Primary Care Case Management in Medicaid: A Strategy for Supporting Primary Care in Rural Areas

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Executive Summary

Primary care case management (PCCM) programs are one of the oldest types of Medicaid managed care, but over time most states have shifted to use managed care organizations (MCOs) to deliver services to Medicaid participants. However, as of 2018, 13 states still delivered services through PCCM programs to about 5.5 million Medicaid participants. In almost all of these 13 states a large portion of the population lives in rural areas, which are more likely than urban areas to have a shortage of primary care providers (PCPs). In recognition of this situation, and considering the key role that PCPs play as the entry point to medical services and in-care coordination, some of the 13 states have begun to leverage their PCCM programs to strengthen primary care. NASHP identified five states (Alabama, Colorado, Maine, Idaho, and Oklahoma) leveraging their PCCM programs to encourage and support PCPs to improve the delivery of care to Medicaid participants and interviewed representatives of three of these states. These five states implemented three major types of strategies:

- Colorado, Idaho, and Oklahoma reward PCCM providers for improving their **capabilities**. Idaho, for example, established a tiered PCCM payment system that rewards PCCM providers who demonstrate greater capabilities with higher per member per month (PMPM) payments.
- Colorado, Idaho, Maine, and Oklahoma all reward PCCM providers for **performance**. Oklahoma, for example, offers PCCM providers incentive payments tied to specific achievements, such as screening patients for potential behavioral health conditions.
- All five states offer **non-financial supports** to PCCM providers, including technical assistance (Idaho and Oklahoma), data analytics (Maine and Oklahoma), and organizations to support affiliated PCCM providers in a variety of ways (Alabama, Colorado, and Oklahoma).

These states' experience also revealed several lessons for designing innovative strategies to strengthen primary care. Perhaps the most important is to identify specific goals and objectives early on to guide the details of design, such as the choice of quality metrics for incentive payments. In addition, it is important to build in measurement at the start and to think of state efforts as iterative — moving to tackle new priorities as performance improves.

The strategies discussed here were developed for PCCM programs. The strategies could, however, be implemented via MCO contracts or even in fee-for-service programs. It is therefore our hope that the strategies and experience presented here will inform the efforts of states operating PCCM programs and those that use other delivery systems.

Introduction

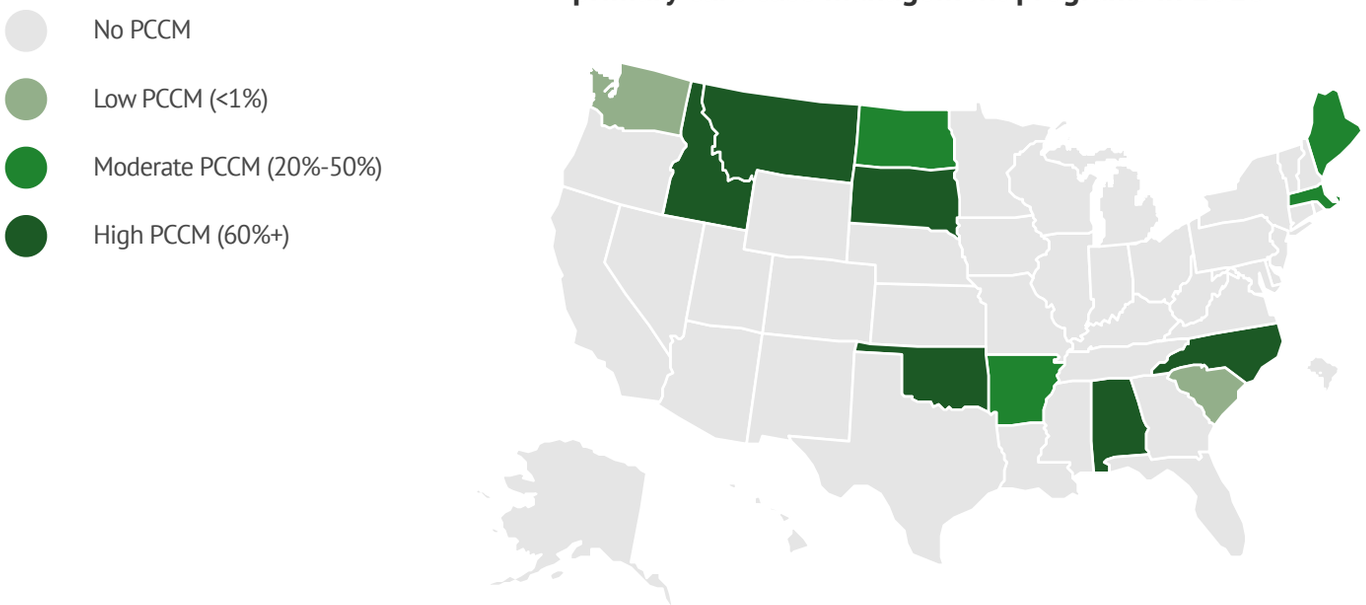
State Medicaid agencies have operated primary care case management (PCCM) programs for 40 years.[1] During this time, these programs have evolved, and in recent years states have begun leveraging these programs to improve primary care. Compared to other states, most states that operate PCCM programs have a greater portion of their population living in rural areas.[2] Rural areas are highly likely to suffer from shortages of primary care and other providers. As a result, these states' efforts to leverage their PCCM programs to improve primary care can produce significant benefits for rural residents. This report examines the efforts of five states to leverage their PCCM programs to strengthen primary care. Because these strategies could be implemented in Medicaid managed care organization (MCO) contracts we hope that the report will be useful not only to those currently operating PCCM programs but also to any state Medicaid agency seeking to strengthen primary care in rural areas.

