

Robert Wood Johnson Foundation Payment Reform Evaluation Project
Washington State Multi-Payer Medical Home Reimbursement Pilot
Puget Sound Health Alliance / Health Care Authority

Autumn 2012 Site Report

Context

The Washington State Multi-Payer Medical Home Reimbursement Pilot (hereafter referred to as the “Pilot”) is the second of two initiatives authorized by the Washington State Legislature to promote the growth of patient-centered medical homes (PCMHs).¹ The first initiative, the Washington Patient Centered Medical Home Collaborative (or “Collaborative”), began in 2008 when the Legislature approved Engrossed Second Substitute House Bill (ESSHB) 2549. The Collaborative was a joint effort of Washington State’s Department of Health, the Washington State Medical Association, and the Washington Academy of Family Physicians to transform 32 primary care practices across the state into PCMHs, each meeting criteria for core capabilities of primary care practice transformation.^{1,2} The Collaborative was completed in September 2011.

In 2009 the Legislature enacted Substitute Senate Bill (SB) 5891, creating the Pilot and authorizing its executive sponsor, the Washington State Health Care Authority (HCA, public payer and purchaser), to test the alignment of payment incentives with the transformation of primary care practices into patient-centered medical homes through one or more pilots. Primary care clinics with medical homes or medical organizations participating in the Collaborative were eligible to participate in the Pilot. Payment is from many of the major health plans and purchasers in Washington State and, under the terms of the Pilot, must include a fixed monthly payment per person for primary care services.³ To build collaboration among health plans and Collaborative sites, the legislation promises immunity from both state and

¹ Source: <http://apps.leg.wa.gov/documents/billdocs/2009-10/Pdf/Bills/Session%20Laws/Senate/5891-S.SL.pdf>

² The Legislature’s rationale for the measure is explained succinctly in ESSHB 2549, Section 1: “The legislature finds that our primary care system is severely faltering and the number of people choosing primary care as a profession is decreasing dramatically...To improve the health and well-being of the people of the state of Washington; enhance the recruitment, retention, performance, and satisfaction of primary providers; and control costs, our statewide system of primary care providers needs to be rapidly expanded, improved, and supported, in line with current research and professional innovations....The legislature further finds that a medical home can best deliver the patient-centered approach that can manage chronic diseases, address acute illness and provide effective prevention...There is a critical need to identify reimbursement strategies to appropriately finance this model of delivering medical care.”

³ “Multi-Payer” is in the Pilot’s name because the pilot’s medical groups have patients with different health insurance plans (or payers). Therefore, a key legislative assumption is the Pilot must include multiple payers covering a meaningful portion of the patients in the medical groups to create financial incentives large enough to motivate providers to change patient care. The rationale for monthly payment is due partly to the weaknesses of fee-for-service payment, as noted in the Pilot’s Charter: “The current fee-for-service payment system tends to undervalue primary care, is ineffective in rewarding quality and value or supporting medical homes, and serves as a potential barrier to medical home development.” Source:

http://www.hca.wa.gov/documents/charter_mhrp_080609.pdf

federal antitrust scrutiny of Pilot activities.⁴ SB 5891 contains no legislative funding for the fixed monthly payments and pilot implementation. Funding for the fixed monthly payments comes from the Pilot's plans with the potential for savings, if the patient-centered medical homes reduce potentially avoidable ED visits and/or hospitalizations.

The Pilot is a joint demonstration of the HCA and the Puget Sound Health Alliance (Alliance), as well as the Governor's health policy office. The HCA and the Alliance, along with the other agencies, are charged with bringing medical groups, providers, health plans and other stakeholders together to work collaboratively to design and implement the Pilot.⁵ After SB 5891 was passed in 2009, the Pilot's design phase began to develop the detailed features of the Pilot. The Pilot was launched on May 1, 2011, and will end on December 31, 2013. The Alliance received funding from the Robert Wood Johnson Foundation to support the work developing the pilot. The Foundation's funding of the project ended in early 2012.

The Pilot's implementation and performance is being shaped by local and national events. First, the number of free-standing emergency departments (ERs) increased during Pilot implementation.⁶ Greater access to EDs in communities may increase the difficulty of reducing unnecessary or avoidable emergency room visits, which is a Pilot goal. In 2008 Washington State's Emergency Department Information Exchange (EDIE) was launched, which tracks emergency room visits in facilities that have signed up for the service, and notifies providers in real time when their patients have ED visits. However, only hospitals in Washington States are connected currently to EDIE. The Pilot facilitated connections for primary care, but only one participating practice is linked currently to EDIE as of March 2013. One medical group has legal agreements in place but is not yet receiving ED notifications. The hospitals that are connected are not notifying medical groups of patient ED visits. At this time hospitals communicate only with each other and health plans on ED patients.

⁴ SSB 5891 states explicitly 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."

