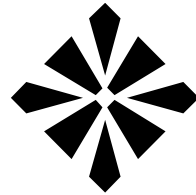


# **Medicare Advanced Primary Care Practice Initiative**

**Application from the Washington State Health Care Authority**



**Washington State  
Health Care Authority**

August 17, 2010

Washington State Health Care Authority  
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## **I. BACKGROUND ON THE STATE REFORM INITIATIVE**

The State of Washington, represented by the Health Care Authority, seeks the participation of the Centers for Medicare and Medicaid Services (CMS) in a Medicare Advanced Primary Care Practice (MAPCP) initiative. The Washington Multi-Payer Medical Home Reimbursement Pilot is a joint effort between health plans, purchasers and primary care providers to find a sustainable approach to improve outcomes and decrease costs. The pilot shifts payment away from a fee for service incentive and toward population care management in primary care practices with qualitative outcome measures of reduced preventable emergency room visits and hospital admissions. This is an extraordinary opportunity for the major health care payers in the state to change payment methods for primary care - to pay for outcomes and quality rather than volume.

If Medicare joins this effort, payers representing 69% of the population would be acting as researchers, evaluators, observers and agents of change by transforming the fundamental incentive structure of health care payment. This unique payment structure could spark a rapid change across all parts of the health care system because it does not prescribe *one way* to do things - but rather provides incentives to do things the *right way*.

### **A. Authority and Historical Background on the State Initiative**

The legal authority under which the state initiative is conducted is Substitute Senate Bill 5891, enacted in 2009, which directs the Health Care Authority (HCA) and Department of Social and Health Services (DSHS) to “design, oversee implementation, and evaluate one or more primary care medical home reimbursement pilot projects in the state to include as participants public payers, private health carriers, third-party purchasers, and health care providers” (see Appendix A. SSB 5891). This law also 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 chapter. The state, through HCA and DSHS oversight, are providing active direction and supervision of the project to support this collaboration. Participation by private health insurers and providers is voluntary, but eight private health insurers who comprise approximately 62% of the Washington market including commercial, Medicare Advantage and

Medicaid Healthy Options (managed care) have been active participants since the beginning of development. These eight health plans include plans participating in the state's two main insured health programs; Medicaid managed care and the Basic Health Program.

The Multi-payer Medical Home Reimbursement pilot is endorsed by Washington State's Governor Chris Gregoire (see letter of support in Appendix B), which aligns with her health reform efforts, including her five point plan to improve health care in 2005 and the Blue Ribbon Commission on Health Reform in 2006. Participation by private health insurers and providers is voluntary, however health plans, providers, and private employers have been actively engaged in pilot design since August 2009, and will complete the design phase in September 2010. We anticipate that final pilot practices will be selected in November 2010, and will start receiving money from the participating health plans in January, 2011.

## **B. Participation of Private Insurers**

The Washington State Multi- Payer Medical Home Reimbursement Pilot includes both public and private Washington State health plans in the design and ongoing operation of the pilot. The pilot includes populations covered under individual, group, self-funded employer-sponsored, and Medicaid Healthy Options with the following payers: three regional commercial health plans that, together, cover a majority of the market (Regence Blue Shield, Premera Blue Cross and Group Health Cooperative); three national commercial health plans (Aetna, CIGNA, and United Healthcare); and two plans who serve Washington State public consumers in Medicaid managed care and the Basic Health Program (Molina and Community Health Plan of Washington).

An estimated 62% of the state's residents are covered by these payers, according to data compiled from state public and private sources. Representatives from all private and public health plans participated in the Participant Group (the design team for the project) and all workgroups to develop project details and guidelines (see Appendix K for full listing).

The process has resulted in the following: 1) health plans now share a common goal with practices to improve care coordination and timely access to primary care and avoid preventable emergency room visits and hospital admissions; 2) both plans and practices potentially face some risk with this pilot model and both potentially share gains; 3) both plans and practices identify the need to have useful data upon which to act, 4) both have identified the need for common methods of measurement and information exchange in order to work across the health care

system and evaluate outcomes, and 5) health plans now see a benefit in working together and with the Health Care Authority to change how hospital and emergency rooms impact patterns of care. Aligning the incentives for payment between health plans and practices sparked a common need to change other factors identified as barriers for success and savings. In this model, because both plans and practices stand to lose money if outcomes are not reached, we have agreed to change how data is shared and how patients are identified and accounted for by practices and plans.

**Estimated Percentage of Total Revenues of Participating Primary Care Practices that is Derived from Participating Private Health Insurance:** The revenues for participating practices will depend on the particular mix of payers for each participating practice. Our selection process favors practices with a higher percentage of their population covered by participating payers to ensure adequate payments to support care coordination and extended hours. The upper limit for size of the pilot is 60,000 covered lives by participating private commercial health plans, and up to 7,000 covered lives by Medicaid plans (Community Health Plan of Washington and Molina). One assumption used in modeling payment design was that approximately 60% of a participating practice would have a combination of commercial and public payers based on reported market share of plans in the state. This working assumption did not include an estimate of Medicare beneficiaries.

### **C. Participation by Medicaid**

The State Medicaid program has been an active participant in the state reform initiative. State legislation authorizing a multi payer demonstration pilot specifically called out the Medicaid program as a lead organization along with the Health Care Authority. Medicaid staff participates in the workgroups and have been contributing members of the steering committee since the inception of the pilot planning period. Medicaid plays a unique role in the pilot, offering expertise as a purchaser of health care through contracted managed care plans and as a direct contractor with providers through its fee for service program.

**Managed Care Medicaid:** Approximately 63% of Medicaid enrollment across the state will be eligible to participate in the initial pilot. These individuals receive coverage through managed care plans (Molina and Community Health Plan of Washington) who are members of the multi-payer workgroup. Of the 40,000-60,000 individuals estimated to be enrolled in the pilot,

approximately 5,000-6,000 are likely to be Medicaid clients. There may be an additional 500-1,000 “dual eligible” individuals enrolled through the Medicare Advantage plans.

**Fee for Service Medicaid:** Approximately 37% of the Medicaid enrollment receives coverage via fee for service. Given operational priorities focused on an MMIS systems conversion to ProviderOne that occurred on May 9, 2010, the Medicaid fee for service program will not be included at the start of the pilot. This population is expected to be added once the new payment system is stabilized and can be programmed to process the new payment methodologies being demonstrated in the pilot. This will probably occur for years two and three of the pilot. While ProviderOne has been designed to accommodate alternative payment systems, it requires a period of stability before support for new activities can reasonably be considered.

#### **D. Support by Primary Care Physicians**

The reimbursement pilot was designed for advanced primary care practices. There is a statewide call for applicants that have made changes or are implementing changes toward a medical home model (this call for applicants was released August 5, 2010). The practice selection process is described in Appendix H. This pilot was designed to fit a variety of practice types, populations, and locations. The Washington State Medical Association (WSMA) and Washington Academy of Family Physicians (WAFP) support the call for applicants among ready candidates and the state’s effort to test the payment model (see Appendix C and D for support letters from both state organizations).

The state initiative has the support of the Washington State Department of Health (DOH) and the Washington Academy of Family Physicians (WAFP), who are both sponsors of the Washington Patient Centered Medical Home (PCMH) Collaborative. DOH and WAFP actively support recruitment among the 33 primary care practices currently adopting medical home principles through the PCMH Collaborative (see Appendix E. for the DOH letter of support). DOH also supports recruitment among its past disease collaborative participants which has nearly 200 practices across the state.

The Washington State Medicare Quality Improvement Organization (QIO), Qualis Health, also supports the HCA’s application for the Medicare Advanced Primary Care Practice Initiative (see Appendix F. Qualis Health Letter of Support).

## II. PROBLEM STATEMENT

**Nature and Causes of the Problem:** Our current system for health care delivery is fragmented and leads to inefficient use of services with poor outcomes. When people do not receive the right care at the right time it means that preventable conditions manifest as complications or urgent acute visits in an emergency room or hospital admission or an overuse of services with costly outcomes for no clear benefit.

**Fragmented Care:** Currently patients can receive care in multiple settings by multiple providers. There is often little communication between health care providers and settings to link information with a patient. With this comes a lack of accountability for the overall outcome of patient care.

**Payment System:** The current fee-for-service method in primary care fosters ongoing fragmentation of the health care system. Paying for services encourages more services being offered or provided for a person with disregard for the overall outcomes.

**Outcomes:** The current pay-for-performance attempts to measure quality of services and outcomes while a natural reaction to correct the results in the health care environment does little to actually correct root problems. The reward payments are often too little to overcome actual problems. Measures often focus on process rather than on the end result and the rewards all too often focus on the same process measures with little connection to improvement in overall system of care.

### **Extent of the Problem and Evidence to Support Pilot Intervention:**

**Medicare:** For Medicare specifically, the goals of reducing preventable emergency room visits and preventable hospital admissions by 30% and 10% respectively are achievable and have been demonstrated in a variety of ways throughout the country.

Forty to seventy percent of emergency room visits were calculated to be preventable in the Medicare population for Tennessee, New Jersey, Texas and Utah (state data reports). These visits could have been prevented if adequate primary care had been available to manage chronic conditions that led to more acute complications, and thus an emergency room visit. Some of

these visits were not urgent and could have been seen in a primary care setting if the patient or family was directed to a practice. People need to know when to go to the emergency room and when to go to a primary care clinic. This requires communication and ability to assess the patient in a meaningful way much like the goals of the patient-centered medical home model.

One out of five elderly patients discharged from the hospital never see a physician before they are readmitted within 30 days. Hospital release processes have been studied and it is clear that more can be done to improve both patients' and families' understanding of what changed with their medical condition and what their next steps are. However, with disconnected payment and objectives there is no expectation to effectively connect the patient with their primary care practice. When a concerted effort was made to share discharge planning information with patients and families and provide support for follow up visits with a provider, a 30% reduction in costly hospital readmissions was found.

Care management capability is highly recommended for practices in this pilot. For example, medication management for chronic disease or acute conditions can prevent emergency room visits and hospital admissions for the Medicare population. The role of care managers to follow up with patients who have been in the emergency room or hospital is a vital role in medication reconciliation and reducing preventable visits for adverse events to medication.

**Pilot Intervention:** This pilot sets a policy direction to align goals, incentives, and outcomes within the health care delivery system. Primary care practices that are ready to implement the medical home model or who have already taken steps to develop patient-centered care systems are given the right incentives, payment, and data to realize their full potential. We know that a medical home can work but it takes resources to achieve it. It also takes a change across the system to align incentives and payment for work that can be done well in the primary care setting. This pilot provides both alignment of incentives and payment to support the work of a medical home, and ties payment to achievable yet significant outcomes.

### III. SOLUTION TO THE PROBLEM

**Proposed Changes to this Pilot:** The solution to the current fragmentation of health care services and lack of focus on overall outcomes is the alignment of incentives, payment, and outcomes. Policy makers have been called on to set specific targets and work with multiple payers. This pilot will demonstrate how alignment of incentives, outcomes and payment among the major health plans in Washington State and primary care practices will affect outcomes. Solutions for changing payment structures are fundamental to aligning incentives. Regional pilots, like this one, are needed to test and evaluate a change in payment structure.

**Aligning Incentives:** Eight major health plans representing a majority of patients in Washington State have agreed on a set of outcomes, payment methods, and goals with primary health care providers, represented by two statewide organizations and by individuals from various practice settings. This group has agreed to reduce preventable emergency room visits and preventable hospital visits in exchange for a care management fee for all patients attributed to a participating practice and plan in the pilot.

Both health plans and practices share benefits and risk in this design. If reductions occur, the initial savings go back to health plans until the sum equals their initial care management investment of \$2.50 per member, per month payments (PMPM) for the first year, or \$2.00 PMPM for years 2 and 3. Beyond that point, further shared savings go to both practices and health plans. If the reduction in preventable emergency room or hospital admissions is less than the budget neutral point, then health plans pay less PMPM to the practices in the next payment period-- but only up to 50% reduction of the previous investment.

Both plans and practices share the same goal, aligning payment to reduce costly preventable emergency room and hospital care, and both agree to an up-front monetary investment in primary care services that should allow for such reductions to result.

**Aligning Outcomes:** The outcomes of reduced preventable emergency room and preventable hospital admissions represent the result of a series of events in health care delivery of services. In this pilot, both plans and practices have agreed to the same outcomes. Both plans and practices have agreed on a common measure for the outcomes. Both have agreed that there are many

ways to achieve the desired outcomes. This pilot sets a target outcome to which all participants agree.

**Paying for Quality:** To maintain a focus on payment for quality and value, rather than volume, the pilot design includes payment that is dependent on quality threshold measures, discussed below under “threshold measures”. Both health plans and practices have agreed to use a specific set of measures. Both have agreed that if quality goals are not met, that practices will not receive shared savings. In the process, both plans and practices see the shared value in having more frequent data exchange between plans and practices to allow for better quality tracking and response. In this pilot new expectations for sharing data have been developed as a result.

The work of redesigning primary care practices to incorporate many of the elements of a medical home is challenging and requires investment by 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 sufficient incentive for change. Because this pilot has brought together eight large health plans in the state, and a variety of physician views, this pilot is designed to work for many different populations of patients and for practices ready to implement the changes needed to create a medical home.

**Unique Features of this Pilot:** All the major health plans in Washington State have been involved in the pilot design, with a conservative estimate of 62% of the state’s insured population covered by these plans. Inclusion of the Medicare fee-for-service (FFS) population would increase representation to 69% of the pilot population potentially covered by nine health plans.

Both health plans and practices share benefits if the outcome goals are reached. Both share risk equally if goals are not met. Payers risk up to 50% of their investment if shared goals are not reached. Practices face up to 50% less in PMPM payment in following years if target goals are not met.