Background

Only 19.3 percent of the U.S. population lives is rural areas.[3] However, as of March 2021, 61 percent of all primary care shortage areas were in rural areas.[4] These shortages of primary care providers (PCPs), who serve as the entry point to medical care and often play a large role in coordinating patient care, create challenges for residents of rural areas, the PCPs who serve them, and the Medicaid agencies responsible for providing access to services for program participants throughout the state. For example, rural residents are less likely than urban residents to obtain preventive services, including services needed to identify health conditions early in their onset.[5] Also, those living in rural areas are more likely to experience a preventable hospitalization.[6] Shortages of other providers — including mental health, oral health, home health, and obstetric providers[7] — exacerbate the primary care shortages as PCPs in rural areas have few other providers to refer their patients to for treatment.

State Medicaid agencies have operated PCCM programs to help manage and coordinate patient care for 40 years. Although most states have now shifted to using MCOs to deliver care to Medicaid enrollees, 13 states still operate PCCM programs that serve about 5.5 million Medicaid enrollees. Ten of these 13 states have a greater percent of their population in rural areas[8] than other states and, relative to their population, have fewer physicians directly delivering patient care.[9]

Figure 1: 13 states enrolled Medicaid participants into primary care case management programs in 2018



Source: Centers for Medicare & Medicaid Services (2018). 2018 Managed Care Enrollment by Programulation (All).

Some of the state Medicaid agencies that operate PCCM programs have begun to view them as a vehicle for investing in primary care and supporting PCP efforts to meet the needs of the Medicaid patients — a critical need in rural areas. Under this model of managed care, the state Medicaid agency has a direct agreement with PCPs (or an entity representing them), who accept responsibility for managing the services provided to their panel of patients. Historically, PCCM providers were paid on a fee-for-service basis for the services they provide plus a small per member per month (PMPM) fee. The PMPM fee was intended to recognize the costs associated with more active management of their patients' care that are not associated with a specific service, such as implementing new office procedures to ensure that all patients are screened for depression or extending office hours.

Through internet research, NASHP identified five states that were using their PCCM programs as a vehicle for primary care investment (Alabama, Colorado, Idaho, Maine, and Oklahoma). Four of these states deployed payment models that create incentives for PCCM providers to develop new capabilities or improve their performance. All five established non-financial supports to help providers improve performance and coordinate patient care. This report examines the approaches these five states have taken to strengthen primary care. It uses information collected from internet research and interviews with state Medicaid officials in three of the five states (Colorado, Idaho, and Oklahoma[10]). It also incorporates input from Montana's Medicaid agency, which had requested this analysis to help it develop options for improving its PCCM program.[11]

PCCM Programs: A Catalogue of Innovations

NASHP identified five states that were leveraging their PCCM programs[12] to encourage and support PCPs to improve the delivery of care to Medicaid participants (Table A). Examining the efforts of the five states finds three major approaches to investing in primary care: payment that rewards providers for improving their capabilities to deliver care, payment that rewards providers for improving performance, and non-financial support to help providers succeed in their efforts to improve care delivery. Each of these approaches is examined in more detail in this section.

Table A: Innovations to support primary care providers in five state PCCM programs

State	Payment to improve capabilities	Payment to incent performance	Non-financial Supports for PCCM providers
Alabama			Coordinated health networks
Colorado	x	x	Regional accountable entities
Maine		x	Provider profiles
Idaho	x	X (effective 7/2021)	Technical assistance provided by Medicaid staff, developing data analytic support
Oklahoma*	x	x	Provider profiles, technical assistance provided by Medicaid staff, and health action networks in some regions

Note: * = Oklahoma plans to move to an MCO delivery system in October 2021.

Using Payment to Promote Practice Capabilities

Three of the study states (Colorado, Idaho, and Oklahoma) established PCCM programs that reward providers for improving their capabilities. These states have both established ongoing payment models that reward PCCM providers with more advanced capabilities with higher PMPM payments and have offered providers time-limited incentives to promote development of specific capabilities.