⁵ Founded in December 2004, the Alliance is a neutral co-convenor of the Pilot's stakeholders and plays the lead role in the day-to-day management of the Pilot. The Alliance is a nonprofit organization that fosters collaboration among health plans, providers and other stakeholders to improve the quality and affordability of care (<http://www.pugetsoundhealthalliance.org/about/index.html>). The Alliance leads the Aligning Forces for Quality initiative in Seattle, which has formed a regional partnership to promote health and high-quality health care partly through public reporting of local health system performance (Source: <http://www.rwjf.org/qualityequality/af4q/communities/seattle.jsp>)

⁶ The state's first free-standing emergency room was built in 2005. In February 2011, six free-standing emergency rooms were in operation, under construction, or under review. Since 2008, Senator Cheryl Pflug has introduced a bill to put a hold on free-standing emergency rooms until their effect on the health care system can be fully assessed. Sources: <http://apps.leg.wa.gov/documents/billdocs/2011-12/Pdf/Bill%20Reports/Senate/5515%20SBA%20HEA%2011.pdf> and http://seattletimes.com/html/localnews/2016867292_hospitalbuild27m.html

A second, key event is federal health system reform. After the Legislature passed SB 5891 in 2009, Congress passed the Affordable Care Act (ACA) in 2010. However, the ACA's future was uncertain until the Supreme Court upheld the law in June 2012 and President Obama was re-elected four months later. The ACA now dominates the policy frontier in Washington State, which has increased momentum toward health system and payment reforms that are aligned with the ACA and its vision of accountable care organizations (ACOs).⁷ Consequently, the Pilot is receiving less attention from stakeholders. In particular, some plans have shifted from a multi-payer orientation toward solo efforts to develop their own payment reform models that create accountability across all elements of the local health system, not just primary care medical homes.

Objective

The objective of the Pilot is to design and implement a per-member-per-month (PMPM) payment structure that enhances primary care teams and creates incentives promoting effective care for patients in the primary care setting. Through these improvements, the Pilot sought to reduce costly, yet avoidable and unnecessary emergency department visits and to a lesser extent, avoidable hospitalizations, which would ultimately produce cost savings. As stated in the Pilot's Charter, the key hypothesis is that, "over time, resources to support the development of a primary care-based medical home will be offset by reductions in costs (e.g., associated with unnecessary or duplicative care, preventable hospital admissions and overuse of emergency room) rather than net new revenue."⁸ Another objective is to identify the features of Pilot implementation that are essential for reducing preventable hospital admissions and emergency room visits.

Approach

Recruitment of Medical Groups. The Pilot began when the HCA, in collaboration with the Alliance, formed a multi-stakeholder "Participant Group," or steering committee, composed primarily of representatives from health plan and provider organizations to design and develop the approach for enrolling medical groups into the Pilot.⁹ A Practice Selection Subcommittee of the Participant Group was formed to develop the eligibility criteria for medical group participation in the Pilot. The preliminary

⁷ Medical group partnerships and consolidations have been on the rise in Washington State, which also may be a response to PPACA. Examples: (1) in 2011, Group Health Cooperative reached an agreement to acquire Columbia Medical Associates; (2) in 2010, Swedish Medical Center and Stevens Hospital merged; (3) in 2010, Northwest Hospital became part of University of Washington Medicine; and (4) in 2010, Skagit Valley Hospital acquired the 81-doctor Skagit Valley Medical Center. Sources: <http://www.seattlebusinessmag.com/article/faqs-about-acos-and-local-medical-group-partnerships> and <http://www.bizjournals.com/seattle/stories/2010/06/28/story2.html?page=all>

⁸ Charter Source: http://www.hca.wa.gov/documents/charter_mhrp_080609.pdf

⁹ The following health plans in Washington State are participating in the Pilot: Premera Blue Cross, Regence Blue Shield, Group Health Cooperative Health Plan, Aetna, CIGNA, Community Health Plan of Washington, and Molina Healthcare (a major Medicaid managed care plan). Several large self-insured employers in Washington -- Boeing, Alaska Airlines, City of Seattle, and King County -- are participating purchasers.

selection criteria were evidence of “medical home readiness”: core capabilities for implementing the patient-centered medical home (including the resources to support primary care with registry and quality improvement functionality), capacity to absorb the unique downside risk in the Pilot payment model, and ability to implement changes at the beginning of the Pilot.

To be eligible for the Pilot, medical groups were required to meet the following criteria:

- Be primary care oriented (family medicine, internal medicine, pediatrics), with a minimum of four full time equivalent providers in one practice location (clinic site), and be located in Washington State.
- Have at least 8,000 active patients (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 patient population.
- Have visible commitment from the medical group’s leadership to engage in the Pilot and to organize and lead efforts within the group 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 able to participate in the Pilot for three years.