Both health plans and practices have agreed to utilize common data measures. The pilot design has led to changes in frequency of data exchange and methods for calculations. Performance measurement and the evaluation plan will use nationally recognized comparison measures of

different studies across the country, to enhance comparability with other similar initiatives nationwide.

#### **IV. DESCRIPTION OF STATE INITIATIVE**

##### **A. Structure and Overall Design**

This pilot is a statewide initiative but is limited to a selected number of practices that demonstrate capability of achieving the pilot goals within three years. Funding limits from both commercial and public payers also restrict the number of practices that can participate. The primary goal of this pilot is to partially shift payment from the current fee for service model toward payment for improved outcomes. This shift will occur by creating additional flexibility for primary care practitioners, through per member per month payments, to provide timely and coordinated care for their patients to prevent costly preventable emergency room visits and preventable hospital admissions.

The pilot objective is to decrease preventable emergency room visits and preventable hospital admissions across all of the participating practices by amounts that are at least budget neutral, and ideally to decrease preventable emergency room visits by 30% and preventable hospital admissions by 10% in order to reduce total spending by payers. Different practices will likely achieve different levels of reduction depending on their patients' current use of the emergency room and hospital admissions; consequently, each practice will commit to achieve a practice-specific minimum level of reduction in emergency room visits and hospital admissions that is targeted to generate sufficient savings to payers to offset upfront payments the practice receives from all participating payers.

The payment model is designed to reward practices for exceeding these minimum reductions in preventable emergency room visits and hospitalizations, by paying the practice a share of the estimated net savings the practice generates from reduced emergency room visits and hospital admissions. Each participating payer will contribute a share of upfront payment and/or shared savings to each practice based on how many of that payer's members are attributed to the practice divided by the total number of members attributed to the practice from all participating payers.

Shared savings for reductions in emergency room visits and hospital admissions beyond minimum levels will be distributed to participating practice groups only if they have met agreed-upon quality performance measures.

As noted in section I of this document, it may be possible to expand the pilot to include the Medicaid FFS patients attributed to participating practices for the second and third years assuming the new eligibility and claims system has proven sufficiently stable to allow the necessary modifications. The impact of such a change on the scale of the pilot and its associated cost will depend on the final mix of participating practices.

## **B. Participating Practices**

**Definition of “Advanced Primary Care Practice” (APCP):** This state initiative defines APCP as having “core capacities” which enable a practice to make a significant reduction in emergency room visits and hospitalizations during the duration of this pilot. The “core capacities” are the qualifications for entry into the pilot and it is expected that there will be varying levels of achievement in the selected practices. The “core capacities” recommended are to:

- Have a clear system for care coordination within the practice. For example, a care coordinator, care planner or case manager, with delineated tasks and team members with *explicit* accountability for follow-through, including proactive outreach to patients recently seen in the emergency room (when known) or discharged from the hospital.
- Have an established system of communication with the hospital that is the predominant provider of acute care services to the practice population that includes 1) timely notification of patient use of the emergency room, and 2) opportunity to coordinate on discharge planning and notification at the time of discharge.
- Have the ability to extend hours to include weekday evening and weekend access to enable the patient to more readily access the practice, particularly for same-day or urgent needs during “after hours”.
- Enable patients to access the practice in multiple ways, including in-person visit *and* by telephone or secure email.
- Have tools and processes in place that enable effective chronic disease management, including:

- Routine use of *established* patient registries for patients with one or more chronic diseases to track and plan for evidence-based care, routine testing, medications, and follow-up
- Proactive outreach to patients based on a system of provider/patient reminders and timely notification of results
- Access to behavioral health with a feedback loop on treatment plan and progress
- Emphasis on self-management support with development of a shared care plan and a system that enables *preventive* health reminders.
- Have a service culture within the practice that includes:
  - Ability to identify and respond to different language/cultural needs
  - Effective phone management
  - Staff competency in listening and motivational interviewing skills
  - Team orientation to delivering care
- Have the ability to measure and report back to the pilot coordinator on three clinical indicators for quality performance measures. These measures will be used for evaluation. Practices will provide a random sample of patients for purposes of surveying for patient experience.

Definitions by the National Committee for Quality Assurance (NCQA) and Joint Principles of Patient-Centered Medical Home *are accepted* and preference will be made for practices currently holding at least a level One NCQA certification or for participating in the Washington State Patient-Centered Medical Home Collaborative using the definition of Joint Principles of Patient-Centered Medical Home.

### **C. Practice Selection Process**

Practices will be selected from responses to a call for applications in a two phase process. Recruitment will focus on practices currently involved in the Washington State Patient-Centered Medical Home Collaborative or a Department of Health-sponsored collaborative between 1999 and 2009. Recruitment includes two webinar presentations and distribution of the pilot description with a formal invitation to apply. Practices are advised on benefits, risks, and criteria for inclusion and exclusion in the pilot (see Appendix H. for practice selection process).

The application questionnaire and narrative sections identify demographic characteristics such as size, location, organizational structure, and population affected by the pilot model. The application also supports evaluating all “core capacity” areas and is scored to reflect how well the practice meets these identified capacities. Practices with a sufficient quantitative score and narrative plan and those that represent a variety of practice sizes, locations, and organizational models will be selected as preliminary practice sites in the initial selection phase.

Practice sites which meet minimum criteria based on the initial application will receive their own baseline data on preventable emergency room visits and hospital utilization, as well as clinical process threshold measures, from all participating payers to set practice-specific targets and assess feasibility of entry into the pilot. This baseline period will include data from calendar years 2008 and 2009 for each practice. Interviews are offered to further assess practice capacities, organizational stability and leadership support. The interview will help identify whether capacities are in place for the duration of the pilot. Final selection of practices is based on overall assessment, practice size, location, organizational structure and number of practices needed for sufficient evaluation power.

#### **D. Identification and Recruitment of Participating Beneficiaries**

Participation will be transparent to the beneficiary. Practices will have an action plan that allows them to achieve specific practice targets for outcomes and therefore impact Medicare beneficiaries. Medicare beneficiaries are not required to receive all their care from the participating practice and there are no specific inclusion criteria set for patient selection into this pilot. Practices will be responsible for informing Medicare beneficiaries about the pilot and how it may be affecting their care. Exclusion criteria regarding patients will be determined for measurement purposes and calculation of outcome measures only and are not intended to exclude Medicare patients from specific care by the practice.

#### **E. Attribution of Participating Beneficiaries**

One common, transparent attribution method will be used by all payers involved in the pilot. Attribution will link health plan members (patients) to a primary care provider affiliated with a participating practice in this pilot. Medicare patients are not asked to limit their care to one practice by this pilot design. Instead the attribution method will identify those patients seen most

often by a primary care provider in the pilot. Once the link is made, care management payments, outcome measures and shared savings are calculated for the practice. There are no specific requirements by this pilot for Medicare beneficiaries to receive referrals for otherwise covered services. If there are disagreements on how to attribute patients to a practice, involved parties will follow the dispute resolution process which will be specified in the practice participation agreement. This process will authorize HCA as the pilot administrator to make final determinations.

CMS will be required to use the same attribution method as Medicaid and other private payers in this pilot, as discussed below. Specifically, this will include beneficiary claims data submission to HCA's business associate, Milliman Inc, in the specified format and at the prescribed time intervals for initial and interval attribution. The initial attribution will require claims data for beneficiaries residing in the counties of candidate practices for the baseline period of calendar years 2008-2009. Interval submissions will be at semiannual for the immediate preceding 6 months, for counties of participating practices.

**Patient Attribution, Performance Measures, Threshold Measures, Payment:**

**Primary Care Provider (PCP) Attribution:** Patients will be attributed to a specific participating medical practice by application of an algorithm developed for the Puget Sound Health Alliance and administered by Milliman, a nationally recognized third-party data aggregator using claims data supplied by participating payers. Attribution will be used to determine the number of patients for whom a practice will receive the PMPM supplemental payment and the distribution of responsibility among payers for that payment. It will also be used to determine the practice's performance against its performance and threshold measures.

PCP Attribution is applied to prevention-related measures based on the concept that the PCP is the clinician that is primarily responsible for a patient's preventive care management.

The PCP Attribution method assigns each patient to a *single* primary care provider who provided the most Evaluation and Management visits over the most recent 24 month period covered in the report. To receive clinician attribution, patients must have a minimum of one service during the 24 month period.

The following is the ranking hierarchy to be used in selecting the single attributed primary care provider for each patient:

1. Most number of E&M visits as defined (see attached list)
2. Highest sum of RVUs (the “relative value units” associated with the services based on the E&M visits in #1 above. The RVU assigns a weight for the intensity of the service -e.g. A service of 99211 would have a lower RVU than 99214 )
3. Most recent service date

**Specialties of Interest:**

The below table shows which specialties are used by each type of measure:

Measures	Attribution Method	Primary Care Specialties											Non-Primary Care Specialties												
		Adult Medicine	Family Medicine	General Practice	Homeopathy	Internal Medicine	Naturopathy	Nurse Practitioner	Obstetrics & Gynecology	Osteopathy	Pediatrics	Physician Assistant	Preventive Medicine	Women's Health	Allergy & Immunology	Cardiovascular Disease	Chiropractor	Endocrinology	Gastroenterology	Orthopaedic Surgery	Physiatry	Psychiatry & Neurology	Pulmonology	Rheumatology	
Appropriate Testing for Children With Pharyngitis	PCP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓											
Appropriate Treatment for Children with URI	PCP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓											
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	PCP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓											
Breast Cancer Screening, age 42-69	PCP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓											
Cervical Cancer Screening	PCP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓											
Chlamydia Screening in Women, ages 16 to 25	PCP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓											
Colorectal Cancer Screening	PCP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓											
Percentage of Generic Prescriptions for NSAIDs	PCP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓											
Percentage of Generic Prescriptions for PPIs	PCP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓											
Percentage of Generic Prescriptions for SSRIs	PCP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓											
Percentage of Generic Prescriptions for Statins	PCP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓											
Antidepressant Medication Management measures	Team	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓								✓			
Asthma Measures	Team	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓								✓		
Beta Blocker treatment after a heart attack	Team	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓										
Comprehensive Diabetes Care measures	Team	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓							
Coronary Artery Disease	Team	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓										
Cardiovascular Condition measures	Team	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓										
Low Back Pain	Team	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓				✓	✓			

**Evaluation and Management (E&M) Visit Codes:**

<b>CPT codes</b>	<b>Explanation</b>
99201	Office/outpatient evaluation and management visit, new patient. Level 1
99202	Office/outpatient evaluation and management visit, new patient. Level 2
99203	Office/outpatient evaluation and management visit, new patient. Level 3
99204	Office/outpatient evaluation and management visit, new patient. Level 4
99205	Office/outpatient evaluation and management visit, new patient. Level 5
99211	Office/outpatient evaluation and management visit, established patient. Level 1
99212	Office/outpatient evaluation and management visit, established patient. Level 2
99213	Office/outpatient evaluation and management visit, established patient. Level 3
99214	Office/outpatient evaluation and management visit, established patient. Level 4
99215	Office/outpatient evaluation and management visit, established patient. Level 5
99241	Office consultation for a new or established patient. Level 1
99242	Office consultation for a new or established patient. Level 2
99243	Office consultation for a new or established patient. Level 3
99244	Office consultation for a new or established patient. Level 4
99245	Office consultation for a new or established patient. Level 5
99341	Home visit for the evaluation and management of a new patient. Level 1
99342	Home visit for the evaluation and management of a new patient. Level 2
99343	Home visit for the evaluation and management of a new patient. Level 3
99344	Home visit for the evaluation and management of a new patient. Level 4

<b>CPT codes</b>	<b>Explanation</b>
99345	Home visit for the evaluation and management of a new patient. Level 5
99347	Home visit for the evaluation and management of an established patient. Level 1
99348	Home visit for the evaluation and management of an established patient. Level 2
99349	Home visit for the evaluation and management of an established patient. Level 3
99350	Home visit for the evaluation and management of an established patient. Level 4
99354	Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service.
99355	Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service.
99358	Prolonged evaluation and management service before and/or after direct (face-to-face) patient care.
99359	Prolonged evaluation and management service before and/or after direct (face-to-face) patient care.
99382	Initial comprehensive preventive medicine evaluation and management of an individual (Age 1-4).
99383	Initial comprehensive preventive medicine evaluation and management of an individual (Age 5-11).
99384	Initial comprehensive preventive medicine evaluation and management of an individual (Age 12-17).
99385	Initial comprehensive preventive medicine evaluation and management of an individual (Age 18-39).
99386	Initial comprehensive preventive medicine evaluation and management of an individual (Age 40-64).

CPT codes	Explanation
99387	Initial comprehensive preventive medicine evaluation and management of an individual (Age 65 and older).
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual (Age 1-4).

**F. Community-based Practice Support**

Mechanisms for connecting patients to community-based resources and providing support for self-care, care coordination, and care transition are the responsibility of the practice. The selection process will favor practices with staff specifically tasked with care coordination. Integration with other state initiatives that provide this support may be encouraged where possible (for example, selecting practices that currently use a hospital in the State Action on Avoidable Rehospitalizations (STAAR) Institute for Healthcare Improvement (IHI) initiative in which Washington is a participating State, or Beacon Community initiatives aimed at improving care transitions). The payment model provides financial investments to practices to choose appropriate patient support in order to reduce preventable emergency room and preventable hospital admissions. The state initiative does not formally plan to organize with outside agencies to provide community – based support.

**G. Integration with Health Promotion/Disease Prevention**

The Department of Health, as previously described in section I., is actively participating in our recruitment of past and present collaborative participants for this reimbursement pilot. This pilot is integrating recruitment efforts with another state project - the Health Information Technology Grant (see Appendix I. for HIT grant details).