Idaho and Oklahoma: PCCM payment varies by provider capabilities

In 2016, Idaho established a four-tiered PCCM program, referred to as Healthy Connections PCMH Tier Program. Under this program, PMPM payments to PCCM providers vary by provider tier. Tiers were named to signal which capabilities were the focus of that tier's requirements. For example, tier 2 was named Healthy Connections Access Plus to reflect that PCCM providers had to offer some form of enhanced access, such as telehealth, to qualify for the tier. The tiers were designed to reward PCCM providers as they gradually increased their patient-centered medical home (PCMH) capabilities. For example, to move from tier 3 to tier 4, the provider must meet all the requirements of tier 3 and several new requirements, such as having a well-established quality improvement process. Idaho also offered flexibility to providers. For example, providers seeking to join tier 2 had five options for demonstrating enhanced access.

Most PCPs can meet the requirements of tier 1 and, at implementation, all PCCM providers that had not qualified for a higher tier were assigned to tier 1. PCCM providers may move up in tier (and thus increase their PMPM payment amounts) at any time by submitting a tier application documenting the required capabilities. In most cases, the Medicaid agency specifies documentation[13] needed to prove capabilities and also verifies the capabilities via telephone or a site visit.

State officials estimate that they spend about $25 million per year on PMPM payments. They also reported that providers did respond well to the program by seeking to qualify for a higher tier, especially in the early years of the program and especially among rural providers, where the need for increased capabilities is greater. As demonstrated in the table below, at the inception of this program, only 66 providers, serving 24 percent of Medicaid participants, were classified as tier 3 or 4. As of May 2021, 156 providers, serving 62 percent of participants, had qualified for an upper tier. One Medicaid official said, "We saw providers in rural areas moving into higher tiers. Many moved into the fourth tier."

Table B: Healthy Connections provider and participant enrollment by tier, 2016 and 2021

	February 2016			May 2021		
Healthy Connections (HC) Tier	**# PCCM Providers**	**# Medicaid Participants**	**% Participants**	**# PCCM Providers**	**# Medicaid Participants**	**% Participants**
Tier I HC	337	100,950	39%	173	42,490	12%
Tier II HC Access Plus	98	96,438	37%	192	90,803	26%
Tier III HC Care Management	41	51,955	20%	43	76,628	23%
Tier IV HC Medical Home	15	11,888	4%	113	134,470	39%
TOTALS	**491**	**261,231**	**100%**	**521**	**344,391**	**100%**

Source: Idaho Department of Health and Welfare

Oklahoma's tiered payment model is very similar to Idaho's. In 2009, Oklahoma created three tiers of medical homes (PCCM providers) and began varying the PMPM payment to the provider based on the provider's tier and each enrollee's Medicaid eligibility group. New medical home providers request a tier assignment, and Medicaid staff evaluate whether the provider qualifies for the tier. Requirements increase gradually as providers move through the tiers, but providers have some flexibility to choose which capabilities they will acquire to qualify for the tier. In Oklahoma, practices seeking to increase their tier level (and payment) apply for the new tier by September 30 of each year. Medicaid staff then evaluate whether the provider meets the qualifications of the higher tier. If approved, the new tier becomes effective on January 1 of the next year. Medicaid staff also audit about one-third of providers each year to make sure that they continue to meet their tier's qualifications. State officials report that, based on the large shift of providers among tiers in the first few years of the program, the program succeeded in encouraging providers to increase their capabilities.

Colorado: Incentives to develop specific capabilities

From 2015 to 2018, Colorado Medicaid operated the enhanced primary care medical provider (PCMP-E) program, which rewarded those PCCM providers (referred to in Colorado as PCMPs) that met at least five of nine enhanced factors with a $0.50 PMPM increase in their regular PMPM rates. The nine factors were extended hours, timely clinical advice, data use and population health, behavioral health integration, behavioral health screening, patient registry, specialty care follow-up, consistent Medicaid provider, and patient-centered care plans. The most commonly met factor was "timely clinical advice," which was defined as "provides timely clinical advice by telephone or secure electronic message both during and after office hours. Patients and families are clearly informed about these procedures." This program was intended to ready providers to meet increased expectations under phase 2 of Colorado's accountable care collaborative (ACC),[14] which was under development at that time.

Using payment to create incentives to improve performance

Four of the five study states (all but Alabama) used payment to create incentives for performance. Most of these states tied provider payments to achieving quality metrics or decreasing growth in the total cost of care (TCOC). However, one has also used payment to increase patient engagement, and one is implementing a shared savings component in their program.