In addition, a unique feature of the Pilot design is the requirement that each medical group and its participating primary care practices commit to a specific Action Plan describing the following:

- How the Pilot medical group intends to reduce potentially avoidable ED visits and/or preventable hospitalizations, including a description of specific program changes, such as new staff roles, expanded program services, or evidence from previous service interventions that may be built upon in this pilot, plus the mutually agreed group-specific targets for annual reductions in avoidable ED visits relative to baseline (average 31 percent), and the corresponding targeted annual reductions of avoidable hospitalizations (average 39 percent).
- Any current or proposed method of communication between the medical group and the emergency room and hospital (where patients are most likely to go) that allows the group to identify its patients with recent or frequent ED visits and hospitalizations, plus how the patient population’s current use of the ED or hospital may change with the Pilot.
- How the medical group structures care coordination for people with chronic conditions and its use of patient registries for tracking and planning care and monitoring medications and lab

tests; proactive outreach to providers and patients with reminders and timely notification of results; self-management support with development of shared care plans; support in linking patients with community based programs; use of a care coordinator, planner, or team members with explicit accountability for follow-through including outreach to patients recently seen in the emergency room or discharged from the hospital.

- Current quality improvement work in the medical group, identifying any staff with specific roles in data analysis, leadership, or dissemination of information and an explanation of how quality improvement work integrates into regular clinic processes.
- How the medical group leadership will support the practice in reaching its specific target goals (e.g. allowing planning time, support for program development and evaluation), plus delineation of other major projects the medical group is undertaking currently or within the next two years (e.g., launching electronic medical records, starting a residency).
- Roles and responsibilities within the medical group to carry out the pilot goals of reaching practice specific outcomes, reporting monthly progress and required data elements.
- Key limitations or challenges the medical group will need to overcome.

Medical groups were excluded if they lacked experience with a registry, were launching an electronic medical record currently or during the Pilot, had fewer than four full-time providers, or had multiple sites and could not combine data and results across sites.¹⁰ Medical groups interested in participating in the Pilot responded directly to a public request for applications issued by the HCA. The Participant Group chose medical groups predominantly from participating clinics in the Washington State Patient-Centered Medical Home Collaborative. Initially, 18 medical groups with 23 clinics expressed interest in participating in the Pilot. Ultimately, eight medical groups with 12 clinics agreed to participate, with seven of the 12 clinics also being Collaborative participants. The main reason that medical groups opted not to participate was concern about financial risk. The participating payers (self-funded employers, public purchasers, and private health plans) account for approximately 27,000 patients in the participating medical groups. The participating medical groups estimate they are receiving Pilot payments for less than 40 percent of their patient populations. All medical groups have chosen to reduce avoidable ED visits, but only one group is reducing avoidable hospitalizations.

Payment Reform. The Pilot's payment model has four components:

- (1) Patient attribution.
- (2) PMPM payment to medical groups.
- (3) Medical group targets for quality of care and cost savings.
- (4) Potential medical group repayment of PMPM.

¹⁰ While the Pilot initially considered inviting small clinics to participate, the ultimate requirements for participation excluded small clinics from the Pilot.

The first component in the payment model is patient attribution, or listing the eligible patients with health insurance from each health plan and identifying which of the eight medical groups are their usual sources of primary care. Patient attribution is measured on the basis of claims experience for primary care services. The method uses an algorithm developed for the Alliance and managed by Milliman (health care consulting firm), which examines the patient's visits over the previous two years and attributes the patient to the provider with the most recent or frequent visits. The patient is then attributed to the medical group with which the patient's provider is affiliated.

The second component is PMPM payments to medical groups based on patient attribution. Health plans provide supplemental, PMPM payments to medical groups with the potential for sharing equally (50-50) in cost savings due to reductions in avoidable hospitalizations and emergency room visits. The upfront PMPM payments are "new money," i.e., incremental dollars in addition to currently contracted fee-for-service (FFS) reimbursement levels.

The amount of the PMPM payments changes over the Pilot's three performance periods. When the Pilot was being planned, the first period was 18 months for medical groups to implement changes in care to reduce preventable events. However, due to delays in securing health care data for planning the Pilot, the first year of the pilot was shortened to eight months, May – December 2011. In the first eight-month period, the payments are \$2.50 PMPM. For the two succeeding 12-month performance periods in 2012-2013, the payment levels are \$2.00 PMPM. The PMPM payment intends to serve two purposes: (1) to infuse seed money for practice transformation in care management and development of the medical home, and (2) to change incentives toward care management of persons over time, rather than piece-rate production of services. Medical groups are paid monthly.

The third component is performance targets. A medical group is eligible for shared savings only if a group satisfies performance targets for quality of care and cost savings. The medical group may receive shared savings if a composite measure of seven clinical quality metrics is maintained from baseline to each performance period.¹¹ For cost savings, performance targets exist for preventable ED visits and inpatient admissions. Each medical group first chooses the target(s) the group wants to achieve. Seven of the eight groups have chosen the performance target for preventable ED visits, and one group has chosen both.¹²

The cost savings are calculated for each medical group through the following steps:

¹¹ Payment incentives do not require an improvement in quality measures for two reasons. One is that the Pilot is intended to test a payment method linked to specific outcomes, reduce preventable ED visits and hospitalizations, rather than quality improvement; and (2) data and resources were not readily available as part of the Pilot to support practices in significant quality improvement efforts.