Practice teams from the Patient-Centered Medical Home Collaborative that apply to the Multi-Payer Reimbursement pilot are eligible to apply for additional grant funding from the Department of Health to support electronic care coordination efforts. The additional funds would enhance, modify, or expand existing health information technology to create interoperable linkages to support one or more of the following key objectives: reduce avoidable emergency

room visits; reduce preventable inpatient admissions; and reduce readmissions to inpatient hospital settings within 30 days of discharge. These outcomes match the Multi-Payer Medical Home Reimbursement pilot objectives.

## **H. Payment Provisions and Methods**

Each participating payer, including CMS, will pay each participating medical practice, in addition to that practice's normal FFS payment for clinical services to its participating beneficiaries, a monthly amount determined by HCA. That amount will be the per member per month (PMPM) payment for that practice for the current payment period multiplied by the number of beneficiaries attributed to that practice by the pilot.

A base PMPM payment of \$2.50 for year one, \$2.00 PMPM for years two and three are paid by each participating health plan based on the number of that plan's patients attributed to a practice. For years 2 and 3, the base PMPM rate will be adjusted to reflect performance in the previous year.

A reconciliation will be performed at a six-month lag beyond the end of each year (at months 18, 30, 42) to accommodate processing the "tail" of claims for services during that year. A new payment period, with PMPM rates reflecting earned shared savings or penalties, will begin at each reconciliation. A final post-pilot payment period will cover months 42-48 to include the adjustments (but no base PMPM) for year three. If a penalty is earned by the practice in year three, it may be recovered by a PMPM reversion from the practice to the plans in the final payment period.

Shared savings or penalties will be calculated on the basis of a standard price for an emergency room visit or inpatient hospital admission, calculated on statewide cost experience for the baseline period. At each reconciliation period, the number of previous-year emergency room visits and inpatient admissions for the patients in the pilot attributed to a practice is compared with the practice's baseline experience. If emergency room and inpatient experience is less than baseline, the "savings" is calculated by applying standard prices to the difference in the number of visits/admissions. This dollar value is compared with base PMPM paid in the previous year; if "savings" are greater than total PMPM, the difference is shared equally between the practice and plans; if savings are less than total base PMPM or are negative, the practice is subject to a

penalty of the shortfall up to 50% of the next year's PMPM paid. Shared savings or penalties are paid in the form of an upward or downward adjustment to the next payment period's PMPM rate for that practice.

The base PMPM rates were calculated on the basis of anticipated core costs for a practice of four full time employee primary care providers (PCP) with a patient panel of 7200-8000. These rates were intended to compensate the practice for enhanced capabilities such as care coordination, extended hours, physician team leadership, business process redesign, reduced productivity and disease registry maintenance. They were not intended to compensate for elements like technology infrastructure enhancement or increased provider staffing. The difference between the first- and second/third year base rates reflects the expectation that there will be some startup costs and operational inefficiencies in the first year that will not be repeated in the successive years.

The PMPM payment is intended to incent practices to introduce or enhance the elements of APCP. It may be used by the practice to implement and/or support the recommended core capacities throughout the pilot. Shared savings payments will be made to practices that achieve decreased spending (beyond minimum targets) on emergency room services and hospital admissions for preventable or ambulatory sensitive conditions. As noted above, these savings will be divided between practices and health plans. Practices must maintain quality performance measures in order to share in any savings. The practices will continue to receive fee for service payments for clinical services to pilot-attributed patients. There are no separate community-based practice support payments.

The payment methods for Medicare beneficiaries are the same payment methods used by other payers in the Multi-payer Medical Home Reimbursement pilot, including both Medicaid and private insurers.

Each participating medical practice and payer will, as a condition of participation, cooperate in a formal evaluation of the demonstration, including submission of cost and other program data and making relevant staff of participating organizations available for site visits by CMS or its contractors.

**Threshold Measures:** These clinical process quality measures will be applied to each participating practice's performance to determine its eligibility to participate in any savings indicated by the outcome measures. During the pilot, a participating practice will be required to maintain its baseline performance level on at least seven of the ten measures. Measures will be calculated by Milliman using methods developed for the Puget Sound Health Alliance. These measurement methods mimic the parallel HEDIS measures.

1. Staying Healthy
  - a. Screening for Breast Cancer (women, age 52-69)
  - b. Screening for Cervical Cancer (women, age 21-64)
  - c. Screening for Colon Cancer (men/women, age 50+)
2. Managing Chronic Conditions
  - a. Diabetes (HbA1c testing, cholesterol testing, nephropathy screening)
  - b. Heart Disease (cholesterol testing, cholesterol lowering medication)
  - c. Depression (medication adherence at 12 weeks and 6 months)
3. Experience Measures
  - a. Patient/Family experience measures
  - b. Provider and staff experience measures

There will be four measurement periods during the pilot, including: 1) Baseline Period to include two years prior to pilot launch (CY 2008, 2009), 2) Period one to include months 1 – 12 of the pilot, 3) Period two to include months 13 – 24, of the pilot, and 4) Period three to include months 25-36. There will be a fourth payment period (but not measurement period) after the conclusion of the pilot (to be used for shared savings payments and repayments associated with period three). See Appendix G. for a graphic representation of pilot periods.

**Performance Measures:** Participating practices will be evaluated on their reduction in preventable emergency department visits and ambulatory-sensitive inpatient admissions, relative to their experience in the baseline period. For those practices whose performance on the threshold measures entitle them to participate in shared savings, savings will be calculated on the basis of a standard dollar value for an emergency department visit and for an inpatient admission, multiplied by the number of visits or admissions avoided in the observation period compared with the baseline period.

**Preventable Emergency Department Visits:** Preventable emergency department visits are measured using the New York University (NYU) ED algorithm:

**Background/Introduction:** With support from the Commonwealth Fund, the Robert Wood Johnson Foundation, and the United Hospital Fund of New York, the NYU Center for Health and Public Service Research has developed an algorithm to help classify ED utilization. The algorithm was developed with the advice of a panel of ED and primary care physicians, and it is based on an examination of a sample of almost 6,000 full ED records. Data abstracted from these records included the initial complaint, presenting symptoms, vital signs, medical history, age, gender, diagnoses, procedures performed, and resources used in the ED. Based on this information, each case was classified into one of the following categories:

- Non-emergent - The patient's initial complaint, presenting symptoms, vital signs, medical history, and age indicated that immediate medical care was not required within 12 hours;
- Emergent/Primary Care Treatable - Based on information in the record, treatment was required within 12 hours, but care could have been provided effectively and safely in a primary care setting. The complaint did not require continuous observation, and no procedures were performed or resources used that are not available in a primary care setting (e.g., CAT scan or certain lab tests);
- Emergent - ED Care Needed - Preventable/Avoidable - Emergency department care was required based on the complaint or procedures performed/resources used, but the emergent nature of the condition was potentially preventable/avoidable if timely and effective ambulatory care had been received during the episode of illness (e.g., the flare-ups of asthma, diabetes, congestive heart failure, etc.); and
- Emergent - ED Care Needed - Not Preventable/Avoidable - Emergency department care was required and ambulatory care treatment could not have prevented the condition (e.g., trauma, appendicitis, myocardial infarction, etc.).

This information that was used to develop the algorithm required analysis of the full medical record. Since such detailed information is not generally available on computerized ED or claims records, these classifications were then "mapped" to the discharge diagnosis of each case in our sample to determine for each diagnosis the percentage of sample cases that fell into these four categories. For example, patients discharged with a final diagnosis of "abdominal pain" may

include both patients who arrived at the ED complaining of stomach pain, as well as those who reported chest pain (a possible heart attack). Accordingly, for abdominal pain, the algorithm assigns a specific percentage of the visit into the categories of "non-emergent", "emergent/primary care treatable", and "emergent/ED care needed-not preventable/avoidable" based on what we observed in our sample for cases with an ultimate discharge diagnosis of abdominal pain.

It is important to recognize that the algorithm is not intended as a triage tool or a mechanism to determine whether ED use in a specific case is "appropriate" (e.g., for reimbursement purposes). Since few diagnostic categories are clear-cut in all cases, the algorithm assigns cases probabilistically on a percentage basis, reflecting this potential uncertainty and variation.

Since the original development of the algorithm, users have expressed an interest in examining separately cases involving a primary diagnosis of injury, mental health problems, alcohol, or substance abuse. Accordingly, these conditions have been pulled out of the standard classification scheme, and can be tabulated separately. There are also a residual of conditions (approximately 15%) where the sample was not of sufficient size to assign percentages for the standard classification - these conditions can also be tabulated separately.

**Ambulatory-Sensitive Inpatient Admissions: Prevention Quality Indicators** - Performance on reducing ambulatory-sensitive inpatient admissions will be measured using the Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators. The Prevention Quality Indicators (PQIs) are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care-sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.

The PQIs are a software tool distributed free by AHRQ. The software can be used to help hospitals identify quality of care events that might need further study. The PQI software programs can be applied to any hospital inpatient administrative data. These data are readily available and relatively inexpensive to use.

Even though these indicators are based on hospital inpatient data, they provide insight into the community health care system or services outside the hospital setting. Patients with diabetes may be hospitalized for diabetic complications if their conditions are not adequately monitored or if they do not receive the patient education needed for appropriate self-management.

Although other factors outside the direct control of the health care system, such as poor environmental conditions or lack of patient adherence to treatment recommendations, can result in hospitalization, the PQIs provide a good starting point for assessing quality of health services in the community. Because the PQIs are calculated using readily available hospital administrative data, they are an easy-to-use and inexpensive screening tool. They can be used to provide a window into the community—to identify unmet community health care needs, to monitor how well complications from a number of common conditions are being avoided in the outpatient setting, and to compare performance of local health care systems across communities.

Patients may be hospitalized for asthma if primary care providers fail to adhere to practice guidelines or to prescribe appropriate treatments. Patients with appendicitis who do not have ready access to surgical evaluation may experience delays in receiving needed care, which can result in a life-threatening condition—perforated appendicitis.

The Prevention Quality Indicators are part of a set of Agency Healthcare Research and Quality (AHRQ) Quality Indicators (QIs) developed by investigators at Stanford University and the University of California under a contract with AHRQ.

The AHRQ QIs expand the original Healthcare Cost and Utilization Project (HCUP) QIs. The PQIs were released in November 2001. The Inpatient Quality Indicators, the second set, were released in May 2002. The third set, the Patient Safety Indicators, were released in March 2003.

### **Provider Payment Facts:**

- The payment plan offers increased net payment to practices with an agreement by practices to achieve minimum reductions in ER and hospital utilization that result in cost savings.

- Comparisons of preventable ER use and preventable hospitalization admissions will be made between a baseline period of 2 years prior to the start of the pilot and time period 1 (start of pilot to 18 months) and time period two (19<sup>th</sup> month to 36<sup>th</sup> month). The difference between the baseline and time periods one and two is the primary outcome measure of this pilot.
- Further work will detail what conditions are considered preventable ER and preventable hospital admissions.
- Practices will receive a net new per member per month five (PMPM) base payment of \$2.50 PMPM in the first year and \$2.00 PMPM in the second and third years. The base rate may be adjusted for a given practice in the second and succeeding payment periods to reflect the practice's share of savings achieved or penalties incurred as a result of performance in the prior period. This is intended to provide additional resources in a flexible way to enable the practice to deliver additional non-visit based services such as care coordination and self-management support, to extend its hours of service or take other steps to improve access by patients.
- Each participating payer will provide this PMPM amount for each of the payer's members attributed to the practice.
- Practice-specific savings targets: Different practices will be able to achieve different levels of reduction depending on how frequently their patients currently use the ER and are admitted to the hospital; consequently, each practice will commit to achieve a practice-specific *minimum* level of reductions in ER visits and hospital admissions that is estimated to generate sufficient savings to offset any upfront payments the practice receives from all participating payers. The overall goal of the pilot is to reduce preventable ER and hospital admissions by 30% and 10% respectively but it is envisioned that practices will start seeing net gains with reductions at lower levels. The minimum level at which a practice and plan would see net gains would be estimated using baseline utilization data and would be provided to the practices prior to the start of the pilot.
- It is *estimated* that, on average, the minimum practice targets would be a 17% reduction in preventable emergency room visits and a 2% reduction in preventable hospitalizations.

However, different combinations of target reductions in preventable ER visits and hospitalizations may be appropriate for different practices depending on the current levels of utilization for their patients and the types of changes in care delivery they plan to implement.

**Rewards for Exceeding Minimum Targets:** If the practice exceeded its practice-specific targets, it would receive a “Shared Savings” payment. “Savings” would be calculated by multiplying a weighted standardized payment level times the additional ER visits and hospitalizations prevented beyond the target reduction. If the practice has also met agreed upon quality performance measures (see #3), it would receive a “Shared Savings” payment (in addition to the PMPM payment specified earlier) equal to 50% of this Savings amount, paid through an increase in the PMPM payment in the subsequent payment period. Each participating payer would pay a share of this amount, with the share calculated as the number of that payer’s members attributed to the practice divided by the total number of patients attributed to the practice from the participating payers. If the practice failed to meet the minimum target, it would see its next period PMPM reduced up to a maximum of 50% calculated as the weighted standardized payment level times the number of ER visits and hospitalizations by which it fell short of its practice-specific targets. This repayment amount would be divided among the participating payers in proportion to the number of their members which are attributed to the practice.