Colorado, Maine, and Oklahoma: Payment tied to quality metrics or total cost of care

Oklahoma offers PCCM providers incentive payments tied to specific achievements and reports, spending $2.9 million on these incentives in fiscal year 2018. The structure of these payments varies by the incentive. Two examples illustrate the possibilities:

- Oklahoma offers PCCM providers $5 for each annual behavioral health screen they conduct (paid quarterly).
- Oklahoma earmarked $250,000 per quarter to be divided among those providers who achieve a specified Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening rate. The funding is divided using a methodology intended to award a bonus payment equal to 25 percent of the standard cost of the EPSDT screens.

In 2013, Colorado, as part of the first phase of its ACC, added a quality incentive to its PCCM payment structure. All PCCM providers received $3 PMPM for all enrollees but were also eligible for incentives of as much as $1 PMPM based on their performance on specific quality measures. Each measure was assigned a PMPM amount, and those providers that met performance criteria for that measure received a bonus based on the assigned PMPM amount. The measures changed each year. The incentive began with an initial set of three measures that were all related to cost containment. These measures sought to promote reductions in emergency room utilization, high-cost imaging utilization, and hospital readmission. Later, the Medicaid agency added a measure related to quality, which sought to promote increases in well-child visits among children ages 3 to 9.

In 2019, Colorado launched its alternative payment model (APM) for primary care providers. Under this program, the fee-for-service payment rates for specific services (referred to as the APM code set) vary based on participating providers' performance on 10 quality measures. This model is for providers who serve at least 200 ACC enrollees or earn at least $30,000 annually in paid claims for providing the services included in the APM code set. Each year each participating provider selects 10 measures from a list developed by the state. In 2021, that list includes 63 measures. Each measure is worth a set number of points. Providers who, across the 10 measures, earn a total of 200 or more points are paid the full fee-for-service rate for the services in the APM code set. Payments paid to those who earn fewer than 200 points are reduced by a percentage calculated based on the total number of points earned. Fewer points result in greater reductions. A provider that did not earn any points would incur a reduction of four percent. All providers who qualify for participation must choose measures or the Medicaid agency will assign default measures. To date, very few providers have been assigned default measures.

Maine created the Primary Care Physician Incentive Payment (PCPIP) in 1998 and spends about $2.6 million per year on the program. The PCPIP rewards physicians who provide quality primary care to their Medicaid patients. Each quarter, physicians receive scores in three categories: access (e.g., total number of Medicaid patients served per quarter), utilization (e.g., emergency visit rate per quarter), and quality (e.g., percentage of mothers in practice who had a checkup within six weeks after delivery). The performance of each physician's practice is compared to that of other practices in their primary care specialty and then given an overall ranking. All physicians ranking above the 20th percentile receive a share of available funds; those who rank below that mark do not receive a share. The size of the share that each receives is determined by their ranking. Those who rank higher receive larger shares.

As of October 2021, Maine plans to merge the PCPIP and both its PCCM and health home programs to create Primary Care 2.0. Participating providers will receive risk-adjusted population-based payments (PBP) based on the three levels of qualifying practice characteristic (base, intermediate, and advanced), with the advanced tier reserved for primary care practices that are part of Maine's Accountable Communities program. This PBP will be adjusted for provider performance on no more than 10 quality measures, one of which is total cost of care and another antidepressant medication management.

In the first phase of the program, providers will continue to receive the current fee-for-service rates for the services they provide. In the second phase, Maine will look to move away from fee-for-service and incorporate more services into the PBPs. Maine has officially aligned this model with the Centers for Medicare and Medicaid Innovation's Primary Care First initiative.

Oklahoma: Patient engagement required for payment

In addition, Oklahoma does not pay for care coordination until a PCCM provider has established a relationship with the patient. Specifically, Oklahoma does not make a PMPM payment to a provider for any enrolled patient unless the provider has provided at least one service to the enrollee within the previous 15 months.

Idaho: Providers earn shared savings

Idaho is currently transitioning to a new model under which PCCM providers may receive shared savings through their participation in an accountable care program. The Healthy Connections Value Care program went live July 1, 2021, and requires participation for PCCM providers. Value care organizations may participate under a risk or shared savings only option. Savings/losses are calculated based on total cost of care for medical services and shared based on the providers' performance on a set of quality measures. Under this approach, PCCM providers will continue to be incentivized to transition to the PCMH model of care as well as provide better quality, more cost-effective care, through their affiliation with value care organizations.

Non-financial Supports

All five of the study states offer non-financial supports to PCCM providers. These supports consist of technical assistance, data or data analytics, and access to networks that support provision of care.

