid in the move toward serving all populations.

The public sector can make the conclusive case that scarce funds consumed by expensive and escalating health care costs are being diverted from other essential functions of state government. Officials from state agencies such as Medicaid, Health and Human Services, and Public Health Departments can serve as thought and implementation leaders.

This may cause some skepticism. Can government be a partner rather than a strong-armed leader? It is important to note that the leaders of these innovative programs were comfortable with the role government played. The planned partnerships of these public-private coalitions, with their advisory and oversight mechanisms, demonstrated their effectiveness.

What is the impact of the electoral process? In some states, but not others, significant staffing turnover occurred following a change in administration. A strong and diverse coalition of partners (including but not limited to individual consumers

and consumer groups, health care and related service providers, commercial payers, and community leaders) can steady the course.

3. A MULTI-PAYER APPROACH IS KEY TO ENGAGING CLINICIANS AND PAYERS ALIKE.

The multi-payer approach not only provides sufficient resources for primary care practices but also aligns those resources with appropriate and consistent incentives to health care providers and aligns policy priorities with system improvement through transformation.

Clinical practices are increasingly burdened by documentation and billing responsibilities, often varying by payer. It is commonly believed that streamlining these processes, including making payment and evaluation mechanisms uniform, will lead to greater provider satisfaction and better quality of care.

Joining forces, especially in combinations that are not traditional—such as putting together commercial insurers who usually compete with one another or Public Health and Medicaid agencies that do not always work synergistically—lends a credibility that empowers all involved.

Medicare beneficiaries can account for 20%–50% of an adult primary care provider's patient panel, a very significant proportion. Medicare participation was catalytic for those collaboratives that benefited from CMS's support. Clinical practices generally resist transforming for only a fraction of their populations. Without Medicare revenue, these practices found themselves without enough resources to consistently make inroads into lasting and meaningful transformation. Even with Medicare participation, no multi-payer innovation is truly all-payer. It has been difficult to convince self-insured employers to invest in these programs, especially since their insurers or insurance administrators are reluctant to make the investments for them. Similarly, national insurers with small-market shares as well as the inevitable presence of uninsured populations make it probable that primary care practices will be unlikely to receive enhanced revenues for all their patients.

4. RELIABLE DATA AND MEASUREMENT, ESSENTIAL TO SUCCESS, REMAIN A CHALLENGE.

The collection, cleaning, analysis, and distribution of accurate and timely information are paramount to meaningful performance measurement. While inroads have been made, all MC members struggled with the complexity and costs involved in providing and effectively using vital data collection tools. In some member states, the investment was in the millions of dollars in annual analytic and evaluation contracts. This is a significant burden but clearly necessary if the programs are to be able to accurately and transparently demonstrate their efficacy.

5. TRANSPARENT SHARING OF EXPERIENCE AND INFORMATION LEADS TO EFFECTIVE LEARNING.

There is consensus that the open exchange of experience and information enabled participants to benefit from the lessons of others. The Learning Health System collaborative model has been embraced enthusiastically from individual primary care practices (the micro-level) to the national setting (the macro-level). The MC members took that concept and made it part of their daily work.

6. THESE COLLABORATIVES ARE IMPROVING OUTCOMES FOR POPULATIONS IN SIGNIFICANT AND SUSTAINABLE WAYS, WITH VARYING LEVELS OF SUCCESS, AND THIS TRANSFORMATION TAKES TIME AND ENERGY.

Support for the work of these initiatives was indicated by the growth in the number of practice sites involved in the initiatives and the number of states undertaking such work. This is illustrated in the nearly tenfold increase in patient participation in the MAPCP since the demonstration began in July 2011.

Only recently have the most experienced MC state initiatives been able to report on statistically significant positive impacts of their interventions. The timing of hoped-for results can be a challenge in a pressured environment where outcomes are desired within a short period, such as an electoral cycle. State leadership has waxed and waned in some places, with deleterious effects on the morale and participation of both payers and providers.

The collaborative model has some weaknesses in its design, which become more apparent with growth. Collective governance and consensus-driven decision making, while promoting trust and credibility, can consume time, result in lower performance standards, and inhibit constructive competition. It is also expensive and time-consuming to align performance measurement with timely, accurate feedback.

These challenges notwithstanding, all MC members were fully committed to demonstrating the efficacy of their individual and combined efforts. The timeframe to provide such evidence has been longer than hoped for, a combination of data issues and the lag time for any change to become adopted as the new norm. Interviewed state leaders uniformly pointed out the time required for demonstrating impacts on clinical outcomes, financial implications, and experience of care, consistent with the IHI Triple Aim.⁴⁴ State leaders referred to this process as “a marathon rather than a sprint.” The expectation of short-term results was unreasonable, but the anticipation that longer-term investments would yield improvements was being fulfilled in several of the MC state initiatives, most notably in Vermont, which, as noted earlier, demonstrated clear reductions in health care utilization. Leadership needs to demonstrate patience and stay the course. Initiative leaders reported that process sustainability and quality improvement were dependent on people changing

the way they do things, such as workflow for providers and lifestyle modification and empowerment for patients. Practice transformation required ongoing support and investment through facilitation, coaching, establishing in-person and virtual learning communities, and other strategies. Patients needed opportunities to influence their health care and overall health. The MC was committed to determining which of these mechanisms were the most effective.

7. THE BUSINESS CASE FOR PRIMARY CARE TRANSFORMATION MUST BE DEFINED AND DEFENSIBLE TO POLICYMAKERS, PURCHASERS, AND PATIENTS.