¹² One medical group reported having very low hospital admission rates with little room for improvement while its ED visits were higher, and therefore, the group chose reducing preventable ED visits.

- 1) The cost of a saved preventable ED visit is computed for each medical group using medical claims from the baseline period. The cost is defined as the average cost of Medicaid and commercial Ed visits, weighted by the proportions of ED visits covered by Medicaid and commercial insurance in the medical group.¹³ Because the average reimbursement for Medicaid ED visits in Washington State (\$217) is much lower than the average reimbursement of commercial ED visits (\$911), the cost of a saved preventable ED visit may be higher if the medical group has reduced ED visits for commercial patients rather than Medicaid patients.¹⁴ A similar protocol is followed for preventable inpatient admissions.
- 2) The medical group's baseline rates for preventable ED visits and inpatient admissions are used to calculate projected preventable ED visit and inpatient admission rates for the performance period.
- 3) If the medical group's actual preventable ED visit and inpatient admission rates for the period are lower than the projected rates, the medical group has reduced preventable ED visits and/or inpatient admissions.
- 4) If preventable ED visits are reduced, the cost savings are calculated by multiplying the cost for that practice (in Step 1) by the saved events. The same protocol is followed for inpatient admissions.
- 5) If the total amount of savings for preventable ED visits and inpatient admission is greater than the amount of PMPM payments paid to the medical group, the medical group is eligible for shared savings.
- 6) Originally, for the first and second performance periods, a medical group must achieve a performance target of 20 percent and 25 percent reduction, respectively, in preventable ED visit rates to maintain the base rate of PMPM payment in the following year. If a medical group is eligible for shared savings in Step 5, the medical group and health plan share equally the savings.¹⁵

¹³ Because all medical groups have performance targets for preventable ED visits but only one group has a target for inpatient admissions, our focus in this report is preventable ED visits.

¹⁴ People covered by Medicaid tend to have worse health and higher ED visits than people with commercial health plans (Holahan J. Health status and the cost of expanding insurance coverage. *Health Affairs* 2001;20(6):279-86; Garcia TC, Bernstein AB, Bush MA. Emergency department visitors and visits: who used the emergency room in 2007? *NCHS Data Brief* 2010;(38, May):1-8).

¹⁵ If the medical group chose to reduce both avoidable hospitalizations and ED visits, the target was set through a different algorithm. First, the proportions of ED and inpatient preventable events at baseline were calculated, and second, the proportions were applied to the PMPM received for the observation period. For example, a clinic had 100 preventable events in the baseline period, and 80 events were preventable ED visits and 20 events were preventable hospitalizations. Therefore, the proportions are 80% for preventable ED visits and 20% for preventable hospitalizations. If the PMPM received was \$100 for the year, the target for ED reduction is the number of ED visits that equal 80% of \$100, or \$80. If the price per ED visit is \$10, the ED target is 8 avoidable ED visits.

The fourth component is repayment. If a medical group's actual preventable ED and inpatient admission rates are higher than its projected rates, or if a group's savings are less than the amount received in PMPM payments, a group is liable to repay up to 50 percent of its PMPM payments to its participating plans. Repayment is calculated as the cost of a preventable ED visit (in Step 1) times the number of ED visits by which the group fell short of the 20 percent target, up to a maximum of 50% of the total amount of PMPM payments it received through the Pilot. A similar calculation is performed for inpatient admissions. Starting July 1, 2012, the original plan was to administer repayment by reducing the \$2.00 PMPM in the Pilot's second performance period based on the ED and inpatient admission calculations. Repayment was scheduled to begin July 1, 2012, but was postponed to January 2013, due to plan reporting delays and data errors. However, this plan was changed later because of critical delays in data reporting. Practices did not receive expected Pilot data until early in 2013, and therefore, faced greater difficulty in making informed decisions for the first 22 months of the Pilot. Consequently, both plans and practices agreed to modify the original risks for savings and losses. For observation period 1 (first eight months of the Pilot), no losses or savings adjustments would be made based on performance. Instead, the time period would be considered a "ramp up" phase to achieve expected results later in the Pilot. For observation period 2, risks for savings and losses would be halved. Medical groups would be liable for up to 25 percent of PMPM received in 2012. Medical groups also would only be able to share up to 25 percent of net savings. By the final pilot year (2013), medical groups and plans would share in savings and losses as originally planned (i.e., up to 50 percent risk for both).