Idaho and Oklahoma: technical assistance

PCCM providers in Idaho and Oklahoma can receive technical assistance and other support from Medicaid staff. Oklahoma's care management and quality departments support the PCCM providers. The nurses in the care management department support PCCM providers by helping their enrollees with complex needs navigate the health care system to access the specialized services needed to treat their conditions. The quality department staff works directly with PCPs to improve the delivery of specific care — usually in alignment with the previously described incentive payment topics (e.g., increasing the EPSDT screening rate or screening for behavioral health conditions). Medicaid staff in both states also visit PCCM providers on a regular basis. These visits are now conducted via telephone, but before the COVID-19 pandemic, they were in-person visits. During these visits, the staff not only check that providers are meeting program requirements but work with them to identify changes the provider could make to qualify for a higher tier.

Maine and Oklahoma: data analytics

Maine and Oklahoma currently generate provider profiles for PCCM providers that show their performance on measures aligned with payment. These reports also help PCCM providers identify "gaps in care," meaning the reports show providers which of their patients need specific services, such as a well-child visit. Oklahoma generates four types of provider profiles showing performance on emergency room utilization, breast cancer screening, cervical cancer screening, and well-child visits. These reports detail the individual performance and how that performance ranks among their peers. With implementation of shared savings, Idaho plans to also begin offering providers reports that show their performance on the quality measures incorporated into the payment model and on cost.

Alabama, Colorado, and Oklahoma: organizations that support provision of primary care

The final type of non-financial assistance that states offer to PCCM providers is access to organizations or networks that help them care for enrollees. Alabama, Colorado, and Oklahoma all offer this type of assistance. In Alabama and Colorado, the networks are themselves categorized as PCCM entities (PCCM-E), which are organizations that contract with the state to provide PCCM services or perform specific tasks that support the provision of primary care.[16] As previously discussed, both of these states also contract with PCCM providers.

In 2019, Alabama implemented a regional PCCM program that featured a single PCCM-E, called an Alabama coordinated health network (ACHN), for each region of the state. The ACHN program combined multiple programs designed to deliver various levels of care coordination to various populations (PCCM, health homes, maternity care, etc.). The state conducted a procurement process to secure the contractors. Each is to serve as a single care coordination delivery system that links patients, providers, and community resources in its region. Like a traditional PCCM program, an ACHN does not deliver medical services. ACHNs are paid a combination of PMPM payments, payments for specific care coordination services provided during a month, and a bonus payment of up to 10 percent of revenue based on performance on 10 quality metrics. Recognizing the unique challenges of rural areas, regional budgets adjusted for rural areas cap total payment in each region. Alabama Medicaid views the program as a quality improvement program built on a care coordination infrastructure and has established performance requirements, such as required screens, for new enrollees. The ACHN assists PCP/PCP groups with care coordination, including providing referrals to medical services and arranging non-emergency transportation.

In 2011, Colorado implemented phase 1 of its ACC, which supported PCCM providers' efforts to deliver care by providing them access to a statewide data contractor and PCCM-Es referred to as regional care collaborative organizations (RCCOs). The data analytics contractor provided a dashboard to each PCCM provider that offered aggregate and patient level data needed to help providers manage their panel. The RCCOs provided care coordination (beyond what would normally be expected of a PCP), including coordination for behavioral health, long-term services and supports, and some social services. They also provided practice support, including tools and technical assistance aimed at helping the practice become and function as a high-performing medical home. In this phase of the program, the Medicaid agency required PCCM providers to affiliate with at least one RCCO. Many providers, however, chose to contract with several RCCOs

In 2018, Colorado launched phase 2 of the ACC when it folded the responsibility for delivering behavioral health services into the program. In this phase, Colorado replaced the RCCOs with seven new PCCM entities referred to as regional accountable entities (RAEs). RAEs support a local network of medical PCCM providers, deliver behavioral health services, coordinate members' care across systems, and are accountable for the cost and quality of care delivered to Medicaid members. Colorado assigns almost all Medicaid participants to a RAE. Through this program, Colorado is seeking to both improve behavioral health services and better integrate them with physical health. PCCM providers are required to contract with one RAE in order to serve Medicaid enrollees. PCMPs continue to receive fee-for-service payments from the Medicaid agency, but the PMPM payments to PCCM providers now flow through the RAEs. State officials report that making the RAEs responsible for distribution has given them greater flexibility to design value-based payment arrangements. Many of the RAEs have established tiered PMPM payment structures based on the capacity/performance of the provider.

In 2010, Oklahoma began piloting three health access networks (HANs), which wrap around PCCM providers to help them fulfill their role as primary care providers. The HANs offer care coordination and care management services to the patients of the PCCM providers that the HAN supports. The support includes helping enrollees access services that address their health-related social needs, such as food insecurity. The HANs also work with enrollees who frequently (and inappropriately) use the emergency room to help them obtain needed care from more appropriate sources. The HANs receive $5 PMPM — and a state evaluation found that the state netted a savings of $3.2 million in one 12-month period. The evaluation also found evidence of improvements in quality, as well as decreased emergency room use. The HANs were selected via an application process that describes them as an entity representing a collection of providers that is "organized for the purpose of restructuring and improving the access, quality, and continuity of care to SoonerCare members, the uninsured and the underinsured; and offers patients access to all levels of care, including primary, outpatient, specialty, certain ancillary services, and acute inpatient care, within a community or across a broad spectrum of providers across a service region or state." (Note: The HANs will cease operation when the new MCO program launches in October 2021.)

