Program Charter

Program Name	Washington State Patient-Centered Medical Homes Multi-Payer Reimbursement Pilot
Department/Program	Health Care Policy, in conjunction with the Department of Social and Health Services
Goal	Design, implement and evaluate one or more provider reimbursement models for medical home services
Sponsor	Richard Onizuka
Project Manager	
Start Date	September 01, 2009

1 PROGRAM OVERVIEW

1.1 Goals of This Work

Near Term: By June 2012, design, implement and evaluate the essential elements of one or more outcomes-based reimbursement pilots to test whether a modified approach to primary care payment will result in improved quality, improved provider and patient experience, and lower total cost per capita for participating practices and patients.

Longer Term: Agree upon one or more outcomes-based payment methods that can be expanded to additional provider groups and payers that will optimize the quality and value of care delivered in the primary care setting.

1.2 Authorizing Legislation: SSB 5891 (2009) Primary Care-Pilot Projects

1.3 Background/Context

There is growing momentum around the concept of the primary care-based 'medical home' as a desirable and important strategy to (1) improve the quality and coordination of care, particularly for patients with chronic conditions, and (2) to slow the rate of growth in health care costs, for example, through reductions in unnecessary or duplicative care, preventable hospital admissions and overuse of the emergency room. The current fee-for-service payment system tends to undervalue primary care, is ineffective in rewarding quality and value or supporting medical homes, and serves as a potential barrier in medical home development. Creation of pilot projects to test some of the most promising alternative reimbursement approaches is an appropriate strategy in search of a payment system that supports the coordination and integration of care through a 'medical home' that can add value for both patients and payers.

The work of redesigning primary care practices to incorporate many of the elements of a medical home (such as enhanced access, use of information technology to support clinical decision-making and patient tracking, and resources to support coordination of care) is very challenging and not without expense to the practice. Involving multiple payers in the project is key to its success, given that multiple payers are necessary to impact a significant portion of a primary care practice, thereby creating a strong enough incentive for change.

SSB 5891, legislation passed in 2009, declares that "collaboration among public payers, private carriers, and providers to identify appropriate reimbursement methods to align incentives in support of primary care medical homes is in the best interest of the public." This new law is intended to provide exemption from state antitrust laws, and immunity from federal antitrust laws through the state action doctrine, for payers involved in activities undertaken pursuant to the 'pilots' described in this charter.

The specific work described by this charter is an initiative to bring multiple payers, providers, and purchasers together in a 'Participant Group' to design, implement and evaluate one or more reimbursement models to align payment with improved value through further development of the primary care 'medical home' concept. The initiative is part of a broader goal to incentivize greater outreach and coordination of care in the primary care setting that will reduce our over-reliance upon a more expensive and fragmented acute care sector.

2 PRINCIPLES SUPPORTING THIS WORK

1. Provider reimbursement reform is *necessary* to achieve delivery system reform.

2. This pilot initiative must include multiple payers to achieve a size and scale that are sufficient to:
   a. Motivate provider participation, support the practice to make needed infrastructure and delivery changes, and drive results; and
   b. Support a robust evaluation and meaningful conclusions.

3. Close State supervision of the design, implementation and evaluation of reimbursement pilots that involve multiple payers is critical to antitrust protection for those payer participants.

4. Payment will be linked to improved outcomes and appropriate utilization of resources.

5. We hypothesize that, over time, resources to support the development of a primary care-based medical home will be offset by reductions in costs (e.g., associated with unnecessary or duplicative care, preventable hospital admissions and overuse of the emergency room) rather than net new revenue.

6. Reimbursement model(s) must be supportive of such activities that produce improved health outcomes within the primary care setting, particularly for patients with multiple co-morbidities and who are at risk for excessive or ineffective use of multiple care delivery resources.

7. Results of the pilot (for example, health improvement, return-on-investment) must be measurable with available data to demonstrate the value of a payment system that supports the coordination and integration of care through a 'medical home'.

8. Modified provider (risk-adjusted) reimbursement must be tied to an ability to assess the provider's progress in implementing and achieving the quality, access and cost-effectiveness objectives of a medical home.

9. Initiatives must be both scalable and relatively easy to administer, to achieve acceptable levels of patient, provider and payer satisfaction with their experience in participating in the pilot(s).

10. Non-reimbursement components, such as practice transformation support and consumer engagement will be considered.

3 APPROACH TO THE WORK

This work will be co-convened by the Washington State Health Care Authority, the Health and Recovery Administration of the Department of Social and Health Services, and the Puget Sound Health Alliance, and will also include Governor Gregoire's health policy office. A multi-stakeholder "Participant Group" will work to collaboratively design the essential elements of the pilot(s), including expectations for results, reimbursement *methods* to be tested, the number and location of practices within the pilot(s), selection of the practices that will participate, performance measures, and evaluation. It is expected that the framework and approach will be jointly agreed upon, but implemented separately – *in a highly coordinated manner* – by each participating payer.