Implementation. The Pilot's approach for achieving objectives is collaboration among stakeholders. Through SB5891 the HCA and the Alliance have authority to convene the Pilot's stakeholders. Under their leadership, the Pilot conducts quarterly steering committee meetings that include all stakeholders. The regular meetings are the mechanism that builds collaboration through stakeholders jointly identifying issues and finding solutions. Collaboration creates "buy-in" that leads to *pro bono* support and a sense of "ownership" of the Pilot. Over time a "stock" of collaboration emerges among the stakeholders that did not exist before the Pilot, and becomes a resource potentially benefiting future health system reforms in Washington State.

Medical groups have flexibility to tailor their approaches for reducing preventable ED visits and inpatient admissions to address the needs of their patients; the Pilot does not prescribe specific interventions to achieve these objectives. Because the Pilot recruited medical groups that met eligibility criteria for patient-centered medical homes, those groups are usually blending their Pilot work with their larger goals of building medical homes. Each health plan is supplying the medical groups with quarterly reports listing attributed plan members with ED visits and inpatient admissions in the past 3-6 months. To create a learning environment, the Pilot has hosted webinars for the medical groups where experts host forums about alternative approaches for reducing ED visits, such as care coordination, increasing access to primary care and health insurance, and building relationships with local emergency departments.

Health plans provide data to support Pilot operations. Because the Pilot has no funds to cover the costs of data provision, and because the plans might opt out of the Pilot if the costs of providing data are excessive, data reporting protocols are flexible and designed to ease the burden of reporting for plans. Consequently, each plan supplies data in different ways to Milliman, who is responsible for combining the data through a contract with the Pilot. Some plans only supply data, with Milliman constructing all the measures of ED visits, quality of care, and so on. Other plans construct some measures using their internal metrics, with Milliman doing the rest, while yet other plans construct all the measures using their internal metrics. While there is one set of common measures with definitions for all plans, each plan has interpreted and computed the measures differently. The result is seven different plans generating Pilot measures in seven different ways.

Two steps were taken to reduce the heterogeneity in the plan measures. First, the Pilot worked with the health plans to resolve discrepancies in how plans interpreted the measures. Second, the data were compiled, processed, and reviewed to identify errors.¹⁶ The complexity of compiling, correcting, and producing Pilot data led to significant delays. To address this problem and provide more timely and actionable data to medical groups, each plan is constructing quarterly reports on ED utilization for attributed members in each medical group. Plans send the reports directly to the groups rather than to Milliman.

Early Results. The HCA and the Alliance have convened regular, quarterly meetings where Pilot stakeholders collaborate to identify and solve issues. In general, medical groups have adopted a “population approach” to identify patterns of ED utilization based on health plan reports, hospital notification, and patient interviews. Because patients with chronic conditions usually visit EDs more frequently than healthy patients, chronic disease management is a common strategy for reducing ED visits.

Medical groups have implemented a variety of strategies to reduce ED visits and hospital admissions. For primary prevention of ED visits, some medical groups have increased access to primary care by expanding clinic office hours, doing more patient education (such as advising patients to contact them before going to the ED), and other approaches. For secondary prevention of ED visits, some medical groups have hired care coordinators who follow-up with patients ideally on the same day as the ED visit and schedule follow-up appointments three days after the ED visit. For this strategy to work, care coordinators must know when the medical group’s patients visit the ED in real time; to accomplish this, one medical group is using EDIE. Some medical groups have established relationships with local

¹⁶ With each health plan supplying data and constructing measures, rather than a central data site, the Pilot was unable to monitor data accuracy.

hospitals and access the hospital's information system and its daily postings of ED patients. In at least one case, a local hospital proactively notifies a medical group when its patients visit the hospital's ED.

All stakeholders have continued to participate in the Pilot. However, three health plans have paired with three medical groups to pursue their own incentive reforms and have withdrawn from the Pilot. These plans are no longer providing PMPM payments to the three groups but continue to report performance data. The plans continue to participate in the Pilot with other medical groups, and the medical groups continue to participate with other plans in the Pilot.

Preliminary results for the first eight-month performance period are as follows:

- 1) Attributed patients had a total of 209,621 member months in the first eight months of the Pilot, with an average of 29,946 months per health plan. The range is from 895 member months (0.4 percent of the Pilot population) for one health plan to 82,436 member months (39 percent of the Pilot population) for another plan.
- 2) Medical groups have received \$541,393 in PMPM payments for an average monthly population of 26,203 members in the first eight-month performance period. The average payment across 11 clinic sites was \$49,218 with a range of \$20,133 - \$100,965.
- 3) Commercial members' utilization rates for preventable ED visits increased 3.9 percent from 63.9 visits per 1000 member months to 66.4 visits per 1000 member months.
- 4) Medicaid members' utilization rates for preventable ED decreased 26.9 percent from 338.4 visits per 1000 member months to 283.7 visits per 1000 member months.
- 5) For commercial members, preventable inpatient utilization rates increased 11.5 percent from 3.8 admissions per 1000 member months to 4.3 admissions per 1000 member months. For Medicaid members, preventable inpatient utilization rates increased 4.5 percent from 8.7 admissions per 1000 member months to 9.0 admissions per 1000 member months.
- 6) Two medical groups achieved their ED performance target and will continue to receive \$2.00 PMPM. All other clinics have reduced PMPM.
- 7) The price of a preventable event directly affects the amount of savings.
- 8) Quality composite measures decreased about three percentage points from baseline to the first performance period.
- 9) Pilot patient volume stayed relatively constant, but medical groups estimate this represents far less than 50 percent of their patient populations.