Lessons Learned Using PCCM Programs to Improve Primary Care

Innovations Need to be Designed to Achieve Specific Goals and Objectives

Interviewees emphasized that the innovations they implemented were designed with specific goals in mind. In most cases, the overarching goal was to strengthen primary care — often by encouraging PCCM providers to develop more advanced PCMH capabilities. Colorado Medicaid stressed making primary care investment a clear policy goal to set the tone for state health planning not just in Medicaid but also in the private health care sector and with the state legislature. State interviewees also reported that it was important to have specific objectives under the overarching goal, such as better integration of behavioral health and primary care or improving children's services. These objectives would govern which provider capabilities states would call out in tier requirements or the performance measures they would attach incentives to.

States reported that it was best to secure stakeholder input and support of these goals and objectives. But at a minimum, providers needed to know what the goals were and why the Medicaid agency was changing the PCCM program.

With the exception of Alabama, all of the study states used multiple, mutually reinforcing strategies to achieve their goals and objectives for improving primary care. Idaho, for example, complemented its payment tiers with technical assistance to help providers develop the capabilities needed to move up in tiers and is developing data analytics that will help providers improve their performance on quality measures. Oklahoma established payment tiers, incentives for making specific improvements, and reports of provider performance on key issues, such as emergency department utilization.

All state officials interviewed said that their programs were iterative. They expected to make changes as they achieved current objectives and were able to tackle new ones. Colorado did not add behavioral health services to its ACC program until phase 2 of that program. State officials made this decision because they wanted PCCM providers to first develop their medical home capabilities and become the focal point of care for patients' physical health services before working to break down the silos in care. Both Idaho and Oklahoma reported that their efforts to encourage providers to gradually increase their PCMH capabilities had worked, as most providers had gradually moved to higher payment tiers. Idaho built on the broad improvements in capabilities by moving to shared savings. Oklahoma, which is implementing an MCO program, is requiring the MCOs to build their networks around a PCMH delivery system.

> "Remember that this program (ACC) is not totally the end. Rather, it is part of a process."
> -Colorado Medicaid official

Available Resources Impact State Decisions

Study states with the resources to make a long-term investment in strengthening primary care were likely to select an ongoing innovation that would produce change over time, such as a tiered payment structure. Idaho, for example, invests about $25 million/year (out of a $3 billion budget) in its tiered PCCM payments. Colorado also secured new funding to increase PCCM payments made under its ACC. However, interviewees reported that not all investments require new funding. Colorado worked with its contracted RCCOs to redirect $.50 PMPM of a performance incentive payment available to the RCCOs to instead be used, through the PCMP-E program, as a short-term incentive for the PCCM providers to develop specific capabilities that would contribute to the RCCOs' success. The three states that tie provider payment to performance on a set of quality measures can also reap ongoing value from these established investments by updating their measure sets to create incentives to promote improvement in new areas.

State resources are not limited to funding for payments. System capabilities and staffing must also be considered. Oklahoma Medicaid, for example, needed to change its claims processing system to track services at the individual provider, and not just the provider group level, in order to implement its policy to only pay PMPM PCCM payments to providers who have seen the enrollee at least once within the previous 15 months. This state also hired provider education

specialists who were tasked with visiting PCCM providers to assist them in meeting the criteria to which payment is tied — both the tier and incentive requirements. Colorado hired new staff to focus on system innovation and invested staff time in creating work groups to receive feedback. Interviewees reported that the audit function (ensuring the PCCM providers meet program requirements) could be particularly staff intensive, and each had developed strategies to minimize that need. Idaho allows providers to "self-attest" to their capabilities when applying for a new tier, but Medicaid staff verify a sample of these applications each year. Colorado delegates this audit function to its contracted RAEs. Oklahoma Medicaid staff visit most PCCM providers about once every three years to verify that the providers are still meeting program requirements but does not visit those providers who are certified as PCMHs by an outside entity such as the National Committee for Quality Assurance (NCQA). State officials in all three states emphasized that the audit visits also provided an opportunity to educate the provider about program requirements and identify changes that the provider could make to qualify for incentive payments or higher PMPM payments.