## V. OPERATING STRUCTURE

### A. Key Personnel and Organizational/Governing Structure

This initiative has multiple payers, providers, and purchasers working together to design implement and evaluate a reimbursement model that aligns payment with improved value through further development of the primary care “medical home” concept. This work is co-convened by the Washington State Health Care Authority, the State’s Medicaid program, and the Puget Sound Health Alliance, and also includes involvement of the Governor’s Policy Office. A multi-stakeholder “Participant Group” – *our design team* - has been meeting for the past 12 months to collaboratively design the essential elements of the pilot(s), including targeted outcomes and associated performance measures, practice competencies, reimbursement *methods*

to be tested, the number and location of practices within the pilot(s), a method for selecting practices that will participate, and evaluation. It is expected that the implementation approach and payment model will be jointly agreed upon, but implemented separately – *in a highly coordinated manner* – by each participating payer.

**Key Project Contacts:**

**Lead Contact:** Richard K. Onizuka PhD, Washington State Health Care Authority, Director of Health Policy. Staff contact is Steve Lewis, Medical Program Specialist in Health Policy in HCA.

**Medicaid Contact:** MaryAnne Lindeblad, Health and Recovery Administration of the Department of Social and Health Services

**Pilot Project Coordinators:** Susie Dade, Puget Sound Health Alliance, Director of Performance Improvement, and Reena Koshy, Puget Sound Health Alliance, Pilot Project Coordinator

**Advisory Committee:** This is referred to as the ‘Participant Group’ in our program charter. A listing of its members is attached in Appendix J.. This advisory group reviewed recommendations from several work groups and has provided recommendations to the Health Care Authority for final pilot design.

The workgroups and their responsibilities are listed below (two additional work groups, on practice solicitation, and refining payment models, have also completed their work). The members of each workgroup are drawn from the Participant Group or subject matter experts from the same participating organizations.

**Workgroups:**

***Practice Transformation:***

This workgroup completed its work between October 2009 and January 2010. The primary objectives of this workgroup were to:

- Identify the *top priority outcomes* for this pilot, i.e., identify the key *results* to be demonstrated through this pilot. The group was asked to recommend one or more

measurable outcomes in each of the following four domains: Utilization, clinical quality, patient experience, and provider/team experience.

- Identify the vital few *core* competencies within a practice that most closely align with the expected outcomes. In other words, identify the *essential* capabilities needed by a medical practice to achieve the expected results.
- Recommend support strategies that may be important to help practices be successful, for example: data/information from outside entities (e.g., health plans, hospitals).
- Provide feedback on the types of payment models that will most likely be needed to successfully drive practice transformation.

***Aligning Incentives Workgroup:***

This workgroup completed its work between December 2009 and May 2010. The primary objectives of this workgroup was to agree upon the payment method or methods that will be tested via the pilot, including specific implementation details to be followed in a consistent manner across payers.

***Consumer Engagement Workgroup:***

This workgroup completed its work between February 2010 and April 2010. The primary objectives of this workgroup were to:

- Recommend a general definition of consumer and family engagement in an advanced primary care practice for the purposes of this pilot
- Develop recommendations regarding how to engage consumers and families in the pilot, including specific requirements and/or strategies to support the recommendations

***Measurement and Evaluation Workgroup:***

This workgroup started in February 2010 and continues at present. The primary objectives of this workgroup are to:

- Identify a framework and appropriate measures and methods to evaluate the impact of the Washington State Multi-payer Reimbursement Pilot, based on the expected outcomes as recommended by the Practice Transformation Workgroup

- Ensure that evaluation approach and measurement strategies are compatible with real-world medical practice and the reimbursement approach(es) selected for implementation in this pilot.

Two additional workgroups have completed their work, one on practice selection and one of refining payment models. The practice selection workgroup developed the inclusion/exclusion criteria for practice participation and the framework for practice participation agreements. It also developed the application process, including the timeline for eliciting/reviewing/selecting practices as well as the application package. Notably, the latter included an advisory statement for potential applicants explaining salient aspects of the pilot and its implications for practices, with an emphasis on the potential risks and benefits.

The refining payment models workgroup focused on payment implementation issues, primarily how to operationalize patient attribution to participating practices, threshold quality measures, performance measures and standard pricing of emergency visits/inpatient admissions for calculating savings.

## **B. Medicare Participation in Multi-Payer Data Systems**

- The population of Medicare beneficiaries whose data the state is requesting includes Medicare Advantage enrollees and traditional (FFS) Medicare beneficiaries.
- The type of data requests include facility and office-based claims for ambulatory and inpatient utilization, pharmacy use, eligibility, and provider data based on limited data sets.
- The time period for which data is requested is for incurred utilization dating from 2008 through 2013, inclusive. Data from 2008 to 2009 will serve as baseline information against which comparisons will be made.
- Claims, eligibility, and provider data will be collected and reported every six months for 2008 through 2013. The claims data will be measured and reported based on incurred and paid claims, and would include Medicare Part A, B, C, and D claims and encounter data.
- The claims and encounter data will be used to measure total health services utilization PMPM, over the six-month intervals indicated above. Measures of total allowed payment

PMPM, hospital days, hospital discharges, avoidable hospitalizations, emergency room visits, avoidable emergency room visits, and office visits (generally, ambulatory care visits) will be calculated. All analyses will compare practices participating in the Washington State Multi-Payer Medical Home Reimbursement Pilot (the “intervention sites”) with a comparable set of control practices not participating in the pilot program. Medicaid fee-for-service and Medicaid managed care program participants and enrollees of the major private health plans participating in the pilot would be included in the analysis of total experience.

- Only the evaluation team and the business associate, Milliman will have access to data on individual Medicare beneficiaries, and the evaluation team will receive a HIPAA-compliant limited data set for analysis from the business associate.
- The data set for evaluation purposes will be housed on a secure server at the University of the Washington Department of Health Services, accessible only to members of the evaluation team and with backup files secured by the business associate. The State of Washington, represented by the Health Care Authority, will execute the CMS data use agreement (DUA) and the corresponding DUAs with Medicaid and private health plans participating in the pilot demonstration, of which the CMS would be a part.

### **C. Use of Consultants and Vendors**

The following are a list of consultants and vendors contributing to the Multi-Payer Medical Home Reimbursement Pilot:

University of Washington Department of Health Services (UW) – *Consultant* Members of the UW Health Services department have volunteered as members of the Participant Group and have actively engaged in the design of the overall pilot. They have led the sub-workgroup on Measurement and Evaluation. The evaluation components are being determined jointly by the UW team and the Participant Group.

Milliman, Inc. – *Vendor* The actuarial firm receives and aggregates administrative data from participating payers to develop a unified (multi-payer) performance report for the practices participating in the pilot on select utilization and quality metrics.

Harold Miller – *Consultant* His consulting services are made available through the Puget Sound Health Alliance which has a grant from the Robert Wood Johnson Foundation, and includes a technical assistance component. Harold is paid for his time directly by the Robert Wood Johnson Foundation.

Participant and workgroup members – *Volunteers* A variety of volunteers participate in the advisory committee (participant group) and sub-committees (workgroups). The names and organizations of Participant Group members are listed in Appendix K.

Academy Health and Commonwealth Fund – the State of Washington, through the Health Care Authority and DSHS received a technical assistance grant as part of the State Quality Improvement Institute (SQII) from Academy Health and the Commonwealth Fund. This grant covered travel to national and regional meetings, as well as access to consultants and technical assistance. Washington was one of eight states awarded SQII grants.

The Health Care Authority oversees the participation of all consultants, vendors, and volunteers in the pilot and chairs the participant group and workgroup meetings.

## **VI. EVIDENCE SUPPORTING EXPECTATION OF BUDGET NEUTRALITY**

### **A. Projected APCP Payments**

The Medicare payments to practices for this pilot are made by base PMPM payments of \$2.50 for year one and \$2.00 for years two and three. As discussed previously, the base PMPM rate will be adjusted for performance-based shared savings or penalties for years 2 and 3, based on the previous year's performance. A limit for participation in the pilot has been set at 60,000 commercially insured/Medicare Advantage patients and 7000 Medicaid Healthy Options (managed care) patients. Based on the experience of the practices that will be given preference in the selection process, 11% of their patient panels are Medicare FFS, which would add approximately 8000 patients across the pilot. Cumulatively these patients do not constitute most practices' entire patient panels, but they represent the universe on which the PMPM rates will be paid.

## **B. Projected Number of Practices in Pilot Plan One**

Eight to 12 practices for all three years with a minimum of 8,000 patients per practice. The final number of participating practices will be determined in part by the size of the respective practices relative to the pilot enrollment ceilings for each payer class

### **Projected Number of Patients:**

- Medicare – 8000 total patients, assuming commercial and Medicaid enrollments at maximum
- Commercially insured – 60,000 total patients maximum
- Medicaid Managed Care- 7,000 total patients maximum

These figures are projected to remain constant for the three years of the pilot. As noted above, it may be possible to include the Medicaid FFS population for years 2 and 3. If so, that enrollment will be a function of the mix of participating practices.

- No projected Medicare, Medicaid or commercial insurance payments to participating practices for community-based ACP support.
- Total payments for 8000 Medicare patients expected to be in pilot - \$220,000 year one, base payments \$192,000 each year, years two and three (actual payments for years two and three may vary from base depending on shared savings. Any increase in total payments will reflect an equal putative reduction in total cost).
- No planned payments for data collection by any health plans currently. If data is to be provided to practices more frequently, expenses would need to be decided on by all health plans.

Budget neutrality would be accomplished in each year of the pilot with minimum reductions of total emergency room use of 7.7%, and preventable hospital admission of 1.5%. The pilot goals however are higher at 12% and 4% respectively, and these expectations have been described in Section II., with evidence to support the feasibility of their achievement. For a discussion of the assumptions underlying these calculations please see Appendix J.

### **C. Projected Impact of State Initiative on Medicare Expenditures**

Across the country, data on emergency room use shows that between 32% -76% are preventable in the Medicare population if adequate primary care were available beforehand. Locally, Group Health Cooperative found that with the development of an advanced primary care practice (Medical Home model) they could reduce emergency room visits by 29% and preventable hospital admissions by 11%. Group Health's provider and patient experience improved with the Medical Home model, and quality of care improved as well. The attributes of the medical home model that allow for better care are longer visits and flexibility in interacting with patients (through phone calls, email, nurse visits for example) and these lead to better coordination of care with patients and families.

These activities are recommended as core capabilities for success in this pilot. The practice needs to know its population in order to improve its ability to meet coordinated care needs. This pilot will impact practices in two ways. It will support them to make changes needed to meet care coordination needs of its patients by paying them a care management fee or per member per month payment. This payment supports the services that are not reimbursed within a fee for service system and the core actions that build trust and communication pathways between patients, families, clinics and hospitals.

Practices will be selected that show the ability or the intent to fulfill recommended core capabilities for success. The second way this pilot impacts practices is to provide them with data they do not have about their patients – how many emergency room visits and hospital admissions are potentially avoidable? This pilot will provide that data through the active participation of eight health plans, aggregating data and analyzing it for preventable emergency room use and preventable hospital admissions using national methodologies. In this way, practices in the pilot will receive data they can act on. Incentives are tied to these outcomes and both practices and plans share the need to know where action can be taken. Primary care will not alone be able to change the rate of preventable emergency room and hospital admissions, and further action will be needed to change the incentives around hospital and emergency room use by patients and tertiary care centers.

Global expenditures for all services combined –Given that conservatively 40% of emergency room use is preventable in the Medicare population and on average from regional studies, 57% of all emergency room visits are potentially avoidable, it is expected that in this pilot, there will be a shift toward the primary care setting but not necessarily resulting in an absolute increase in fee for service visits. Group Health in its study showed 6% fewer in- person visits to the primary care practice, and 94% more email and 12% more phone calls. There were 12% more specialty visits, 11% fewer preventable hospitalizations, and 29% fewer urgent and emergency room visits. After one year, the difference was cost neutral despite an estimated \$16 per member per month investment.

The goal of this pilot is to decrease preventable emergency room use by 30% and ambulatory-sensitive inpatient admissions by 10% by providing primary care practices with a care management fee to support the necessary infrastructure and personnel needed to implement an advanced primary care model described in our core capabilities.

To calculate savings, Washington State information provided by the Decision Information Tool (DIT) from CMS was used. Total Medicare emergency room expenditures and inpatient volume were used to describe expected costs without the pilot intervention. Estimated savings were calculated showing reductions in estimated preventable emergency room visits and preventable hospitalizations resulting from primarily preventable emergency room visits. Because there is not a specific enrollment process or disease condition intervention, calculations for predicted savings were not done using the ~~Input~~ “predicted” or ~~Impact~~ “impact” tabs of the provided tool. This pilot does not prescribe clinical interventions to practices but rather aligns incentives, payment, and outcomes on evidence-based reductions achievable with supported advanced primary care practice models.

#### **D. Related Medicaid Waiver Requests**

On July 7, 2010, Washington State submitted a proposal for an 1115 demonstration waiver to support a transitional bridge to National Health reform for two state-funded programs, the Basic Health and Medical Care Services programs. Members covered under these programs would not have a significant impact on the total number of individuals served by the multi- payer demonstration pilot and participation in the multi payer demonstration pilot is unrelated to the

transitional bridge demonstration waiver. Furthermore, we do not anticipate a need for any new waivers or state plan amendments to support participation in the pilot.

## VII. EVALUATION PLAN

The full evaluation design is included in Appendix L. Project Evaluation, Schedule, Design, and Work Plan. The evaluation team works jointly with the state to develop the study components with the advisory “Participant Group”, but is independently seeking outside grant funding to support the pilot’s evaluation process. An initial evaluation phase is planned to assess implementation of the payment method over the first year. The evaluation will continue into year four to study outcomes after the pilot ends in year three. The strengths of the evaluation include: use of comparable measures used in other pilots testing medical home outcomes and the comparison of more than one payment method.

