

# Washington Primary Care Coalition

## Recommendations on Medical Home Reimbursement

### **INTRODUCTION AND BACKGROUND**

The Washington Primary Care Coalition (“Coalition”) is pleased to present to the Washington state HCA and DSHS our best current thinking on medical home reimbursement. We hope this will assist HCA and DSHS as they embark on the study of appropriate reimbursement for medical homes as prescribed in HB 2549 (2008) and SB 5930 (2007). This proposal is built upon a previous white paper prepared last year by the Coalition and titled: *The Future of Primary Care in Washington*.

We believe that medical homes represent a desirable form of primary care whose scope of functions and capacities are presently absent from most primary care practices in Washington. How a medical home is defined will have implications for determining appropriate reimbursement. But, the definition of a medical home remains a topic of nationwide debate. Various professional medical groups have collaborated on the principles of a medical home, whereas other organizations --such as those focused on quality-- have tried to develop operational definitions based on a combination of processes and outcomes. Although one can debate the merits of different definitions, the medical home remains an aspirational idea whose realization will likely not be achieved for several years, perhaps as agreement is reached on how to appropriately measure a successful medical home.

Through the work of the Washington State Medical Home Leadership, a definition of medical homes has been developed and adopted by DSHS in its work to provide medical homes for children (see attachment 1). To ensure congruity with state sponsored medical home efforts, the Coalition has also adopted the Washington State Medical Home Leadership definition.

Medical home adoption will not only require that care is provided differently, but that practices are appropriately paid to provide a different kind of care. Given that many primary care practices are consumed with basic survival, expecting them to restructure themselves quickly to become medical homes is unrealistic. Rather, payment methods must be designed to promote a smooth transition from our present state of primary care to a medical home model. For most practices, change will initially mean a focus on creating a foundation upon which medical homes can be built. On the other hand, we recognize that there are some practices which have already incorporated various requirements of a medical home. The new medical home reimbursement system needs to be designed to recognize and financially support these practices as well.

Our proposal is built upon the recognition that medical homes are evolving and payment systems need to be flexible enough to be relevant. Each primary care practice’s journey toward a medical home will likely vary. Our recommendations are intended to

be flexible enough to provide adequate reimbursement for practices no matter where they are in the medical home journey, hopefully without being overly complex. This proposal assumes that most payors will participate in implementing the recommendations, but recognizes that one or more may choose not to, or otherwise not be able to participate without legislative action (like Medicare). We still believe that progress can be made by aligning payments of state agencies and willing private sector payors behind the recommendations.

## **PROCESS USED TO DEVELOP RECOMMENDATIONS**

In early May, 2008, the Coalition created a Payment Subcommittee to meet and prepare recommendations for the full Coalition to consider by early June, 2008. Marty Levine, MD, the Washington Academy of Family Physicians physician representative, chaired the subcommittee with the assistance of Scott Plack, Director of Regulatory Affairs at Group Health Cooperative and the co-chair of the Coalition.

Dr. Levine convened two meetings of the Payment Subcommittee, one on May 22nd and another on May 29<sup>th</sup>. Invitations to participate were extended to all members of the Coalition as well as some content experts on medical home design who participated in person and by conference call. In all, 16 people attended both meetings. For each meeting, participants were given reading materials on various models of payment reform. Meeting summaries are available upon request from the Dr. Levine who can be reached at [azohwa@gmail.com](mailto:azohwa@gmail.com).

Decision making was by consensus at both meetings. Dr. Levine and Mr. Plack were responsible for drafting summary documents and distributing them to attendees. This summary document was then presented to the entire Coalition for its consideration, modification and approval.

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## **RECOMMENDATIONS**

The recommendations in this proposal envision the current medical home environment as what could be described as a continuum of “medical homeness”. On one end of the continuum, there are many primary care practices that are fragile, financially unstable, focused on day-to-day survival, and do not have the capacity to even consider how they might transform themselves into medical homes. Towards the other end of the continuum, there are practices that have some of the components of a medical home in place, and are working to better organize and coordinate those components into a more advanced level of a medical home. The notion of a continuum is not strictly addressed in our definition of a medical home, but we believe it fairly reflects the reality of the current state of adoption of medical homes in our state.