Consider Measurement from the Start

Several interviewees reported that if they were designing their innovations now, they would place a greater emphasis on measurement and assessment. Officials from both Idaho and Oklahoma explained that they can demonstrate that providers increased their capabilities because over time more providers have shifted to higher tiers. Evidence indicates that these provider capability improvements should produce patient outcome improvements. These states, however, did not incorporate patient outcome measures into their plans and, thus, have not been able to quantify those improvements. Building in patient outcome metrics as part of program development would help to support further program improvement and budget justification over time.

> "We need more data on the outcomes. We want to show that people have less hospitalization and people with diabetes are getting A1C."
> -Idaho Medicaid Official

Motivate PCCM Providers to Participate

Interviewees reported that one of their keys to success was to motivate PCCM providers to participate in their innovations. These states implemented strategies to secure provider interest and support and designed their innovations to be attractive to providers. To secure provider interest and support, states engaged providers in program design and worked to obtain the support of physician leaders.

> "Every year, we talk with physicians and groups and discuss what we missed. Every year we would add an element to the tiers."
> -Oklahoma Medicaid Official

Oklahoma established a primary care physician task force in 2008 to help the state re-envision their PCCM program. Members of this group, who were all well-respected by their peers, were dissatisfied with the capitated PCCM model then in place in Oklahoma. This was also the time when many states were pursuing PCMH initiatives, so the task force and the Medicaid agency worked together to develop a new PCCM program that would foster development of a PCMH-based delivery system. The task force, which included a broad range of providers, held monthly meetings with Medicaid staff. The staff did research between meetings, including learning from

other states, to develop proposals to bring back to the group. Together, the group developed a tiered PCCM payment system group members agreed was fair. The group believed that the tiers give physicians freedom to choose the tier that best fits their business model. Similarly, Colorado implemented an extensive and ongoing effort to engage not just providers but also other stakeholders in ACC design. Idaho did not develop a specific task force but had worked closely with the Idaho Primary Care Association (IPCA), which represents federally qualified health centers (FQHCs), for many years and had a strong relationship with the organization and the FQHCs. The agency also had a strong relationship with the Idaho Academy of Family Physicians (IAFP) and its then-president. Both the IPCA and the IAFP were involved in the design of Idaho's tiered PCCM payment system and were strong supporters of the model. They played a key role in helping other providers understand the model and how they might benefit from it.

> "Find a champion to get buy-in. Find someone who understands why the changes are important."
> -Colorado Medicaid Official

Interviewees had three specific suggestions for innovation design that they believed would make it easier to engage PCCM providers in actively working toward the state goals embodied in the innovation. These suggestions were to align payment criteria with national standards, make the reward obtainable, and offer providers flexibility.

Idaho, for example, aligned the criteria for its payment tiers with those of NCQA's PCMH recognition standards, including requiring PCMH recognition to enter the fourth tier. The tiers provided a path of gradually increasing criteria (and payment) to obtaining recognition. Each tier was achievable from the previous one. Idaho Medicaid also offered providers flexibility in meeting the criteria. For instance, to enter tier 2, a PCCM provider had to demonstrate enhanced access, but the Medicaid agency gave providers five options for meeting that criterion, including offering at least 46 hours per week of primary care access, telehealth, or a patient portal. Similarly, Colorado drew the nine factors considered in its PCMP-E program from NCQA's PCMH standards and enabled PCCM providers to earn the incentives by implementing any five of the nine factors.

Finally, Colorado Medicaid officials noted that providers are motivated by recognition as well as money. They found that, often, the competition to earn reward payments was as important of a motivating factor as the payments themselves. Providers also realized, due to the alignment with national standards, that meeting the Medicaid standards could also earn rewards from other payers, including Medicare. The distinction of being an advanced primary care provider was also a draw for some providers. In light of these observations, Colorado began offering providers certificates recognizing their achievements in addition to payment.

Help PCCM Providers Succeed

State officials reported that, because the innovations were designed to achieve state goals, the state benefitted from helping providers succeed in earning the rewards associated with the innovations. In other words, helping providers develop new capabilities or improve their delivery of care for the chronic or potentially high-cost conditions prevalent among Medicaid enrollees ultimately helped the agency contain cost and improve care quality. Medicaid officials in all three interview states reported providing assistance to providers.

> "Prepare providers. Providers were comfortable where they were, but they welcomed the tiers as a new opportunity."
> -Idaho Medicaid Official

In both Idaho and Oklahoma, Medicaid staff provided technical assistance to PCCM providers. Prior to the COVID-19 pandemic, the assistance was delivered in provider offices, but it is now offered virtually. These staff found that explaining that their assistance could result in financial rewards increased provider interest in implementing specific improvements that addressed state goals. Colorado worked with local organizations, such as the Children's Healthcare Access Program, that were already providing relevant technical assistance to providers to develop assistance that explicitly supported the improvements incented by the ACC. The Children's Healthcare Access Program created resources to share data and teach providers about ACC requirements and goals.