**Study Design and Methods:** The evaluation will use a quasi-experimental design with matched control for intervention method. There are two payment models being tested. The impact analysis will be based on a difference-in-differences analysis, controlling for patient-level and practice-level covariates, and using the two years *pre-pilot* intervention as the baseline period anchoring the comparison of changes over time between the intervention and control practices with comparable control practices selected in a 2:1 ratio to pilot intervention practices.

**Types of Data and Data Sources to be used in the Evaluation:** Qualitative data will be gathered through baseline key informant interviews, medical provider and staff experience surveys, patient experience surveys. Quantitative analysis will use claims data from health plans to calculate total costs, estimated preventable emergency room visits, estimated preventable hospital admissions, ambulatory care visits and attribution. Quality measures will be collected from health plans and shared with pilot practices on 10 clinical process measures including: screening for cervical cancer, breast cancer, and colon cancer among the population at risk; for chronic conditions; testing among diabetics for HbA1c levels, cholesterol, and nephropathy; among patients with heart disease, cholesterol levels and use of cholesterol-lowering medication; among patients with depression, medication adherence at three and six months, respectively. Practices will provide status (outcome) data on three health measures of HbA1c control among

diabetes patients, blood pressure control for diabetes and/or heart disease patients, and cholesterol management for patients with diabetes and/or heart disease.

**Study Questions:** While Medicare will participate only in Plan 1, the pilot evaluation will ask the follow questions which involve analysis of two different payment interventions: 1) What factors affect the formation and implementation by multiple health plans and health care purchasers of two reimbursement methodologies for primary care in Washington State? 2) What is the impact of each payment method on outcomes, cost, health services utilization, and patient and provider experience? 3) What is the trend in cost, utilization, and outcome measures over the three year period of the payment intervention?

**Use of the Evaluation Results:** Policy makers will understand the impact of distinct payment methods in accelerating achievement of targeted outcomes by primary care practices and in assessing primary care practices' abilities in transitioning to forms of accountable care payment. Health plans , public and private healthcare purchasers seeking to implement creative payment methodologies will understand what factors bend the health care cost curve downward, while also achieving improvements in the processes and outcomes of healthcare.

**Name of Evaluation Team Lead:** The University of Washington, Department of Health Services, School of Public Health. Lead investigator: Douglas Conrad PhD.

**Timeline:** The proposed evaluation would span four years: 2011-2014, utilizing a combination of baseline incurred experience data from 2008-2010, and prospective data for 2011-2013 calendar years. Reporting periods would coincide with the timing of six month feedback to participating practices, as planned in the larger pilot demonstration and evaluation, of which this CMS demonstration is a part.

The State of Washington, represented by the Health Care Authority, will share findings from the evaluation results with CMS.

### **VIII. COMMITMENT TO COOPERATE IN EVALUATION**

The State of Washington, represented by the Health Care Authority, and the participating providers and payers as a condition of participation, will agree to cooperate in an independent formal evaluation of the demonstration including submission of cost and other program data and making relevant staff of participating organizations available for site visits by CMS or its contractor.

### **IX. LIMITATION ON PARTICIPATION IN OTHER MEDICARE DEMONSTRATION PILOTS**

The selection process informs practices that they are disqualified if participating in any other Medicare demonstration pilot and that they are unable to join additional demonstration pilots once engaged in this pilot. The application form asks specifically if the practice is currently involved in Medicare demonstration pilot or if a network or parent organization is involved. The application also identifies practices that may be located in a county with an ongoing CMS demonstration pilot for purposes of exclusion.

**Appendix A. Substitute Senate Bill 5891**

**CERTIFICATION OF ENROLLMENT  
SUBSTITUTE SENATE BILL 5891**

61st Legislature  
2009 Regular Session

Passed by the Senate April 20, 2009  
YEAS 39 NAYS 6

\_\_\_\_\_  
President of the Senate

Passed by the House April 8, 2009  
YEAS 97 NAYS 1

\_\_\_\_\_  
Speaker of the House of Representatives

Approved

\_\_\_\_\_  
Governor of the State of Washington

**CERTIFICATE**

I, Thomas Hoemann, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **SUBSTITUTE SENATE BILL 5891** as passed by the Senate and the House of Representatives on the dates hereon set forth.

\_\_\_\_\_  
Secretary

FILED

Secretary of State  
State of Washington

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SUBSTITUTE SENATE BILL 5891

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AS AMENDED BY THE HOUSE

Passed Legislature - 2009 Regular Session

State of Washington                      61st Legislature                      2009 Regular Session

By Senate Health & Long-Term Care (originally sponsored by Senator Keiser; by request of Governor Gregoire)

READ FIRST TIME 02/25/09.

1            AN ACT Relating to establishing a forum for testing primary care  
2 medical home reimbursement pilot projects; adding new sections to  
3 chapter 70.54 RCW; creating a new section; and providing an expiration  
4 date.

5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

6            NEW SECTION. Sec. 1. The legislature declares that collaboration  
7 among public payors, private health carriers, third-party purchasers,  
8 and providers to identify appropriate reimbursement methods to align  
9 incentives in support of primary care medical homes is in the best  
10 interest of the public. The legislature therefore intends to exempt  
11 from state antitrust laws, and to provide immunity from federal  
12 antitrust laws through the state action doctrine, for activities  
13 undertaken pursuant to pilots designed and implemented under section 2  
14 of this act that might otherwise be constrained by such laws. The  
15 legislature does not intend and does not authorize any person or entity  
16 to engage in activities or to conspire to engage in activities that  
17 would constitute per se violations of state and federal antitrust laws  
18 including, but not limited to, agreements among competing health care

1 providers or health carriers as to the price or specific level of  
2 reimbursement for health care services.

3 NEW SECTION. Sec. 2. A new section is added to chapter 70.54 RCW  
4 to read as follows:

5 The health care authority and the department of social and health  
6 services shall design, oversee implementation, and evaluate one or more  
7 primary care medical home reimbursement pilot projects in the state to  
8 include as participants public payors, private health carriers, third-  
9 party purchasers, and health care providers. Based on input from  
10 participants, the agencies shall:

11 (1) Determine the number and location of primary care medical home  
12 reimbursement pilots;

13 (2) Determine criteria to select primary care clinics to serve as  
14 pilot sites to facilitate testing of medical home reimbursement methods  
15 in a variety of primary care settings;

16 (3) Select pilot sites from those primary care provider clinics  
17 that currently employ a number of activities and functions typically  
18 associated with medical homes, or from sites that have been selected by  
19 the department of health to participate in a medical home collaborative  
20 under section 2, chapter 295, Laws of 2008;

21 (4) Determine one or more reimbursement methods to be tested by the  
22 pilots;

23 (5) Identify pilot performance measures for clinical quality,  
24 chronic care management, cost, and patient experience through patient  
25 self-reporting; and

26 (6) Appropriately coordinate during planning and operation of the  
27 pilots with the department of health medical home collaboratives and  
28 with other private and public efforts to promote adoption of medical  
29 homes within the state.

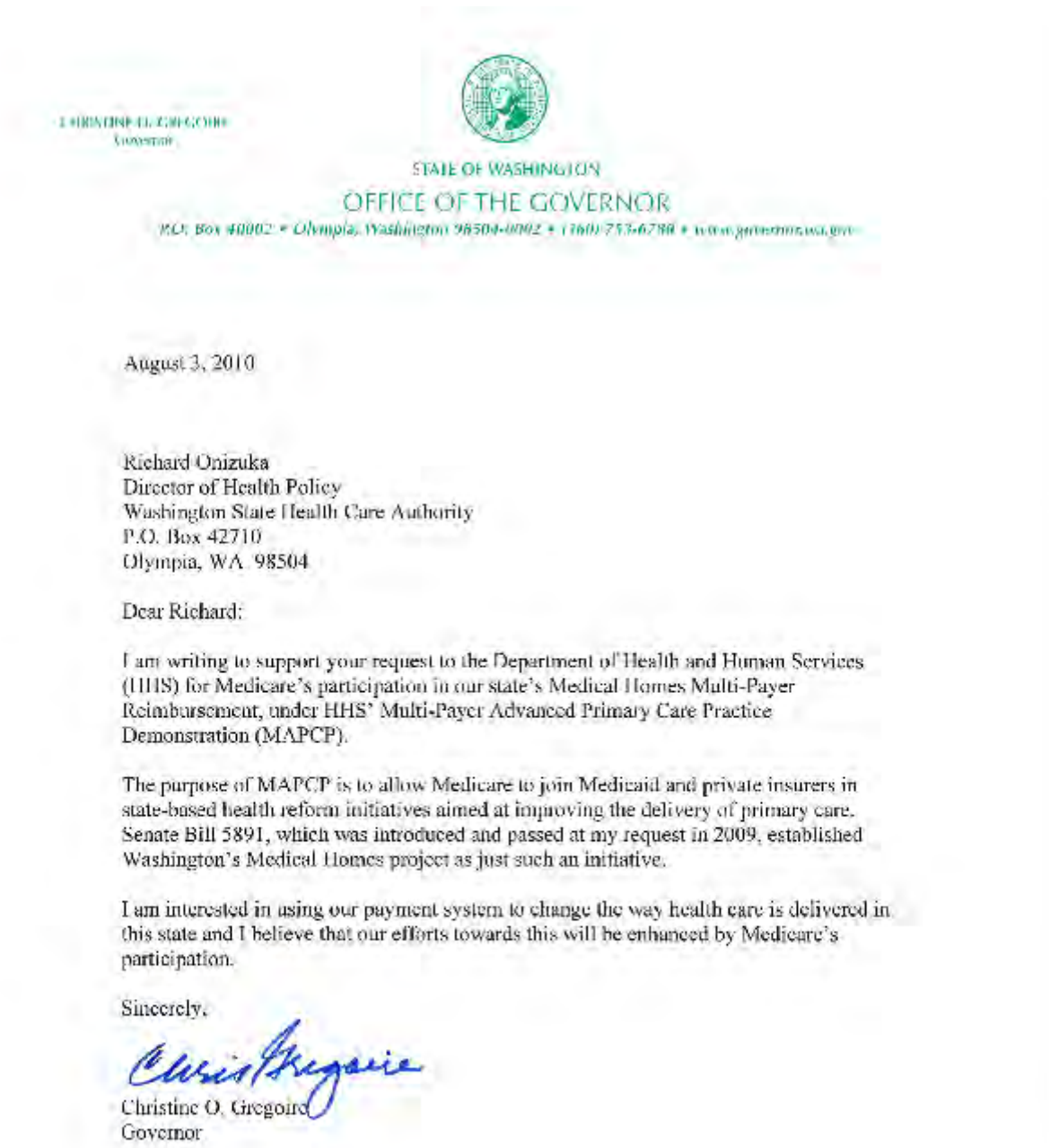
30 NEW SECTION. Sec. 3. A new section is added to chapter 70.54 RCW  
31 to read as follows:

32 The health care authority and the department of social and health  
33 services may select a pilot site that currently employs the following  
34 activities and functions associated with medical homes: Provision of  
35 preventive care, wellness counseling, primary care, coordination of  
36 primary care with specialty and hospital care, and urgent care

1 services; availability of office appointments seven days per week and  
2 e-mail and telephone consultation; availability of telephone access for  
3 urgent care consultation on a seven-day per week, twenty-four hours per  
4 day basis; and use of a primary care provider panel size that promotes  
5 the ability of participating providers to appropriately provide the  
6 scope of services described in this section. The reimbursement method  
7 chosen for this pilot site must include a fixed monthly payment per  
8 person participating in the pilot site for the services described in  
9 this section. These services would be provided without the submission  
10 of claims for payment from any health carrier by the medical home  
11 provider. Agreements for payment made directly by a consumer or other  
12 entity paying on the consumer's behalf must comply with the provisions  
13 applicable to direct patient-provider primary care practices under  
14 chapter 48.150 RCW. In addition, the agencies may determine that the  
15 pilot should include a high deductible health plan or other health  
16 benefit plan designed to wrap around the primary care services offered  
17 under this section.

18 NEW SECTION. **Sec. 4.** This act expires July 1, 2013.  
Passed by the Senate April 20, 2009.  
Passed by the House April 8, 2009.  
Approved by the Governor April 30, 2009.  
Filed in Office of Secretary of State May 1, 2009.

## Appendix B. Governor Governor's Letter of Support



## Appendix F. Qualis Health Letter Of Support

**Washington  
State Medical  
Association**

Physician Driven  
Patient Focused

**WSMA**

2033 Sixth Avenue, Suite 1100  
Seattle, Washington 98121  
206-441-9762  
1-800-552-0612  
Fax: 206-441-5863  
e-mail: wsma@wsma.org

1800 Cooper Point Road SW  
Bldg 7, Suite A  
Olympia, Washington 98502  
360-352-4848  
1-800-562-4546  
Fax: 360-352-4303

July 26, 2010

Deborah J. Harper, MD  
*President*

Dean Martz, MD  
*President-Elect*

Cynthia A. Markus, MD  
*Past President*

Nicholas Rajacich, MD  
*1st Vice President*

Michael S. Weinstein, MD  
*2nd Vice President*

Douglas R. Myers, MD  
*Secretary-Treasurer*

Dale P. Reisner, MD  
*Assistant Secretary-Treasurer*

Thomas J. Curry  
*Executive Director/CEO*

Dr. Richard Onizuka  
Director, Health Policy  
Washington State Health Care Authority  
P.O. Box 42710  
Olympia, WA 98504-2710

Dear Dr. Onizuka,

Dr. Peter McGough has been serving as the physician liaison for the Washington State Medical Association (WSMA) on the Washington State Multi-Payer Medical Home Reimbursement pilot advisory committees, representing a practicing physician perspective. Over the past year the WSMA has been discussing the potential benefits of the patient centered medical home, including the concept of a reimbursement pilot that will support primary care practices, improve care outcomes and control unnecessary costs. The association has been following the progress of the Multi-Payer pilot closely, appreciating the updates and suggesting ideas intermittently.