The work of this initiative will be organized to address key elements *in the following sequence*:

1. ***Specific Goals, Objectives and Expectations:*** It is essential to agree upon the desired or expected outcomes and results prior to embarking upon design of the details of the pilot. We will collectively agree upon what we are trying to achieve through the reimbursement pilots. Each stakeholder will approach the initiative with its own needs and interests. Finding the common ground among these needs and interests, in the context of advancing Washington's overall 'public good,' will be the necessary first step of the initiative.

2. ***Practice Transformation***: We will agree upon the outcomes targets and structural elements (e.g. increased access to care and care coordination) of a primary care-based medical home. Recognizing that practice transformation occurs over time and not all elements are achievable early on or simultaneously, we will prioritize those 'vital few' competencies that most closely align with the expected outcomes and results for the pilot. We will agree upon a mechanism for assessing the practices' progress in demonstrating the prioritized core competencies. Discussion will also include consideration of transformation support strategies (in addition to modified payment) that will likely be necessary to enable practices to be successful. For example, practices may require timely information from hospitals on admissions/discharges and ER use, and/or hospitalization, re-admission, ER and pharmacy data from payers.

3. ***Aligning Incentives:*** We will agree upon the payment methods that will be tested via the pilot(s). Although implementation will be conducted separately by participating payers, strong and clear agreement to implement the methods in a highly consistent manner will be essential to evaluate the pilot's success. Discussion here will include such items as variations on capitation versus modified fee-for-service, payment for care coordination and other currently non-billable activities, and treatment of shared savings tied to specific outcomes. There is no foregone conclusion about payment method(s) at the start of this initiative.

4. ***Patient Enrollment and Consumer Engagement:*** Effective coordination of care and efficient use of health care resources requires that the consumer/patient be in an active, participatory role, especially with regard to adherence to recommended care for chronic conditions and effective self-management. We will work to agree upon adjacent strategies for 'informed enrollment' of patients in the medical home pilot sites and to activate them as partners in care. Effective consumer engagement (i.e., patient 'buy in') is integral to the primary care team's ability to influence patients' choices.

5. ***Evaluation:*** The goal of this initiative is to test whether a modified approach to primary care payment will result in improved quality, improved provider and patient experience, and lower total cost per capita for participating practices and patients. Building a robust evaluation component prior to the start of implementation will enable data capture and reporting based on quantitative measures agreed upon upfront. Evaluation components may include measures of clinical process and outcome, utilization, cost, and patient/provider experience.

The proposed ordering of these components does not necessarily imply a rigidly segregated sequence—in reality, one component will likely overlap one or more of the others. However, the ordering reflects a philosophical approach that certain elements have to be in place and agreed to before others can be effectively developed. It is particularly important that we discuss items 1 and 2 before initiating a detailed discussion about payment methods. We need to be clear about what we are trying to achieve and we need to recognize that, while provider reimbursement reform is necessary to achieve delivery system reform, it is not sufficient in and of itself. Other practice transformation supports will be important.

4 ORGANIZING TO DO THE WORK

A detailed work plan will be developed to reflect the specific tasks and timing of phase 1 (design), phase 2 (implementation), and phase 3 (evaluation). Certain elements of these phases can be done in parallel,

such as patient enrollment and provider preparation for participating. Some basic elements can be identified at this juncture:

1. *Leverage the learning's of other states' and stakeholders' experience:* Ongoing scans of recent and current efforts – both locally and nationally - will help identify opportunities, challenges, what works and what doesn't. We will build upon the experience of others. It is an expectation of participation that there will be a free exchange of information to support the work.

2. *Division of Labor:* Stakeholders and staff support will be organized in small subject-area or task-specific groups that will meet more frequently to develop/draft specific deliverables and report to the larger Participant Group for collective discussion and action. We will strive to ensure coordination among smaller subgroups.

3. *Meeting Frequency:* It is expected that the Participant Group will meet every two to four months. Smaller subject-area or task-specific groups may meet more frequently to produce deliverables in a timely fashion.

4. *Decision-making:* Pursuant to the authorizing legislation, decisions regarding program design, implementation and evaluation will be made by the Health Care Authority and Department of Social and Health Services, in consultation with the Department of Health and health care payers, providers and purchasers who choose to participate in implementing the pilot(s).

5. *Timeframes:* It is anticipated that a detailed work plan for designing, implementing, and evaluating the pilot(s), including timing for key milestones, will be developed. Every indication from other medical home pilots going on nationally, is that a minimum of 18 months of implementation is needed to produce a reputable evaluation and meaningful conclusions. Therefore, at present, broad guidelines for timing include the following:

Phase 1 – Design	September-December 2009
Phase 2a – Practice Selection /Preparation	Begin January 2010
Phase 2b –Patient Enrollment Launch	October 2010
Phase 3 – Evaluation/Preliminary Results	June 2012