All three states also offered other resources. Idaho provided forms that providers could use to demonstrate that they met tier criteria, and Colorado tasked its RAEs with providing both technical assistance and data analytics to PCCM providers to help them earn rewards by improving performance. Oklahoma first created a compendium of screening tools that providers could use to qualify for the behavioral health incentive payment. Providers, however, were concerned that they would not be able to act on any positive screening results because they did not know where to refer enrollees with potential behavioral health conditions for services. In response, the agency gave PCCM providers information about every behavioral health provider available to serve Medicaid enrollees in their county.

Summary

States can leverage their PCCM programs to strengthen primary care, particularly in rural areas where access and care coordination can be challenging. States that have taken this approach have found that they can design innovations that reward providers for improving the care most often needed by Medicaid enrollees. Through these programs, states can offer PCPs incentives to increase their capabilities or improve their performance. They can also offer non-financial supports such as technical assistance and access to the aggregate and person-level data they need to improve performance. States, however, need to design these innovations to achieve (and show they have achieved) clear goals and objectives and with consideration of available resources. They also need to ensure that PCCM providers understand, and ideally agree with, the goals of the program and offer providers the flexibility to implement the specific improvements that make sense for their practice.

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Notes

[1] Primary care case management programs were authorized by the Omnibus Budget Reconciliation Act of 1981.
[2] In 2010, 10 of the 13 states with PCCM programs were among the 25 states with the greatest percentage of their population living in a rural area. Source: U.S. Census Bureau (2010), Percent Urban and Rural in 2010 by State. www2.census.gov/geo/docs/reference/ua/PctUrbanRural_State.xls.
[3] U.S. Census Bureau (2019). What is Rural America? www.census.gov/library/stories/2017/08/rural-america.html.
[4] U.S. Health Research and Services Administration (2021). Designated Health Professional Shortage Areas Statistics. Second Quarter of Fiscal Year 2021. Designated HPSA Quarterly Summary. https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport.
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[7] Rural Health Information Hub. Rural Healthcare Workforce. 2020. www.ruralhealthinfo.org/topics/health-care-workforce#characteristics.
[8] In 2010, 10 of the 13 states with PCCM programs were among the 25 states with the greatest percentage of their population living in a rural area. Source: U.S. Census Bureau (2010), Percent Urban and Rural in 2010 by State. Retrieved from www2.census.gov/geo/docs/reference/ua/PctUrbanRural_State.xls.
[9] Nine of the 13 have fewer active patient care physicians per 100,000 than the nation as a whole. Source: https://store.aamc.org/downloadable/download/link/id/MC4wNzQ5NDEwMCAxNjE3NzQxMTQ3NzY0MDIzNjkxMjAxMTE2OQ%2C%2C/.
[10] After the interview Oklahoma began moving its delivery system to an MCO delivery system, which is planned for launch in October 2021.
[11] The information presented in this brief was gathered to help Montana Medicaid better understand its options for improving its PCCM program. Thus, Montana's program is not part of this study, but Montana state officials selected the interview states, participated in the interviews, and provided input to the findings presented here.

[12] Four of these states also operate other managed care programs: Colorado made its RAEs responsible for operating the state's prepaid inpatient health plan (PIHP) for behavioral health; Idaho operates a PIHP for behavioral health, one prepaid ambulatory health plan (PAHP) for oral health services, a second PAHP for non-emergency transportation (NEMT), and has two contracts with health plans to serve dually eligible Medicaid program participants; and both Maine and Oklahoma have PIHPs for NEMT.
[13] For example, providers who choose to use a patient portal to meet one of the tier 3 requirements must, according to the application, submit the following along with their application: portal policies and procedures or other documentation that includes clinic's expected response time to portal inquiries and screenshots of their live patient portal demonstrating that the portal has the features required by the state.
[14] The ACC is Colorado's version of a Medicaid ACO program.
[15] Maine Department of Health and Human Services. MaineCare Benefits Manual, Chapter II, §90.09-4. (2019 update) www.maine.gov/sos/cec/rules/10/ch101.htm. Retrieved June 18, 2021.
[16] Per §438.2 of the CFR, primary care case management entity (PCCM-E) means an organization that provides any of the following functions, in addition to primary care case management services. (1) intensive telephonic or face-to-face case management; (2) development of enrollee care plans; (3) contract and/or oversight responsibilities for the activities of providers in the fee-for-service program; (4) payments to fee-for-service providers on behalf of the state; (5) enrollee outreach and education activities; (6) operation of a customer service call center; (7) review of provider claims, utilization, and practice patterns to conduct provider profiling and/or practice improvement; (8) implementation of quality improvement activities; (9) coordination with behavioral health systems/providers; (10) coordination with long-term services and supports systems/providers.