On behalf of the WSMA, I want to express our support for the Multi-Payer Medical Home Reimbursement pilot request for applications. The reimbursement pilot will help us understand how payment methods affect clinical and performance outcomes. These initial steps are necessary to make further changes that lead to sustainable support for all primary care practices.

The WSMA also supports the Washington State Health Care Authority's application for the Center for Medicare and Medicaid Services (CMS) Multi-Payer Advanced Primary Care Practice Demonstration. Support for advanced primary care practices is feasible only when a majority of a practice population is covered by participating payers. Inclusion of Medicare as a payer will provide significant support for pilot practices and generate further insight to the effectiveness of the payment model tested.

We are proud to be part of this initiative, and support the State's effort as it moves forward with the implementation phase of the Multi-Payer Medical Home Reimbursement Pilot.

Sincerely,



Deborah J. Harper, MD  
President

cc: Peter McGough MD, WSMA Liaison, Washington State Multi-Payer Medical Home Reimbursement Pilot  
Thomas J. Curry, WSMA Executive Director/CEO

## Appendix D. WAFP Letters Of Support



WASHINGTON ACADEMY OF FAMILY PHYSICIANS

August 4, 2010

Dr. Richard Onizuka  
Director, Health Policy  
Washington State Health Care Authority  
P.O. Box 42710  
Olympia, WA 98504-2710

Dear Dr. Onizuka,

I am writing on behalf of the Washington Academy of Family Physicians (WAFP) to support the Washington State Health Care Authority's application for the Center for Medicare and Medicaid Services (CMS) Multi-Payer Advanced Primary Care Practice Demonstration. It is our hope that inclusion of Medicare as a payer in testing alternate payment models will provide additional data that will lead to sustainable support for primary care practices transformation work and improved patient care that we all believe in.

Sincerely,

Stephen Albrecht, MD  
President

cc: Karla Pratt, WAFP LVP



## WASHINGTON ACADEMY OF FAMILY PHYSICIANS

August 4, 2010

Dr. Richard Onizuka  
Director, Health Policy  
Washington State Health Care Authority  
P.O. Box 42710  
Olympia, WA 98504-2710

Dear Dr. Onizuka,

The Washington Academy of Family Physicians (WAFP) strongly supports and is heavily invested in developing the patient centered medical home (PCMH) model of care in Washington State. We believe that the PCMH care delivery model through Family Medicine will improve health care outcomes and reduce costs by improving quality, care coordination, and patient safety; and we further believe it is critical for the future of Family Medicine and the health of our patients. We also know from experience that achieving these goals is time consuming, expensive, and very difficult, transformative work. We believe the model has been tested and proven elsewhere, and truly only awaits serious reimbursement/payment reform to become the dominant model for the delivery of primary care.

As you know, the WAFP currently leads the Patient-Centered Medical Home Collaborative in conjunction with the Department of Health and is guiding the practice transformation work of 33 participating primary care practices. That work helped guide the Academy delegates' ability to bring the physician perspective to the design work of the Washington State Multi-Payer Medical Home Reimbursement pilot.

On behalf of the WAFP, I am writing to support the Multi-Payer Medical Home Reimbursement pilot request for applications. The reimbursement pilot will help us understand how payment methods affect clinical and performance outcomes. These initial steps are necessary to make further changes that lead to sustainable support for all primary care practices.

We encourage applicants to the pilot. Applicants, which will be primary care practice sites, will be provided with a baseline analysis of their recent utilization of Emergency Department services and hospital admissions for their attributed patients using standard methods. These data should enable applicants to make reasonable economic and feasibility decisions regarding participating in a commitment to this three year trial, without initially committing to such participation. We hope for a robust group of applications for this initial phase, so that those willing and able to commit to three years can make such a bold and large commitment to transforming their practices to reduce unnecessary emergency room use and unnecessary hospitalizations while building the capacities needed to truly transform their organizations into patient centered medical homes.

Sincerely,

Steve Albrecht, MD  
President

cc: Patricia Boiko, MD, Dave Lynch, MD, Paul Buehrens, MD, Kevin Murray, MD  
Karla Pratt, WAFP EVP

---

1239 120th Avenue NE, Suite G, Bellevue, WA 98005

Ph: 425-747-3100 WA Only: 800-621-8424 Fax: 425-747-3109 admin@wafp.net www.wafp.net

## Appendix E. Washington State Department of Health Letter of Support



STATE OF WASHINGTON  
DEPARTMENT OF HEALTH

PO Box 47896 • Olympia, Washington 98504-7896  
TEL: (360) 336-4501 • FAX: (360) 586-7424 • TDD Relay Service: 1-800-833-6388

July 23, 2010

Washington State Health Care Authority  
Dr. Richard Onizuka  
Post Office Box 42682  
Olympia, Washington 98504-2682

Dear Dr. Onizuka:

In the past ten years, the Department of Health has trained over 200 primary care practices in the internationally known Institute for Healthcare Improvement's Breakthrough Collaborative process. Teaching primary care practices how to deliver population-based care using an electronic registry and measuring performance outcomes on a routine basis is the foundation of a collaborative process.

We have partnered with Qualis Health, the Group Health Center for Health Studies, the Washington Academy of Family Physicians, and Washington Health Plans to make these large quality improvement efforts available for primary care. The Department of Health, in partnership with the Washington Academy of Family Physicians, sponsors the Washington Patient Centered Medical Home Collaborative for 33 high performing primary care practices in Washington State. This two year collaborative training teaches practices the critical elements of a medical home. Practice changes are measured by provider satisfaction, patient experience, and a carefully selected panel of diabetes and prevention focused clinical outcomes.

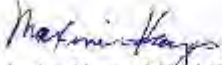
Payment reform is critical to the sustainability of primary care practice change. Busy primary care practices that are reimbursed only in a fee-for-service system cannot afford to spend time not seeing patients. The effort put into practice redesign to achieve quality improvement is not compensated by our current reimbursement system. The Washington Multi-Payer Reimbursement Pilot is a unique opportunity for the Center for Medicare and Medicaid Services to shift payment in primary care towards outcomes rather than volume of services. In this pilot, Washington State has the majority of health plans willing to pay advanced primary care practices for quality care in exchange for outcomes which include reduction in avoidable emergency department visits and preventable inpatient admissions.

The Department of Health supports the addition of Medicare to Washington's Multi-Payer Reimbursement Pilot. Doing so will provide a unique opportunity to test a much needed

Dr. Richard Onizuka  
Page Two  
July 23, 2010

payment design and build upon our work. Please contact me at [maxine.hayes@doh.wa.gov](mailto:maxine.hayes@doh.wa.gov) or 360-236-4030 if you have any questions or need additional information.

Sincerely,

  
Maxine Hayes, MEd, MPH  
State Health Officer

## Appendix F. Qualis Health Letter Of Support



10700 Meridian Ave N • Suite 100  
PO Box 53409  
Seattle, WA 98153

Office: 206.368.9700  
Toll Free: 1.800.943.7635  
Fax: 206.368.2413

[www.qualishealth.org](http://www.qualishealth.org)

July 19, 2010

Dr. Richard Onizuka  
Director, Health Policy  
Washington State Health Care Authority  
P.O. Box 42710  
Olympia, WA 98504-2710

Dear Dr. Onizuka,

On behalf of Qualis Health, I wish to offer our strong support for the Washington State Health Care Authority's application for the CMS Multi-payer Advanced Primary Care Practice Demonstration. My understanding is that Washington's multi-payer medical home reimbursement project is in the final stages of design and that practice enrollment will commence in August 2010 with an anticipated launch of 1<sup>st</sup> quarter 2011. It is encouraging that the project has such robust support from multiple commercial payers in our state as well as the state Medicaid program.

Qualis Health is dedicated to improving the quality of healthcare delivery and health outcomes for individuals and populations across the nation. We serve as the CMS-designated Quality Improvement Organization (QIO) for Washington and Idaho. As the lead organization for the WIREC, the Washington and Idaho Regional Extension Center for Health Information Technology, we offer healthcare providers a local resource for technical assistance, guidance and information on best practices to support and accelerate healthcare provider efforts to become meaningful users of electronic health records.

Qualis Health also leads the Commonwealth Fund-sponsored Safety Net Medical Home Initiative (SNMHI). The SNMHI is a national initiative intended to assist primary care practices serving vulnerable populations in five states to become high-performing patient-centered medical homes. In the course of this project, it has become clear that participation of Medicare in multi-payer initiatives is critical for optimal alignment of regional payment reform efforts.

Given its significant role as a payer, Medicare's participation in our state effort will have a tremendous impact on our ability to evaluate whether advanced primary care practice will reduce unwarranted use of the emergency room and avoidable hospitalizations – both significant drivers of overutilization and high health care costs.

We are excited about our state's opportunity to collaborate with the Centers for Medicare and Medicaid Services and wish you the best of luck in submitting your proposal.

Sincerely,

A handwritten signature in black ink that reads 'Jonathan R. Sugarman MD, MPH'.

Jonathan Sugarman, MD, MPH  
President and CEO

**Appendix G. Multi-payer Reimbursement Pilot Timeline**

	Multi-payer Reimbursement Pilot Timeline							
Payment Period	1			2		3		4
Observation Period	1		2		3			
Reconciliation			1		2		3	
	06	12	18	24	30	36	42	48
	Month							

## Appendix H. Washington State Multi-Payer Medical Home Reimbursement Pilot – Practice Selection Process

### Washington State Multi- Payer Medical Home Reimbursement Pilot

while reducing the fee for service component by an equivalent amount. For year one, the per member per month amount would equal \$2.50, in years 2 and 3 it would equal \$2.00. Because there is not additional revenue to practices, practices will not set a practice-specific target. Estimated shared savings will be calculated if a reduction in preventable emergency room and hospital admissions is noted. In this plan, initial savings go first to the practice, which has made the investments in the past to implement change that is resulting in reduction of costly tertiary care. The practices would receive up to the equivalent of \$2.50 for year 1 and \$2.00 for year 2 and 3. Savings that occur beyond that amount would be shared between practices and plans.

#### What are the risks?

For both payment models, practices must maintain their baseline quality performance measures. 10 quality measures will be defined and practices must maintain their levels on 7 out of 10. Plan 1 carries the risk that a practice that does not meet its break-even point or practice-specific target will receive less additional payment in subsequent years. Both plans carry the risk that shared savings generated do not cover all of the practice investment made to implement care coordination and advance primary care development.

#### What is the time line?

The pilot will start in early 2011 and continue for 3 years. Call for applications will start August 2010 and the deadline is **September 10, 2010**. Preliminary candidates will be selected mid-September with final candidates selected by early December 2010.

#### Who should apply?

Any practice is invited to apply who can show a willingness to share required data for quality care and outcomes reporting, an ability to participate in the pilot for all three years, and a motivation to achieve the goals of improved patient-centered care. While these are not required, a preference will be made for practices who are current participants in the Washington Academy of Family Physicians/ Department Of Health Patient-Centered Medical Home Collaborative; that have reached at least a level INCQA certification in the patient centered medical home recognition program; or were past participants in a Washington State Disease Collaborative. See attached “Application Instructions” for details.

#### Contact Information:

Reena Koshy  
Project Coordinator –Puget Sound Health Alliance  
Washington State Multi-Payer Medical Home Reimbursement Pilot  
[reenakoshy@gmail.com](mailto:reenakoshy@gmail.com)  
phone (630)-885-9383

Steve Lewis – Health Care Authority  
Email [Steve.Lewis@hca.wa.gov](mailto:Steve.Lewis@hca.wa.gov)  
Phone (360)-923-2824

## Inclusion and Exclusion Criteria

### Washington State Multi-Payer Medical Home Reimbursement Pilot 7/29/2010

Capacity: 8-20 clinics (contingent on funding and total population size)

#### Inclusion Criteria:

The following criteria will be used to determine a practice site's entry to the pilot and whether it is well positioned to achieve the targeted outcomes of the pilot. It is not expected that practices have all criteria in place *prior* to entry into the pilot but they should have a plan to implement the following through one of the payment models selected.

#### Eligible practices will:

- Be primary care oriented (family medicine, internal medicine, pediatrics), have a minimum of four full time equivalent providers in one practice location (clinic site), and be located in Washington State. A clinic site with fewer than 4 full time equivalent providers may combine with another clinic *site if they are able to meet all inclusion criteria functions as a single entity* and similarly do not meet exclusion criteria;
- Have at least 8,000 active patients in the practice (to ensure adequate numbers for quality measures and avoid negative impacts of outcome measures)
- Have a commitment to working towards implementing key principles of the "patient-centered medical home" and to make changes that *impact their entire practice population*;
- Have visible commitment from practice leadership to engage in the Pilot and to organize and lead efforts within the practice to achieve targeted outcomes;
- Have in place or plan to implement a system for care coordination *with delineated tasks and team members (for example nurse care manager or health educator/care planner) with explicit accountability* for follow-through, including proactive outreach to patients with more complex care needs and those patients recently seen in the emergency room or discharged from the hospital
- Routinely use an electronic patient registry for patients with one or more chronic conditions to support effective care coordination;
- Be willing and have the capability to measure and report quality measures *as defined by the Pilot* at least bi-monthly; and,
- Be willing and able to participate in the Pilot for three years

#### Exclusion Criteria:

The following practices will **not** be eligible to participate in this Pilot:

- Specialty practices (non-primary care)
- Practices where a *majority* of patients are or are expected to be under a capitated or sub-capitated payment structure.