A successful reimbursement system must be designed to pay for both ends of the continuum, and everything in between. This presents a more difficult challenge as we believe that multiple approaches are needed to provide appropriate financial support of practices, wherever they are on this continuum. Our recommendations are organized into steps and options that acknowledge and address the different ways to reimburse practices along this continuum.

We made the assumption in this analysis that most primary care practices, regardless of where they are on the continuum are reimbursed using some sort of a fee-for-service method. We recognize that there are practices using other payment methods. For example, a primary care group practice may be paid on a capitation basis and its providers may be salaried. The proposal we describe below is designed to be adaptable to these differences.

## **I. Pre-Medical Home – The Foundational Step:**

For most primary care practices, medical home payment reform needs to begin by building upon existing systems of reimbursement. This step prepares a practice to begin the journey of being converted to a medical home through the use of data and technical assistance. This means that in the short term, the fee-for-service system would remain intact for most primary care providers. On top of that payment, primary care practices would receive financial incentive payments to begin the process of collecting and analyzing patient report data. Such data would allow the practice to understand how patients experience care (in contradistinction to whether they find it satisfying or not).

Data describing the experience of care captures the capabilities of a practice that define a medical home and thus, are measureable (e.g., access, continuity, coordination, self management support, proactive outreach efforts). Financial incentives would be used to motivate providers to use patient report data to change their practices. Once a practice completed this pre-medical home step, the focus would shift toward adopting and measuring the other aspects of a medical home that are important but which cannot be measured with patient report data (e.g., adoption of electronic medical records, disease-specific clinical processes and outcomes, adoption of the chronic care model).

### **Understanding the Role of Patient Reporting Data**

This recommendation is built on the central role of linking patient report data to payment incentives to create stability in multiple primary care practices across the state, such that at a later date these practices could be nurtured into medical homes. Before proceeding further, it is important to spend some time defining patient report data and discussing why it is a powerful, and, to date, underused tool for health care reform.

Patient report data in health care is usually of two types: (1) satisfaction data; and (2) experience data. Satisfaction data is generally well understood by the public and is intuitive (e.g., “On a scale of 1-10, rate how satisfied you are with your personal primary

care provider”). Experience data is a little different and offers more information than satisfaction data.

Patient experience data describes how a patient perceives the functional capabilities of a given medical service. For example, “On a scale of 1-10, rate how easy you find it to get an appointment with your primary care provider when you need it? Or, rate how well your primary care provider teaches you how to take your medications safely? Or, rate how well your primary care provider ensures you have close follow-up after being hospitalized?” As can be seen by these examples, patient experience collects clinical information about a medical practice and obtains this information from the patients, as opposed to relying on things like claims data or third party audits and site visits.

In all definitions of medical homes, care is supposed to have a whole person orientation as opposed to a disease focus. Determining whether a practice is delivering whole person care is best determined by asking patients whether or not they have perceived, or *experienced*, this kind of medical care. Only patient experience data allows the capture of such information.

Another reason that patient experience data is important for the development of medical homes is the fact that patient experience data is useful both clinically and from an improvement perspective in small primary care practices that constitute the bulk of primary care delivery in Washington. When disease-specific data (e.g., hemoglobin A1C rates) or preventive care data (e.g., mammography rates) are used, unless there is a large sample size—which is not possible to obtain in small practices—the data is not useful either clinically or in terms of improvement. But patient experience data is helpful even in small quantities and demonstration of statistical significance is not needed; practices will act on clinically meaningful patient experience data when delivered in short time intervals like days, weeks, or months. Patient experience data is meaningful to practices at the front lines and will motivate them to engage in primary care reform.

A final reason that patient experience data is important is that it can be obtained much less expensively than other kinds of data (e.g., claims, site visits.). Whereas claims data requires a third party to do the measurement for the practice, patient experience data can be collected directly from patients via an internet portal and then reported back to primary care practices directly on a monthly, weekly, or even daily basis. This is inexpensive, practical information that practices can use to establish some stability. Measurement costs are much less because the only cost is related to the maintenance of the web portal.