Logic Model

To achieve its objectives, the Pilot must include multiple payers to create payments that are of sufficient size and scale to motivate medical groups to participate and supply resources for changing the groups' infrastructure and care delivery to reduce avoidable emergency room visits and hospitalizations.¹⁷

¹⁷ Source: Pilot Charter (http://www.hca.wa.gov/documents/charter_mhrp_080609.pdf)

If this goal is met, the logic model explains why additional payments are expected to reduce avoidable emergency room visits and hospitalizations. In brief, financial incentives – in this case, up front PMPM payments and potential for shared savings -- act to motivate up front structural changes in the medical group as well as alter provider behavior, which in turn, change clinical care processes. When the PMPM payment is aligned with the medical home, access to primary care is increased, which may reduce the ER as a usual source of care. Medical groups are more likely to integrate the continuum of care (primary care, specialty care, inpatient care, post-acute rehabilitation) and deliver proactive coordinated care in a timely manner. In principle, proactive, coordinated care should introduce greater efficiency in the allocation of health care resources; that is, appropriate services are delivered in a timely manner and inappropriate services are avoided. As a result, the reduction of unnecessary and preventable services in concert with the improved delivery of appropriate services generates downstream benefits in terms of cost-savings and improved outcomes, as well as better care experiences for patients, providers and staff. Patients with multiple comorbid conditions are an important target population of the Pilot because they are at greater risk for excessive or ineffective use of health care resources. In contrast, the FFS payment incentive encourages use of services, provision of acute care treatments, and does not promote prevention or proactive management of chronic conditions and, therefore, is less likely to produce similar results. Another feature of the logic model is return on investment. To be sustainable, the Pilot must largely pay for itself: no new funds are available from the Legislature or other sources. The Pilot's objective to reduce preventable ED visits and hospitalizations is chosen because ED visits and hospitalizations have high costs, and reducing them may generate sufficient savings to offset the PMPM payments and therefore, the health plan's financial risks. If medical groups do not produce cost savings, the groups must return a portion of their PMPM payments to the plans, and thus, medical groups share the financial risks with plans. An assumption is that the shared risk may create incentives for medical groups to identify interventions that are strong enough to produce savings that offset the PMPM payments.

Facilitators and Barriers

The facilitators and barriers are presented in no particular order of importance.

Facilitators:

- Context. Several local features facilitated the Pilot's design and implementation. The Alliance has a history of fostering collaboration among diverse stakeholders. The Washington State Legislature offered a mandate to implement the Pilot and antitrust protection. Medical groups had prior experience participating in a medical home collaborative.
- New forms of collaboration have emerged to solve common problems. A broad group of stakeholders met regularly to design the Pilot. After the Pilot started, the Pilot's health plans and medical groups meet regularly to identify and solve problems.

- Leadership. The HCA and the Alliance are the conveners of the Pilot's stakeholders and facilitators of collaboration, which is essential for developing a common vision of the Pilot, planning its features, and achieving Pilot objectives. Medical group leadership support facilitates changing the medical group's care patterns to reduce emergency room visits and hospitalizations.
- RWJF Conference. The Foundation facilitated payment reform by convening a conference in October 2012 for the leaders of the Foundation's payment reform and quality improvement projects. The purpose was to share best practices in payment reform work and explore solutions to overcoming challenges and barriers.

Barriers:

- Turnover in HCA leadership. After stable HCA leadership in the planning phase of the Pilot, turnover in HCA leadership occurred during Pilot implementation, resulting in a loss and discontinuity of Pilot experience and human resources for convening stakeholders and building collaboration.
- Market competition. Health plans in Washington State have a history of competing in the marketplace. While there is a legislative directive to implement a payment pilot with multiple plans, there is no mandate for health plans, employer groups or medical groups to participate in the Pilot.
- Limited funds. The legislative directive authorized the Pilot, and the Robert Wood Johnson Foundation provided funds to support project management in the early design and implementation of the Pilot. However, the Pilot is a huge, complex undertaking, and RWJF funding only covered the cost of one part-time project coordinator for two years. Since early 2012, the Alliance has been supporting a part-time project coordinator because of its commitment to seeing the Pilot through to completion, and the HCA has provided some part-time staffing as well. Consequently, the Pilot is understaffed to manage day-to-day operations, and is heavily dependent on in-kind support, which creates a reliance on flexibility; this in turn reduces accountability because leaders have no management authority over stakeholders to set requirements and enforce timelines. This is particularly the case for data reporting. Ideally, the Pilot would collect uniform, standard data for quality of care, preventable ED and inpatient admissions, and other metrics that are calculated the same way by all plans. To produce the standard metrics, each health plan must re-program its computer systems, which increases its uncompensated costs and might reduce its participation in the Pilot. Therefore, to control these costs, reduce data burdens and retain plan participation, the Pilot adopted a flexible data approach, where plans supplied data at the lowest cost and with little re-programming. This decision, however, has trade-offs and has led to data errors and discrepancies, which in turn has led to reporting delays and missed deadlines. In contrast, if the Pilot had additional funds for implementation, health plans might be compensated (at least partly) for their re-programming