## Washington State Multi- Payer Medical Home Reimbursement Pilot

utilization data on preventable emergency room and hospitalization rates for a specified baseline period. The preliminary practices will then consider feasibility of reaching pilot goals. Practices are offered an interview to discuss the informed consent process which will include confirmation of the payment model selection, specific practice targets for outcome measures, and potential financial consequences of generated savings or losses.

### **Advisory**

From recent experience with similar multi-payer medical home pilots around the country, it is strongly advised that practices do not undertake transformation projects such as this while simultaneously implementing a new electronic medical record or addressing other **major** organizational changes due to limited ability to manage both successfully. Similarly, practices without steady leadership and adequate staffing to reasonably expect to successfully achieve the targets associated with this Pilot will face increased risk.

To test the payment models under the widest variety of conditions we reserve the right to select clinics which represent a diverse range of practice sizes, ownership structures and rural and urban settings. **The Washington State Health Care Authority RESERVES THE RIGHT TO MAKE SUBSTITUTIONS OR CHANGES TO THE INCLUSION CRITERIA BASED ON ACTUAL ENROLLMENT.**

### **Advisory Letter for Practices**

Your involvement in this Pilot would be an opportunity to participate in a test to demonstrate enhanced primary care capability in managing care and costs, which will hopefully lay the foundation for establishing a different and more advantageous approach to primary care reimbursement in our State.

As you consider enrollment in the Pilot – in either Plan 1 or Plan 2 - it is important to consider both the potential benefits and risks for your practice.

Practices will be considered well-positioned for success if they have the following in place. Carefully consider how your practice either does or can in the near future include the following elements:

- Have extended hours to include weekday evening and weekend access to enable patients to more readily access the practice, particularly for same-day or urgent needs during “after hours;”
- Enable patients to access the practice in multiple ways including by in-person visit and by telephone or secure email;
- Have a clear system for care coordination within the practice with *delineated tasks and team members (nurse care manager or health educator/care planner) with explicit accountability* for follow-through, including proactive outreach to patients with more complex care needs and those patients recently seen in the emergency room or discharged from the hospital;
- Have an established system of communication with the hospital (or be willing to actively engage in developing such a system) that is the predominant provider of acute care services to the practice population that includes (1) timely notification of patient use of the emergency room, and (2) opportunity to coordinate on discharge planning and notification at the time of discharge; and,
- Have a strong service culture within the practice that includes a team orientation to delivering care.

#### **In Plan 1, this Pilot is an *opportunity* to:**

- Earn *additional* revenue for your practice on a per member per month basis that you can use to enhance patient care, develop your core competencies as a practice and strengthen your clinical performance;
- Share in the savings associated with appropriately reducing ED visits and hospitalizations for your patients;
- Develop a stronger relationship with the hospital or hospitals where your patients are most likely to receive care.
- Receive data from health plans on preventable emergency room and preventable hospital admission patterns that may allow you to better address the concerns of your patients
- Share in savings when maintaining your current level of clinical quality measures

## Washington State Multi- Payer Medical Home Reimbursement Pilot

With these potential benefits come some potential *risks*. As you think about enrollment, consider the following:

- As a participant in Plan 1, if you fail to achieve the targets associated with reduced ED visits and hospitalizations, you will be required to reduce *up to 50%* of future per member per month payment that you receive. This reduction would be implemented by each health plan as a reduced per member per month payment in the next scheduled payment period, over 6 to 18 months.
- Depending on the mix of patients you have in your practice, you may have a higher or lower per member per month payment. In other words, you will want to make sure that you have a sufficient number of patients with insurance *from the health plans participating in this Pilot* to make your participation worthwhile. Take into consideration any payments you are already receiving from participating health plans to reduce ED use or hospital admissions as these plans may not duplicate payments for the same patients.
- The practice will need to sign an addendum to existing health plan contracts that describes only the changes expected in this pilot for the duration of the pilot. This may require up to eight new contract addenda depending on the mix of patients and participating payers in your practice. Common language will be provided to each health plan to ensure that the process is streamlined but sufficient time would need to be allowed for these negotiations to occur by beginning of January 2011.
- The Pilot is anticipated to last 36 months. If you hire additional staff during the Pilot based on your increased revenue, these positions may not be funded adequately at the conclusion of the Pilot unless you are able to sustain that higher level of revenue over time or to generate cost savings in other practice inputs.
- If you currently have an ineffective (or nonexistent) relationship with the hospitals where your patients are most likely to receive care, you may have less chance of success in collaborating with these facilities during a time limited Pilot.
- From recent experience with similar multi-payer medical home pilots in other places, it is advised that practices do not undertake transformation projects such as this while simultaneously implementing a new electronic medical record or addressing other **major** organizational changes due to limited ability to manage both successfully. Similarly, practices without steady leadership and adequate staffing to reasonably expect to successfully achieve the targets associated with this Pilot will face increased risk.
- In order to allow for outcomes measurements, shared savings, and evaluation of the payment pilot, practices and plans will have to agree to one common method for many calculations including: attribution of patients to plans and practice, calculations of performance measures, calculation of outcome measures, calculation of shared savings and penalty payments. While there is no perfect measurement method for all the calculations and outcomes we are tracking, there are consequences tied to use of the measures such as achievement of practice specific targets and performance measures. The consequences can result in bonus payments by payers and penalty payments by practices. The methods used in this pilot may be different than measures used by your practice or plans previously.

## Appendix I. HIT Grant Information



### Announcement of 2010 Funding Opportunity for Health Information Technology to Support Collaborative Teams

#### I. Eligibility

Funds are available exclusively to teams enrolled in the Washington Patient-Centered Medical Home Collaborative who have made initial application to the Washington State Multi-Payer Medical Home Reimbursement Pilot. The Collaborative is jointly sponsored by the Department of Health and the Washington Academy of Family Physicians. The Reimbursement Pilot is jointly sponsored by Washington Health Care Authority and Puget Sound Health Alliance.

Funds must be used to enhance, modify or expand existing health information technology (HIT) to create interoperable linkages to support one or more of the following “Key Objectives” listed in Box 1 below. Interoperable can be described as the ability of a system or a product to work with other systems or products without special effort on the part of the customer.

*The relationship between the health information technology improvement and the selected objective must be explicitly described.*

#### II. Key Objectives

- Reduce avoidable emergency department visits
- Reduce preventable inpatient admissions.
- Reduce readmissions to inpatient hospital settings within 30 days of discharge.

**Box 1**

#### III. Important Dates

Announcement of Funding Opportunity	August 9, 2010
Q & A period	August 9-August 16, 2010
Applications Due	September 10, 2010

Award announcements	October 1, 2010
Fund spending deadline	June 30, 2011
Final report due	August 15, 2011

#### IV. Desirable Outcomes

1. Increase two-way electronic information flow between primary care and emergency departments, and between primary care and inpatient settings related to patient discharges and admissions.
2. Increase two-way electronic information flow between primary care, specialty care , ancillary clinical services, and other community supports.
3. Increase care coordination within and across primary practice boundaries. Increase care coordination for identified populations of patients using community multi-organization teams.
4. Decrease the overuse of supply sensitive care. Supply sensitive care **is** care whose frequency of use is not determined by medical theory or scientific evidence. Overuse of supply-sensitive care is particularly apparent in the management of chronic illness. Supply-sensitive services include physician visits, diagnostic tests, hospitalizations and admissions to intensive care among patients with chronic illnesses. The cause is an overdependence on acute care and a lack of infrastructure necessary to support the management of chronically ill patients in other settings.

#### V. Project Description

Awards to eligible applicants will fund partial costs to expand, enhance, modify or link Health IT systems. Successful applicants must already have some elements of Health IT integrated into current work processes.

Funding will not be made available at this time for preliminary exploration of systems or assessment of the viability of electronic health record adoption.

##### All projects must at minimum:

- Align with specific elements of the Collaborative change package. (Appendix A)
- Focus on health information technology.
- Show logical and specific connections to the Key Objectives. (See box 1)

#### VI. Potential projects

- Two-way information exchange with emergency departments, hospital discharge planners, specialty care, key community resources, or ancillary clinical services.
- Continuity of care records that span care settings.
- Patient personal health records which interface with the electronic health record and which support proactive planned care and continuity of information across care settings.
- Information accessibility which improves after-hours access for patients.

## Appendix J. Budget Neutrality Assumptions and Calculations

### Budget Neutrality Assumptions and Calculations

This pilot is expected to achieve at least budget neutrality, and probable net savings, for CMS's participating on behalf of the Medicare FFS population in Washington State. Our calculations indicate that budget neutrality will be achieved with a reduction of 7.7% in the total number of emergency room visits and 1.5% reduction in total inpatient admissions. As discussed in the application text, experience from other initiatives indicates these levels of reduction are well within the range of feasibility. Performance targets for participating practices will actually be higher than these levels, depending on their individual current performance levels and capacities.

Our calculations are based on the following major assumptions:

- Budget neutrality will be achieved by a combination of reduced preventable emergency room visits and resultant inpatient admissions due to chronic ambulatory care sensitive conditions. The mix of these targets will vary from one participating practice to another, as will their respective levels of performance. Each practice will, as a condition of participation, establish separate performance targets for emergency room and inpatient reductions which will combine to achieve at least budget neutrality.
- Because the pilot is not prescriptive as to specific interventions, projected reductions are not predicated on changes in utilization rates for specific services within the categories of emergency and inpatient utilization; rather, they are based on conservative expectations about the general proportion of emergency services that are preventable, on the proportion of preventable emergency services that a practice will be able to prevent with the resources provided through the pilot, and on a conservative estimate of prevented inpatient admissions.

--As discussed in the application text at B—Problem Statement, experience from other initiatives statewide indicates that a range of between 40% and 70% of Medicare emergency room visits are preventable. For purposes of this analysis we took the lower estimate, 40% of all emergency room visits.

--For preventable inpatient admissions, we considered that a conservative estimate for reduction would be admissions through the emergency room for conditions representing chronic Prevention Quality Indicators (PQI) using the Agency for Healthcare Research and Quality (AHRQ) algorithm. Our calculations, described below, indicate that the reduction estimate represents approximately 15.6% of PQI-related inpatient admissions.

- Again because the pilot is not prescriptive, no assumptions are made about the relative contribution to cost reduction made by the number of users in the beneficiary population, units of service per user nor unit cost for services in specific diagnostic categories. For purposes of analysis these variables are held constant at their baseline values.
- No difference is assumed in utilization patterns between pilot-participating beneficiaries and Washington FFS beneficiaries as a whole.
- The budget neutrality calculation is based on the first-year PMPM base rate of \$2.50. It is recognized that second- and third-year base rates will be different, and that individual practices' adjusted rates will fluctuate up or down for the second and third years to reflect either shared savings or performance penalties. At this time it is not practically feasible to estimate the variation across the aggregate PMPM payment given that the final mix of participating practices and their future performance is unknown. Given that the base rate for years 2 and 3 will be 20% lower than for year 1, it seems reasonable that budget neutrality projected for year 1 should hold for the following two years as well, even assuming that some practices' adjusted rates for those years will be above the base. Again, calculating budget neutrality on the basis of the first year's base rate appears a conservative approach.
- The units of service for emergency room visits were calculated on the basis of the frequency counts for facility utilization provided by CMS in the DIT dataset. This also reflects the observation that claims for professional services associated with such visits are distributed across multiple service categories. The facility service count, however, should be an accurate indicator of the number of emergency room visits.
- The costs for emergency room visits were calculated based on emergency room evaluation and management (E&M ) services plus emergency room facility costs. Again, it was recognized that other costs associated with emergency room services were distributed among other service categories, but this more conservative estimate of potential contribution to savings was taken for purposes of analysis.

Quantitative assumptions for the calculations include the following:

--**Medicaid FFS participating beneficiaries: 8000.** This estimate is based on the participation limit agreed within the Participant Group at 60,000 commercial/Medicare Advantage and 7000 Medicaid managed care patients. Given these limits and the 11% average Medicare FFS penetration of target practices, approximately 8000 such additional participants are anticipated.

**--Cost per PQI Admission: \$5000.** Washington Medicare DIT data indicate a cost of \$7025 per short-term inpatient medical stay. While this would be a reasonable surrogate for the cost of a chronic PQI stay, we chose a more conservative value to ensure a more rigorous neutrality test.

**--PMPM Cost Per Year: \$220,000.** This is based on CMS's use of 11 member-months per beneficiary x 8000 beneficiaries x \$2.50 PMPM, the first-year base rate. The base rate for years 2 and 3 will be \$2.00, a potential 20% reduction in each payer's (including CMS) financial commitment. Over the 3 years of the pilot, the base PMPM cost will average **\$190,960.**

Data supporting the calculations were drawn from three primary sources:

- Washington-specific data from the Decision Information Tool (DIT) provided by CMS
- Washington-specific data from AHRQ's 2007 Nationwide Emergency Department Sample and Nationwide Inpatient Sample
- Medicare data from the 2007 Washington Comprehensive Hospital Abstracting Report System (CHARS)
- Data from analyses of ER visits in other states and regions showing what proportions of ER visits were preventable.

From these data, the key values for the calculations are:

- Emergency room visits (Medicare FFS participants/calculated): 5509
- Preventable visits (from assumptions): 40%
- Required reduction in preventable visits (calculated) 19.3%
- PQI visits as percentage of preventable visits (calculated): 30.2%
- Chronic PQI visits as percentage of PQI visits(calculated): 53%
- Emergency room cost/beneficiary (from DIT): \$116
- Chronic PQI visits resulting in admissions(calculated) 44%
- PQI inpatient admissions as percentage of Medicare total (calculated): 15.8%
- Chronic PQI admissions as percentage of adult PQI admissions: 60.9%

The calculation method would started with an estimate of reductions to emergency room visits and then determined the associated reduction in inpatient admissions; the estimate of reduction in emergency room visits was then adjusted until the required total (combined) reduction, to match the CMS investment, was found. This reasoning reflects the substantial disparity in unit cost between emergency room visits and inpatient admissions; potential savings are driven by a much smaller number of reduced inpatient admissions than emergency room visits. Based on experience from other initiatives nationwide, this required reduction target is in emergency room visits is considerably lower than the reduction that is potentially achievable, and is thus highly conservative.