This is a work in progress—not enough time has lapsed or experience acquired to make the case definitively for or against the specific innovations under way at the time the survey was completed. That said, the PCPCC 2014 review of both industry and peer-reviewed academic studies⁴⁵ demonstrated that health care resource utilization and cost, health care quality, and patient experience—essential components of the Triple Aim—were improving. The PCPCC report is one of many emerging publications that will help make the case for continued and expanded investments. The question is no longer whether primary care transformation–based interventions are effective, but rather how to improve, refine, and spread them.

8. THE FINDINGS OF THIS REPORT HAVE IMPLICATIONS FOR FUTURE PAYMENT REFORMS.

It is generally accepted that the fee-for-service payment system that predominates in medical care is a significant barrier to a more sustainable, value-promoting health care system. Efforts to promote activated consumers and market-oriented incentives for them—such as price transparency and consumer directed health plans—will not by themselves achieve these needed payment reforms. These reforms will require the action of payers.

The Innovation Center at CMS—the nation’s largest payer—is testing many types of provider-specific payment reform initiatives. Using Medicare payments as a tool, the Innovation Center has supported implementation and assessment of such mechanisms as Accountable Care Organizations⁴⁶ and episode-of-care payments. Concurrently, many commercial payers (WellPoint, CareFirst, Premera Blue Cross, UnitedHealth, and myriad others) are experimenting with their own payment schemes involving many of the same concepts.⁴⁷

These experiments have some inherent limitations. They are all single-payer initiatives, relying on payment incentives such as pay-for-performance. They focus less attention on theories of change involving adult learning and system improvement and fail to address evidence regarding the importance of the social determinants of health, which indicates that the true drivers of population costs and health are outside the medical care system.

The local and state-based multi-payer collaboratives studied in this report have the advantage of being able to address these weaknesses, while facing the challenges documented here. The lessons learned from the collective and individual experiences of the MC state initiatives can be seen as the foundation for “best practices” for states and communities embarking on or refining primary care transformation, and for any systemic reform initiative.

How will the needed transformation of the health care delivery system occur? Will it be driven by Medicare, with private payers falling in line as they generally have done with the dominant fee-for-service hospital and physician payment mechanisms? Will financially incentivized consumers select value-producing practitioners and reward them with their business, as one would expect in a functioning economic market? Or will communities and payers, informed by evidence linking individual and population health to forces outside the health care system, define broad health goals and work to align payments to providers to achieve those goals?

These very real questions are being asked and answered in the wake of the Affordable Care Act. A systemic perspective is necessary—no single entity can independently drive lasting and meaningful change in health care. Given the reality of our multi-payer world and the characteristics of medical care that defy principles of a market economy, the collaborative model—which attends to the dynamics of system change despite its challenges—may be a vital way in which systematic health and health care delivery system transformation can occur and be sustained.

Appendix

INTERVIEW QUESTIONS

INTERNAL TO YOUR STATE'S PROGRAM

1. What have been your engagement strategies with commercial payers? Employers? Patients/consumers?
 - a. Which have been most effective?
 - b. How sustainable are these arrangements?
2. Are payments “transparent”? If so, only to “players” or to the public?
 - a. Per-patient-per-month (PPPM) or Per-member-per-month (PMPM) to practices?
 - b. Community Health Team/Care Coordination Team support/salaries?
 - c. Payments for delivery of health care services?
3. Does your program support “transformation” activity?
 - a. At what level (individual practices, groups of practices, community, other)?
 - b. What are the mechanisms used (in-person, webinar, curricula)?
 - c. How is it funded?
 - d. Is there a Learning Health System you can describe? At what level?
4. What have been your biggest challenges internally?
 - a. Political climate?
 - b. Internal funding?
 - c. Administrative burden?
 - d. Change fatigue?
 - e. Data collection?
 - f. Data analysis?
 - g. Other?
5. Can you share outcomes data?
6. Can you share a summary of the governance of your program?

EXTERNAL TO YOUR STATE'S PROGRAM

1. MAPCP or CPC (if applicable)
 - a. Communication
 - i. Accessibility of CMS Innovation Center staff and contractors
 - ii. Usefulness of feedback reporting
 - iii. Future plans (after the demonstrations end)
 - b. Requirements
 - i. Data submission
 - ii. Attribution
 - c. Payment
 - i. Timeliness
 - ii. Accuracy (attribution, other methodology)

2. The MC
 - a. Has this been helpful? If so, why and how?
 - b. Are there improvements you would make?
 - i. Communication (frequency, venue/mechanism)
 - ii. Topics
 - iii. Advocacy activity
 - c. Would you change the membership of the group? If so, how?

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Resources

STATE WEBSITES

Maine Quality Counts: <http://www.mainequalitycounts.org/>

MiPCT Demonstration Project (Michigan): <http://mipct.org>

Patient-Centered Medical Home CSI-Rhode Island: <http://www.pcmhri.org>

Community Care of North Carolina: <https://www.communitycarenc.org>

Adirondack Region Medical Home Pilot: <http://www.adkmedicalhome.org>

Pennsylvania Academy of Family Physicians: <https://www.pafp.com>

Transitional Care Model (Pennsylvania): <http://www.transitionalcare.info>

Minnesota Health Reform: <http://www.health.state.mn.us/healthreform/homes/medicare/>
and <http://www.health.state.mn.us/healthreform/homes/index.html>

Vermont Blueprint for Health: <http://hcr.vermont.gov/blueprint>

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) WEBSITES

CMS Innovation Center: <http://innovation.cms.gov>

Multi-Payer Advanced Primary Care Practice (MAPCP): <http://innovation.cms.gov/initiatives/Multi-Payer-Advanced-Primary-Care-Practice/>

Comprehensive Primary Care (CPC) Initiative: <http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/>

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