### **Putting it together**

Validated, electronic-based patient report tools (e.g., [www.howsyourhealth.org](http://www.howsyourhealth.org)) already exist, have been shown to be practical in small practices, and have a published literature supporting their use. Specifically, the data will show practices how to: 1) improve access, efficiency, and continuity; 2) respond to what matters to patients; 3)

support self management; and 4) improve care coordination. Most importantly, the use of such data creates a solid foundation in primary care practices that can be built upon as the practice moves toward adoption of medical home requirements (e.g., such as defined by the National Committee of Quality Assurance).

The size of the payments for the collection and use of patient report data will need to be sufficient to offset the competing productivity pressures of present primary care. Payment reform can easily fail simply because supplemental funding is inadequate to allow practices the breathing room to engage in improvement. Many primary care practices will also need outside technical assistance in order to know how to interpret and use patient report data to make changes in their practices. The medical home incentives must be structured to encourage primary care practices to reach out and use consultants, participate in collaboratives, and engage in regional quality improvement efforts. It may be that other funding sources are also needed to help provide technical assistance to practices that are struggling to adopt medical homes.

Successful completion of this stage of the continuum should allow a practice to move on to the next step. It is expected that most practices will move through this preliminary step as quickly as is practical.

## **II. Medical Home Adoption Step:**

Once primary care practices are supported foundationally with payments linked to the use of patient report data, Washington will have a diversity of practices that are capable of developing into medical homes. For practices already on the road to a medical home, the foundational step can be sidestepped (though some of these practices may want to collect patient experience data since the opportunities for improvement can be made even in the most sophisticated practices) and they can appropriately start at this step of the process. The trajectories that practices follow would be different and payment reforms should be multiple such that practices could pursue improvements that play to their strengths. Hence, the choice of options below should be made collaboratively between payors and the practice. Generally speaking, we believe each option to be more advanced than the one preceding it. Payors and practices should choose the most appropriate method depending where the practice lies on the medical home continuum. Further, a practice may move through the options stepwise as it becomes a more advanced medical home.

### *Option A (DRGs and Case Management Fees)*

A case management fee is added on top of typical fee-for-service payments made through the diagnostic related group (DRG) evaluation and management (E&M) codes that practices use to bill payors for primary care services. The case management fee will compensate the practice for providing medical home services such as extended visits focused on self management support, care coordination efforts with other providers, outreach, and maintenance of registries. There are several such examples of this type of payment reform already being experimented with in several states. In addition, new

payment categories should be added to allow for reimbursement for provider activities in support of medical homes and may not be covered under case management, such as reimbursement of physician-led interdisciplinary care conferences.

*Option B (APGs and Risk Factor Adjustments)*

The visit-based payment system is maintained under this option, but payment would shift from following the provider's definition of the work (i.e., inherent in the E/M codes) to the patient's presenting medical conditions such as those captured by the ICD9 codes (International Statistical Classification of Diseases and Related Health Problems – Ninth edition) payment methodology. Off-the-shelf actuarial databases already exist and are in use to provide payments based on the average cost of treating a presenting disease (e.g., such as APGs or Ambulatory Patient Groups classification system). These payments, which are based on the cost of care for a specific disease and its complications, would serve as an incentive for providers to care for sicker patients.

To further encourage providers to treat sicker and/or chronically ill patients this payment method could be enhanced by using risk adjusters which take into consideration certain factors associated with a patient's degree of illness (e.g., age, gender, utilization, health status) and result in overall enhanced payments to providers. Similarly, to ensure that providers provide high quality care and demonstrate resource stewardship, quality bonuses linked to appropriate reduction in hospitalizations based on ambulatory sensitive conditions could be added.

*Option C (Base Payment and Incentives for Quality)*

Under Option C, practices would continue to get base payments according to Options A or B. Additional payments would be made available to reach certain quality targets, be they disease-based (e.g., diabetes) or preventative in origin (e.g., immunizations, mammography, colon and cervical cancer screening).

*Option D (Capitation and Risk Factor Adjustments)*

Capitation puts practices at financial risk and likely only a minority of practices in the state would be able (at least currently) to successfully participate in a capitated system. Under capitation, primary care practices receive a set payment each month for each patient to cover the cost of care and the practice must manage patient care within that payment. Capitation payments should be adjusted upward to compensate, incentivize and reward practices as they adopt increasing levels of sophistication (by installing an EMR system, increasing access through evening appointments, uses e-mail communication with patients, adoption of the chronic care model and so forth).