**Reduced inpatient admissions** were calculated as a targeted percentage of inpatient admissions in the pilot Medicare FFS population resulting from chronic PQI emergency room visits. Because the admissions to be reduced are a result of emergency room visits,

$$5509 \text{ visits} \times .40 \text{ (preventable)} \times .30 \text{ (PQI preventable)} \times .53 \text{ (chronic PQI preventable)} \times .44 \text{ (chronic PQI admissions from chronic PQI ER visits)} \times .193 \text{ (calculated required target reduction)} = \mathbf{30 \text{ admissions reduced (rounded)}}.$$

This calculation is based on the assumption that the admissions to be reduced result from emergency room visits, which in turn requires a value for the overall reduction in preventable visits. That in turn requires a value for the savings resulting from reduced inpatient admissions. Thus by a process of trial and error, **reduced emergency room visits** were calculated as the required percentage of preventable visits which, when combined with reduced inpatient admissions, would result in budget neutrality. The combined savings from reduced preventable emergency room visits and ambulatory-sensitive inpatient admissions must equal at least CMS's investment of \$220,000 for the first year (\$2.50 PMPM x 8000 beneficiaries x 11 months).

**Savings from reduced inpatient admissions** were calculated as the number of admissions reduced multiplied by the assumed unit cost of a chronic PQI admission from the emergency room.

$$30 \text{ (reduced admissions)} \times \$5000 \text{ (cost per chronic PQI admission)} = \mathbf{\$148,000 \text{ (rounded)}}$$

At the same reduction target for preventable emergency room visits, the **savings from reduced emergency room visits** are calculated as

$$\$116 \text{ (ER cost/beneficiary)} \times 8000 \text{ (beneficiaries)} \times .40 \text{ (preventable visits)} \times .193 \text{ (target reduction in preventable visits)} = \mathbf{\$72,000 \text{ (rounded)}}$$

**Budget neutrality** (\$72,000 + \$148,000=\$220,000) is achieved by a reduction of 19.3% in preventable emergency room visits and the resultant reduction in chronic PQI-related inpatient admissions (15.6% of Medicare preventable admissions). These values equate to 7.7% reduction in total Medicare FFS emergency room visits and 1.6% reduction in total Medicare FFS inpatient admissions. As discussed in the application text, these reductions are well below historical experience from other initiatives nationwide.

As noted above, these calculations assume the first year's base PMPM rate. It is acknowledged that the adjusted PMPM rate for individual practices will vary either up or down in years 2 and 3 depending on performance, but as the base rate drops 20% (from \$2.50 to \$2.00 for those years), there is little if any reason to expect second- and third-year experience to fail to meet their test of budget neutrality. More importantly, participating practices will set performance targets based on their individual capacities and room for improvement, and budget neutrality will be the floor for those targets. The pilot makes

resources available to practices specifically to support and enhance their capacity for performance improvement in preventable emergency room and ambulatory sensitive inpatient utilization, and both the payer and provider community are confident they can make such improvement happen.

## **Appendix K. Washington State Multi-Payer Medical Home Reimbursement Pilot Participant Group Listing**

### **Participant Group Members:**

Richard Onizuka (Chair)	Washington State Health Care Authority
Steve Lewis	Washington State Health Care Authority
Susie Dade	Puget Sound Health Alliance
Mary McWilliams	Puget Sound Health Alliance
Reena Koshy, MD	Puget Sound Health Alliance
Pat Boiko	Washington Academy of Family Physicians
Doug Conrad	University of Washington, Department of Health Services
Jay Fathi, MD	Swedish Hospital and Medical Center
Joe Gifford, MD	Regence Blue Shield
Theresa Helle	The Boeing Company
Al Fisk, MD	The Everett Clinic
Scott Kronlund, MD	Northwest Physicians Network
Laurel Lee	Molina
MaryKay O'Neill, MD	CIGNA
Mary Anne Lindeblad	DSHS/Medicaid
Rich Maturi	Premera Blue Cross
Drew Oliveira, MD	Aetna
Brad Pope, MD	Group Health Cooperative
Tom Richards	Alaska Air Group
Jonathan Seib	Office of the Governor
Donna Steward	Association of Washington Businesses
Pete McGough, MD	Washington State Medical Association
Stuart Freed, MD	Wenatchee Valley Clinic
Howard Springer	Community Health Plan of Washington
Roger Muller, MD	UnitedHealthcare
Deonne Brown-Benedict	ARNPs United

## Appendix L. Project Evaluation, Schedule, Design, and Work Plan

The evaluation project is designed as a quasi-experimental study with two reimbursement pilot intervention arms (one for Plan 1 and the other for Plan 2) and a matched –control” arm for each of the distinct intervention arms. The intervention and control organization of interest is the medical *practice*. In the case of large integrated medical groups with multiple practice locations, either the entire medical group organization at all locations will be selected for intervention and matched to a comparable control organization, or a subset of the group’s practice sites will be selected and matched to comparable control practices. The individual medical practice constitutes the unit of intervention and unit of analysis for the formative and process evaluation, whereas the individual patient will be the unit of analysis for clinical quality, health outcomes, and health services utilization and cost (taking into account statistically the clustering of patients within the medical practice to which the individual is attributed). The impact analysis will be based on a difference-in-differences analysis, controlling for patient-level and practice-level covariates, and using the two years *pre-pilot* intervention as the baseline period anchoring the comparison of changes over time between the intervention and control practices with comparable control practices selected in a 2:1 ratio to pilot intervention practices.

### Identify types of data and data sources used for evaluation:

The evaluation is composed of two parts:

- a) Formative and process evaluation of the implementation of the two intervention arms, which will document systematically the consideration of alternative payment models, the pros and cons considered in assessing the alternatives, the rationale for adopting the particular payment methods ultimately chosen for the reimbursement pilot, and the process for selecting provider organizations to participate in the reimbursement pilot. Through key informant interviews of the administrator, medical director, and a sample of providers in each participating intervention practice, the practice’s response to, and perceptions of, the pilot payment method will be assessed. Medical practice surveys will be conducted to obtain baseline descriptive data from each participating intervention and control practice on the following constructs: organization and management, number and type of providers (including specialty mix), payer mix, distribution of revenues by type of payment (fee-for-service; per case or episode-of-care; primary care, professional, or global capitation, or other), physician compensation method, patient panel size and characteristics, and quality improvement and care management activities. In addition, we will conduct key informant interviews of the members of the Participant Group (those senior management representatives of provider and payer organizations participating in the design and implementation of the pilot), to assess their perceptions of implementation, first-year results, and lessons learned for the future.
- b) Quantitative analysis of the first-year impacts of the pilot payment methods on the level of health services utilization and total health services cost per person, clinical quality, and health outcomes -- paying particular attention to first-year reductions in avoidable, ambulatory care-sensitive hospitalizations and emergency room visits, which are posited to be major total cost drivers amenable to influence by primary care providers. The analysis of cost also will estimate the extent to which any savings realized in the first year

of the pilot were sufficient to cover the additional net new revenues distributed by the participating payers to pilot practices in the first year.

The clinical quality (process) metrics are screening for cervical cancer, breast cancer, and colon cancer among the population at risk; for chronic conditions: testing among diabetics for HbA1c levels, cholesterol, and nephropathy; among patients with heart disease, cholesterol levels and use of cholesterol-lowering medication; among patients with depression, medication adherence at 3 and 6 months, respectively. The health status (outcome) measures are HbA1c control among diabetes patients, blood pressure control for diabetes and/or heart disease patients, and cholesterol management for patients with diabetes and/or heart disease.

Preliminary power calculations suggest that a total sample size of 12 intervention practices -- 8 small-to-medium size practices under Plan 1 and 4 larger, integrated medical group practices under Plan 2, matched to twice that number (16 and 8, respectively) of comparable control practices for each of the two intervention arms -- would be sufficient to detect statistically significant ( $\alpha \leq .05$ ;  $\beta \leq .20$ ) and meaningful differences in avoidable hospitalizations (10% reduction) and emergency room visits (30% reduction). Comparable effect sizes for total cost, clinical quality and outcomes improvement would be detectable with these sample sizes.

## **2. Purpose of the evaluation:**

- To document and evaluate the process and formative stages of implementation by multiple health plans and health care purchasers of two reimbursement methodologies for primary care in Washington State – one innovative approach designed to accommodate the distinct organizational and risk-bearing capacities of small, independent primary care practices (Plan 1) and one expected to be used by larger medical group practices (Plan 2).
- To estimate the early (first-year) impact of those distinct payment methods on the outcomes, cost, and health services utilization of the two types of practices.

## **3. Description of the project's targeted audience(s):**

This project aims to make unique contributions to selected target audiences:

- Health plans and public and private healthcare purchasers seeking to implement creative payment methodologies that will bend the health care cost curve downward, while also achieving improvements in the processes and outcomes of healthcare
- Public policymakers, practitioners, and researchers seeking to evaluate the impact of distinct payment methods for different practice configurations and to find ways to enable small primary care practices transition to broader forms of accountable care payment.

## **4. Reflecting the purpose of this evaluation, we anticipate that the reports, presentations, and published papers will generate the following outcomes:**

- New insights regarding the barriers to and facilitators of implementation of original payment models designed to align incentives for primary care practice transformation, including but not limited to, the patient-centered medical home – especially highlighting the different challenges confronting small to medium size practices as compared to larger medical groups

- Valid and reliable estimates of the early impacts of these payment models on healthcare utilization, costs, quality, and outcomes in a range of practice settings – including estimates of the early returns on investment for both providers and payers
- Research papers and presentations that add to the evidence base and state-of-the-art in health services research

The state will use the results of this study to inform the implementation of legislation emerging from the Governor’s Blue Ribbon Commission on Health Reform recommendations of 2007. The legislation focused especially on demonstration of the patient-centered medical home and payment reform. Both elements are addressed in the pilot and proposed CMS demonstration.

**5. Name and organization conducting evaluation:**

The University of Washington, Department of Health Services, School of Public Health

**6. Timeline for completion of evaluation, interim reports:**

The proposed evaluation would span 4 years: 2011-2014, utilizing a combination of baseline incurred experience data from 2008-2010 and prospective data for 2011-2013 calendar years. Reporting periods would coincide with the timing of 6-month feedback to participating practices, as planned in the larger pilot demonstration and evaluation, of which this CMS demonstration is a part.

**Schedule and Workplan:**

The proposed grant period would be from April 1, 2011 through March 31, 2013. The flow of tasks in the project workplan is outlined below:

- a) Pre-test baseline key informant interviews and practice surveys: April – June 2011
- b) Submit human subjects application with final key informant interview and practice survey instruments: June 2011
- c) Define data elements and file layouts for quantitative analysis of health services utilization, cost, clinical quality, and health outcomes – including health plan claims and encounters, eligibility, pharmacy, and provider data: April – July 2011
- d) Receive human subjects approval for initiation of key informant interviews and practice surveys and quantitative analyses of utilization, cost, quality, and outcomes: August 2011
- e) Conduct key informant interviews of the administrator, medical director, and two providers in each of the intervention and control practices: Sept – Dec 2011
- f) Conduct baseline surveys of intervention and control practice characteristics: Sept – Dec 2011
- g) Test the patient attribution algorithm with a 2-year baseline incurred claims sample (2009-2010) of health plan administrative data from the multiple participating payers (health plans and healthcare purchasers), allowing for nine months run-out of incurred claims experience: Sept – Dec 2011
- h) Based on the finalized patient attribution algorithm, a) define, and extract baseline (2009-2010) health plan and purchaser administrative data for, the eligible patient sample for each intervention and control practice, b) develop descriptive data and plots of cost,

utilization, quality, and outcome measures by practice and by study arm for the two baseline years, and c) estimate preliminary multivariate models testing for baseline differences between the intervention and control practices: Jan – March 2012

- i) Prepare report summarizing results of key informant interviews and practice surveys and comparing intervention and control practices: April – June 2012
- j) Prepare report for 2009-2010 baseline incurred experience, based on descriptive and multivariate comparisons of on cost, utilization, quality, and health outcomes: April – June 2012
- k) Conduct follow-up key informant interviews with practices: July – Oct 2012
- l) Assemble analytic files for patient sample from health plan and healthcare purchaser databases for first-year, post-baseline (2011 incurred claims experience) of intervention and control practices on utilization, cost, quality, and health outcome metrics: Oct – 2012
- m) Perform descriptive and multivariate, differences-in-differences analyses of utilization, cost, quality, and outcomes to estimate the first-year impact of the reimbursement pilot, as implemented in the two distinct intervention arms and based on complete data for the two baseline years (2009, 2010) and post-intervention year one (2011): Nov 2012 – Jan 2013
- n) Conduct interviews with Participant Group senior management representatives from provider organizations and payers to assess perceptions and lessons learned through the first-year of the reimbursement pilot: Feb 2013
- o) Submit draft report for review by Commonwealth Fund program officer, program staff, and evaluation project participants: early March 2013
- p) Submit final report to Commonwealth Fund and project participants, and submit two papers for publication – one articulating the impact of the pilot intervention on utilization, cost, quality, and outcomes and the other on lessons learned for implementation: late March 2013
- q) Follow-up dissemination activities, including presentations at national and regional meetings: April - July 2013