costs; this might increase management control over reporting and resolve the data problems, and ultimately result in uniform data with standard definitions across plans.

- Limited information for designing the Pilot. Limited information about emergency room visits and hospitalizations slowed the design and implementation of the Pilot. At the outset the costs of avoidable ER visits or hospital admissions were unknown. Plans were unable or unwilling to provide pricing data to the third party data analyst, thus delaying a key data component: establishing an average price of emergency room and inpatient admissions. Proprietary protections and complexity of calculations were important reasons for the lack of information on these two components. A related issue is that a significant price difference of an ED visit exists for Medicaid and commercial insurance, which has a significant impact on the calculation of cost savings and payment incentives. Another complication was that the rate of preventable ED visits for the region was unknown.
- Data reporting and analysis by health plans. The Pilot required quarterly reports of patient attribution and semi-annual reports of outcome measures that required new computer programming by health plans to produce. Delays were more likely the more the Pilot's payment and requirements differed from a health plan's automated procedures. Delays occurred partly because of communication problems in moving from the design phase to the operations phase of the Pilot. Pilot design discussions took place over several months, and the full picture of the Pilot's design was not always communicated to separate operation teams in the health plans and medical groups that were charged with implementing the design. Delays occurred when operation teams were unaware of how Pilot design differed from day-to-day work and were unable to plan for data reporting or contract development. Furthermore, because health plans rely upon claims data for their analysis, they have less ability to produce results that are considered actionable by providers.
- Data sharing, timeliness, and definitions. Medical groups have limited information about the emergency room and hospital utilization of their patients, which limits their ability to coordinate care. Plans are providing quarterly ER utilization reports containing utilization over the past six months directly to medical groups, but the groups want real-time reporting of emergency room visits for managing care transitions. Because the seven plans generate their own customized ED reports, medical groups receive seven fragmented reports, which are challenging to manage. Furthermore, the ED utilization reports and lists of attributed members with PMPM payments in the medical group sometimes arrive late or not at all and frequently contain errors, resulting in further delays when plans have to retract the reports and make corrections. Some medical groups also are unclear how preventable (or avoidable) ED and inpatient admissions are defined by the health plans, and whether the definitions are the same or different across plans. Consequently, groups tend to reduce overall ED visits without focusing on whether the visit is preventable or not.

- Hospitals are absent. Hospitals are not participating in the Pilot, which may limit the sharing of information about ED patient visits in real time. However, hospital participation must be sensitive to the possibility that reductions in ED visits represent lost revenue for hospitals.
- The Pilot patient population was smaller than expected. Medical groups estimate that less than 40 percent of the practice population is currently receiving payment through the Pilot, and plans also expected a larger population count. One reason for the low counts depends on how a plan counts administrative services only (ASO) populations; some plans include them in their attribution and others do not. The Pilot was designed to include ASO populations. Another cause for low counts stems from exclusion of attributed patients that change health plans. Because the population can change coverage or lose it entirely, the count cannot be assumed constant among the participating health plans. The payment model makes it difficult for plans to include populations that are no longer members during the pilot. Despite the low count of patients attributed to the pilot, the payments made to practices in the first eight months are approximately 88 percent of estimated payments using baseline attribution counts. The absence of Medicare also reduces the number of eligible patients in the Pilot.
- ASOs and self-insured employers. As their name implies, ASOs provide administrative claims service for self-insured employers and other members, and generally do not control all of the expenses of all of its members. Pilot PMPM payments appear as expenses on employer accounts and may ultimately require employer approval.
- Patient attribution. There is little public information on how patients change insurance or move between insurance plans in the region. There is no way to track patients who move between plans with a unique identifier, which creates problems for making accurate patient attribution, patient counts, and payments.
- Patient preferences. Medical groups report that not all high risk patients want to be in a medical home and receive more highly coordinated care. Some patients have long-standing habits of visiting EDs that are difficult to change. Medical groups report their patients sometimes say they visit EDs because they have health insurance with ED benefits.
- Size of PMPM payment. The amount of the PMPM payment, particularly for Medicaid patients, may not cover the costs of medical group reforms to reduce emergency room visits and hospitalizations, which reduces the value of the incentive in the eyes of some medical groups. The amount of the PMPM payment also is influenced by the number of PMPM patients in the group.