Capitation could be further structured to allow practices to share different gradations of risk not only for the care provided in the practice but also to manage any specialty care provided outside the practice. As providers become more skilled in coordination of patient care, holding the practice at some financial risk for care provided

outside the practice would represent a high level of medical home achievement. Capitation works best when combined with risk adjustment methodologies involving age, gender, disease, function, and socio-demographic data which adjust each capitation payment based on an individual patient's risk for illness.

Capitation, however, presents unique challenges given the current move to design insurance benefits with large patient out-of-pocket expenses. Converting to capitation payments will require convincing employers and payors to design benefit packages that provide first dollar coverage for primary care services and that require no more than modest copayments on the part of consumers. Otherwise cost sharing arrangements (large copayments, co-insurance or deductibles) confound capitation as consumers pay these cost shares to providers directly before insurance benefits start. These direct payments can easily exceed the amount of the monthly capitation payment for that patient and then require burdensome and complex payment recovery activities on the part of the payor.

## **CONCLUSION**

Payment reform is central to any effort to develop medical homes in Washington State. For many practice, it will mean initially focusing on stabilizing chaotic primary care practices and building a foundation. Using patient experience data should be the main lever used to eliminate this chaos and establish good foundations in multiple primary care practices. Once multiple practices are on sound footing, practices can be segmented and offered a variety of payment options to encourage innovation and create medical homes in Washington.

Much of the rather limited current research on the reimbursement of medical homes seems to favor approaches that are either based on (1) paying for the average cost of treating a disease, adjusted for risk with incentive payment incentives for care coordination and quality outcomes (Option B or Option C with B as the base), or (2) paying a comprehensive payment (roughly equivalent to a capitation) with a risk adjustment as it provides built-in incentives for meeting medical home criteria (Option D). We believe it is necessary to consider all the options described in this proposal, in order to implement a statewide medical home infrastructure. The critical point is that we doubt that a "one size fits all" approach can successfully work.

Our recommendations require at least some change for practices, and in some cases perhaps significant change, from the current reimbursement practices for primary care. It may be appropriate that the options identified in this proposal be piloted prior to broader implementation, perhaps in combination with the medical home collaborative work or other efforts underway to sponsor or otherwise provide assistance to practices adopting medical homes.

Another key consideration is that multiple payors must be involved in supporting any payment reform, not just the state. This may require a set of negotiations with

private payors and their overall willingness to consider payment change. Payors will be understandably cautious if not nervous about the feasibility and plausibility of payment reforms. Piloting may prove to be the optimal way to ease into change in a measured way that provides a level of comfort and an opportunity to fine tune as we learn.

## APPENDIX 1

**Definition of “Medical Home”** While we acknowledge that the “medical home” term is evolving and will likely change due decisions made by large payors (like Medicare) and through advances in research and adoption of best practices. Because of the several-year multi-stakeholder process that the University of Washington Medical Home Leadership Network and the state Department of Health undertook in 2005 and 2006 to develop a consensus definition of “medical home” in this state and because of that definition’s focus on children’s health issues, we recommend using the definition of medical home in the “Washington State Medical Home Fact Sheet.”<sup>1</sup> This definition describes the core elements of a Medical Home as:

### **Accessible & Continuous**

- Care is provided in the community.
- Changes in insurance providers or carriers are accommodated by the medical home practice.

### **Coordinated & Comprehensive**

- Preventive, acute care, specialty care, and hospital care needs are addressed.
- When needed, a plan of care is developed with the patient, family, and other involved care providers and agencies.
- Care is accessible 24 hours a day, 7 days a week.
- The patient’s medical record is accessible, but confidentiality is maintained.

### **Family-Centered**

- Families and individual clients are involved at all levels of decision-making.

### **Compassionate and Culturally Effective**

- The patient’s and family’s cultural needs are recognized, valued, respected, and incorporated into the care provided.
- Efforts are made to understand and empathize with the patient’s and family’s feelings and perspectives.

**The full text of the Medical Home definition can be found at:**

[www.medicalhome.org/about/medhomeplan.cfm](http://www.medicalhome.org/about/medhomeplan.cfm)