Evaluation and Sustainability

The Pilot presently lacks funding and data to perform an in-depth evaluation. Given these constraints, a limited evaluation is planned, comparing the performance of medical groups with performance in the region. Health plans supplied data with inconsistent methods, which also limit the scope of the

evaluation. The growth of free-standing EDs in the region may have offset any reductions in preventable ED visits and inpatient admissions caused by the Pilot.

Whether the Pilot's payment model is sustainable may depend on the results – particularly for cost-savings – when the Pilot ends in December 2013. Key informants in medical groups report that even if the Pilot ends, the groups will continue their interventions to reduce ED visits and inpatient admissions as part of their larger organizational transformations to patient-centered medical homes, which they regard as the “right thing to do.” If support for the Pilot continues, some key informants suggested the next step is to learn from the Pilot's experiences and scale-up implementation to reach a larger population of medical groups and patients.

Lessons Learned

The main lesson learned is that a State's legislative directive to conduct a multi-payer medical home-payment reform pilot is no guarantee that implementation will be timely, low cost and with few hassles. Having multiple payers means there are more stakeholders, which in turn, has increased the Pilot's complexity, the difficulty in reaching agreement, and the chances for implementation delays. Some key insights at this point in the Pilot's history are presented below.

- Collaboration does not happen by chance but must be promoted by leaders who are respected by stakeholders. When health plans and medical groups do not have a history of collaboration, either within or between these two groups, local leaders may play pivotal roles in opening communication channels and facilitating participation.
- A major barrier is the lack of sufficient funds for Pilot implementation and management, which increases the dependence of the Pilot on in-kind contributions from stakeholders.
- Another major barrier is the lack of data to support all phases of the Pilot development, implementation, management and evaluation. Uniform data reporting is essential for accurate and actionable information for decision making. Medical groups cannot manage different, fragmented reports from each health plan even if delivered on time, and groups cannot easily combine them to create a population profile of their patients, which is essential for managing ED and hospital utilization. Accurate, local data for pricing ED visits and hospitalizations are still not available.
- Another potential insight is that the Pilot runs for nearly three years to find out whether payment reform reduces preventable ED and inpatient utilization. On one hand, the three-year follow-up period is a strength of the Pilot. Examining long-term effects may be important if the Pilot's benefits emerge only after several months of implementation. On the other hand, the three-year follow-up may be too long for different reasons. Health plans are at financial risk for their PMPM payments, and therefore, it is not surprising that plans want a return on investment in a relatively short time. With the ACA upheld by the Supreme Court and President Obama's re-election, ACA reforms now dominate the health policy landscape, and the pace of change in

markets is accelerating. In short, markets move on and cannot always wait for interventions like the Pilot to produce results, and instead continue to innovate towards other forms of practice transformation and payment reform. As a consequence, stakeholders may become less engaged in the Pilot's collaborative work – particularly plans, which are pursuing other models of payment reform precipitated by ACA. This raises a generic question of how much time is required to know whether a payment reform is working as intended.

- Pilot start-up was reduced from 18 months to eight months due to data delays. It is unclear whether the reduction compromised the ability of medical groups to produce cost savings.
- The Pilot determined whether a medical group reduced ER visits or inpatient admissions by comparing the baseline period with the reporting period. Other methods of estimating the impact of the medical group's efforts exist, and it is unclear if the methods yield similar or different results.
- Another insight is that while medical groups are committed to medical homes and reducing ED visits, the PMPM incentives are not strong because they do not cover the costs of their ED-reduction efforts. This raises the question of what are cost-effective approaches for reducing preventable ED visits and inpatient admissions. A related issue is that when a medical group does not meet its ED performance target, repayment occurs by reducing the group's PMPM. It is unclear whether the reduction in the PMPM incentive will reduce the group's motivation or ability to reduce ED visits in the future.
- The growth of free-standing ERs may have undermined the Pilot's efforts to reduce preventable ED visits.
- The Pilot was designed for medium to large medical groups that could handle potential downside financial risk and had sufficient patient counts, and the Pilot's payment scheme may not be suitable for small practices.

In closing, payment reforms originate from different sources and different reasons. The Washington State Legislature authorized the Pilot, linking the payment reforms to prior legislation promoting patient-centered medical homes. This context raises important policy questions. Are payment reforms more successful when they are implemented in response to a legal mandate? A related question is whether collaboration among health care organizations is more successful when mandated by law versus when organizations coordinate care voluntarily. Does the structure of the payment incentive matter: are larger payment incentives that target the sickest, highest-cost patients more effective in controlling the level and growth of health care costs than much smaller payment incentives targeting large populations with a mixed risk profile of healthy and sick patients? The Pilot's results may begin to address some of these and other related questions.